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# POST-RETIREMENT HEALTH BENEFITS

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- Plan design
- Retiree eligibility criteria and premiums
- Controlling costs for pre-Medicare retirees
- Valuation of liabilities

MR. WILLIAM A. REIMERT: What I would like to do is go through a brief introduction for those of you who may not be familiar with what has been developing over the last decade in the retiree health areas. I will then provide an overview of the basic things that plan sponsors have been doing to try to modify their plans by scaling them down and to make them more affordable. Basically, the background here is that retiree health benefits are a type of benefit provided primarily by very large companies. If you look at the giants, probably 90-95% of them provide health insurance benefits to their retirees. As you get down to medium-sized companies the percentages drop off dramatically and the smaller companies haven't tended to offer this type of coverage in the past. Typically these plans provide coverage both for people who retire early, to bridge the period of time until they become eligible for Medicare, as well as after age 65 when Medicare is in effect. For those of you who aren't quite as old as I, you may not remember back in the mid-1960s when Medicare was enacted. Shortly thereafter a lot of companies started seeing that they could extend their health insurance to their retirees over age 65 for a very low cost. It cost $2, $3, or $4 a month to extend the coverage. It looked like a cheap benefit and at the time the economy was quite strong. So many companies felt that this was a nice benefit that could be provided to its employees and enhance the type of health insurance coverage that they had over age 65.

But quite a few things have been happening since then. Medical care costs have been the fastest growing segment of consumer spending for quite a while and they have been averaging 5-10% higher than the rate of inflation for probably the last decade or more. At the same time that medical care costs have been escalating rapidly, the federal government has been trying to control the cost of Medicare by holding down the amount of physician fees that it will reimburse. Since most companies offset what they pay by what's covered by Medicare, as the federal government cuts back on what it's providing, company costs have been going up. With the Catastrophic Medicare Act that was enacted last year, there is going to be a big increase in the amount of the coverage provided by Medicare that's being phased in this year and next year with Part A and Part B, and then with the drug benefits being phased in. But we also still see the same kind of phenomena going on in Washington. There are new budget proposals coming out of the administration involving curtailing reasonable physician reimbursements to cut back on the growth in Medicare spending.

On top of what's been happening with the growth of medical costs and the scaling back of Medicare, companies have been trying to reorganize and downsize and they are encouraging people to retire early. This has had a dramatic effect on the number of retirees. It has resulted in an increase of people under the age of 65 being covered under these programs. As you can imagine, before people are Medicare-eligible, the cost of providing health insurance is much higher than it is after they become eligible for Medicare.

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To add a little bit more fuel to the fire, starting in the early 1980s when companies started trying to cut back on their programs, retirees didn't like what the companies were doing and some retirees took their employers to court. I would characterize some of the initial court cases as being cases where judges would look very hard first of all at the legal document and then all the way down to exit interviews to see if there was some point where somebody from the employer made something that could be characterized as a promise. And if it found one, courts had a tendency to view what might have been just an exit interview comment such as, "don't worry, you have retiree health insurance for life" as being a legal enforceable contract binding the employer to provide the current level of coverage. Recently courts have been moving away from that a bit but there is still a tremendous amount of uncertainty about the extent to which companies legally can change their plan, whether it be for current retirees or for people already eligible to retire.

As a result, the Financial Accounting Standards Board started looking at the way companies were expending these plans which have been typically on a pay-as-you-go basis -- the same way they pay for the term insurance health coverage they provide to active employees. Recently FASB issued an exposure draft which will require companies to start expending for these benefit programs in a manner similar to what they have to use with their pension plans. For a lot of companies that is going to result in an increase in their expense charges somewhere in the neighborhood of three to ten times what they have been paying in the past.

Companies in the past have also not been funding for these programs. There is a selection under 401(h) that allows companies to set up accounts in a pension plan to provide for retiree health benefits. Those are not widely used and the IRS has not been very forthcoming and encouraging to employers who want to set up those accounts. In addition, there are voluntary employee beneficiary associations (VEBAs) in 501(c)(9) trusts. These have existed a long time but with DEFRA in 1984 Congress put severe restrictions on the deductibility of contributions and also imposed taxes on the investment income on noncollectively bargained VEBAs.

Treasury is concerned about tax revenue losses. That is what's driving most of the discussion in Washington these days on benefit matters. Politicians want to balance the budget and they are scared to raise taxes. So they go about it in indirect ways. Prefunding doesn't solve the cost problem and this is important to keep in mind in all this. What it provides is benefit security for the retirees. It is important to remember that what the Financial Accounting Standards Board is not talking about requiring companies to actually put the cash aside; it's only saying they have to recognize the liabilities and accrue them on their balance sheet. Whether you fund them is a totally independent issue.

Now what I'd like to do is just jump into some of the basic plan redesign options that some companies have looked at and I want to start off talking about what I'll characterize as a defined coverage plan or a defined benefit plan. A lot of the terminology in retiree health isn't very precise; people use phrases differently. But what I mean by this is the kind of plan that is provided to an active employee. The company defines the deductible, co-insurance, maximum out-of-pocket, lifetime maximum and whatever other inside limits might exist within the plan. Then it's an all-or-nothing coverage. Either the employee is covered under the plan or he's not covered under the plan. As a result of that, companies have an obligation to just pay whatever it costs to deliver that level of insurance, period. And so it's an open-ended, if you will, liability that companies have undertaken.

Some employers are looking at the existing types of programs and seeing how they can tinker with them and try to come up with some ways of bringing these costs more under control. Some of the things they are thinking about include varying the amount of coverage by length of service. (I have a specific example I would like to share with you on that.) Another possibility for change is to require contributions either for the basic coverage or for spouse or children's coverage. A third area would be taking a very careful look at how the plan coordinates with Medicare. I want to spend a little bit of time and get into that. It seems like sort of a boring technical issue, but there are lots of bucks when you take a look at it and there are a lot of people who weren't doing a very careful job of trying to control that. Companies are also increasing deductibles or trying to change the nature of their plans.

The first thing that I would like to spend a little bit of time talking about is varying coverage by length of service. This is based on a situation we went through with a client where they ended up doing something to vary the amount of coverage by length of service. The plan that we were

looking at for this client was what I would characterize as a fairly generous plan but it was not out of this world. It didn't have a $100 deductible; it had a $1,000 out-of-pocket max covering all employees who have retired directly from the company. No contributions were required from retirees. (For the actual client we worked with that's not quite true, but the contribution was so trivial that it's not worth talking about.) Full spouse coverage was provided still at no cost. There was no minimum service requirement at all for people who were going out at age 65. If you will, somebody hired at age 64 could work a year and get health insurance coverage for the rest of their life. And if somebody retired early at age 55, all he needed was ten years of service to get full lifetime health coverage for himself and his spouse.

When we started looking at this, we were trying to communicate, in this case to senior management, what was really going on. Graph 1 compared the relative value of the pension and the life and health insurance benefits provided to retirees. The first three bars on the left are going to represent the values of benefits provided to people retiring with ten years of service. The three in the middle are values of benefits for people retiring with 20 years of service. The three on the right are values of benefits for people retiring with 30 years of service. If you look at each of these graphs within each of those groups of three, the one on the far left is somebody retiring early at 55, the one in the middle is somebody retiring at 62, and the one on the right is somebody retiring at 65.

When you look at this, a couple of things just jump right out at you if you are an employer. Probably for decades you have been going out of your way funding a pension plan, spending lots of money, time and effort investing assets, getting actuaries and consultants, and trying to structure the plan so you have a sensible pattern of how benefits are accrued. And then you take a look at what's really been happening and where all the bucks are being spent for short-term people. The medical insurance plan is much more valuable than the pension benefit you are paying to people. And even for somebody retiring after 20 years of service, there is not much difference between them. You have to wait until you get to a long-term person before the pension plan is really the more important piece of what you are paying.

Now, if you are thinking we put a cheap pension plan on top of this, that isn't the case at all. For those of you who are familiar with pension plans, it is a 60% of final average salary, offset plan with every early retirement bell and whistle you might imagine. You can go out at age 60 with an unreduced pension, with a full temporary supplement bridging for the Social Security offset until you hit age 65 and automatic cost-of-living adjustments (COLAs).

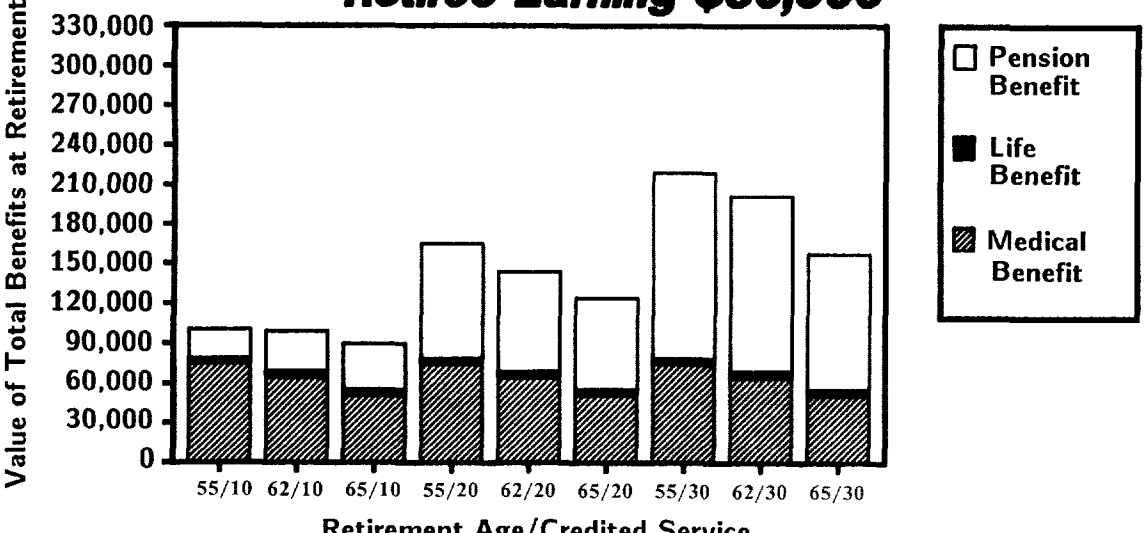
If you haven't really looked at one of these plans and you think these benefits aren't really all that big a deal, take a close look. And for short service people in particular, these benefits are probably at least as valuable, if not more valuable, than the pension benefits that they are going to get from an employer. So, as I said earlier, under this company at age 65 you get the full coverage. There is no minimum service requirement. If you retired early with ten years of service you could get full lifetime coverage at age 55.

This just doesn't make any sense. And so we decided it was worth figuring out a way of sharing the cost with the employee instead. Essentially the company decided that for people who retire with under ten years of service, they will make the coverage available to take advantage of group purchasing power, but the company won't, beyond that, pick up any portion of the cost of the retiree health benefits. It will just make it available, make the retiree pay the full cost. Once you put in ten years, the company will pay 20% of the cost; after 15 years the company's cost commitment goes up to 40%, and so on until reaching 100% after 30 years. There is nothing magical about this pattern. Some companies like to have the increment go up with each year of service. Maybe for every year of service you work, the company contribution goes up 4% a year. The client decided it wanted to have more discreet steps, it didn't want many little funny percentages floating around. They thought this would be easier to communicate and explain. There is nothing magical about the 30 years of service. Some companies have done things similar to this, providing what they consider full coverage for somebody with 20 or more years of service, or 40 years. For this company, this will not have a tremendous effect on their current work force because they used to hire a lot of people right out of high school. The typical employee was really a full career employee. That's no longer the case for them. So in terms of their current work force and their current liabilities, this arrangement isn't going to have a dramatic cost reduction in the liabilities for them. They really see it as something that will produce savings down the

# PATERNAL CORPORATION

## VALUE OF POSTRETIREMENT LIFE, MEDICAL AND PENSION BENEFITS

### Retiree Earning $30,000



road based on their current hiring practices and what they perceive those practices will be in the future.

I also mentioned that I wanted to talk a little bit about Medicare and this is sort of technical and boring. It's basic and if you go back and read any of the *Records* from prior Society meetings you'll see these things talked about for at least five years in sessions like this. A year ago I was giving a talk to a group of probably 75-100 companies. I started going through the importance of how you coordinate with Medicare and somebody stood up in the audience and asked how many people still do some of these old ways. I said I didn't know; I've never seen surveys on it.

So we took a poll. Well first of all, half of the people had no idea what they did, which is typical. But amazingly half of the people said they knew what they did. Whether they do is a whole other matter. But they said they did. So then we took another poll. And of the people who said they knew, over half of them were still using a coordination-of-benefits approach and under half of the people who knew were really using a carve-out. So while this stuff is boring and it's old and people should know and have been doing it for years, there's a lot of money involved and so I want to spend a little bit of time on it.

As an introduction, Medicare covers people over age 65. Depending on the kind of plan a company has, it might cover about 75% of health insurance costs for retirees. Plans have a lot of different ways of integrating with Medicare. I just want to talk about two different approaches as extreme cases. I'm going to call one coordination of benefits (COB) because many of you who work in health insurance are familiar with COB provisions in the health insurance plans; it really derives from that. I'm going to call the other one the carve-out approach. It's important, though, to realize that if you are working with a client on this, don't expect the document to tell you everything. The descriptive language in plans is often weak and lots of times you have to go down to the people who process the claims and figure out how they really do the arithmetic. But, having said that, what I'm going to call coordination of benefits is just having a plan that will provide the balance of whatever is not covered by Medicare, subject to a limit that it would never pay more than the plan would have paid if Medicare weren't paying for anything at all. A carve-out approach would go through the process of figuring out what the plan would have paid without Medicare and subtract whatever Medicare is paying.

Let me throw out a little example up here quickly and let's take just a hypothetical claim here. Somebody under age 65 went into the hospital, ran up total hospital, physician bills, drugs, etc., of $3,690. He's under 65, so he's not Medicare-eligible. In the plan at which we are looking, the employer would pick up $2,872 and the employee would be left picking up $818. We were working with a $100 deductible, 80% co-insurance plan. If at age 65 the employer continued the same plan but it coordinated with Medicare using a coordination-of-benefit approach, Medicare (after the insured paying the $560 hospital deductible and using a rough assumption of what might be considered reasonable physician charges) might pay about $1,780 of the total bill. So under a coordination-of-benefits approach you pay whatever Medicare didn't pay up to the total charges, but no more than the plan would have paid if Medicare didn't exist at all. Well, in this case the balance due is $1,350 and the retiree pays nothing. He gets full coverage and is in much better shape than either an active employee or somebody under age 65.

Under a carve-out approach instead you do the arithmetic by just taking the amount that is paid by Medicare and subtracting it from what the employer's plan would have otherwise paid. This puts the retiree back in the same position that he would have been in if Medicare hadn't existed. The point of this is not that coordination of benefits costs 2.5 times what the carve-out does. The point of this example isn't that this is a typical or expected value claim, but there is a big difference between these approaches. The exact cost difference depends on how big a deductible you have and so on. This is really a big item, though, and if you are either with a company or you are doing any consulting with clients, this is really an important area to take a look at.

Now, aside from this, and I went through a laundry list of what some companies are doing to reduce the cost for their plans, I should also note that people are using a lot of ingenuity in this area. I just read last night that Johnson & Johnson was working on a program that they hope to implement in 1990 or 1991 that will provide a catastrophic health insurance plan for retirees with a very large deductible, around $1,000, and a large out-of-pocket maximum. They are going to provide that to all their retirees so that everybody will have at least catastrophic coverage. They will then put in a plan to fill in under the $1,000 deductible. The company will pay for a portion

of that cost depending on the employee's length of service. So companies are trying to find their own approaches to try to continue to deliver a specific level of health insurance coverage and to control their costs.

But there are some other approaches that people have been using which are called either defined dollar or defined contribution approaches. Under a defined dollar plan, essentially what happens is that the company tries to transfer the risk of future health inflation to the retiree. It does this by effectively providing something that looks like a pension benefit. It provides only a specific dollar contribution toward the provision of health insurance. For example, maybe it provides a $500 annual payment toward retiree health. The retiree has to pick up the balance. What the employer is really trying to do is transfer the risk of future health inflation over to the retiree or at least limit the extent to which it is going to increase its cost commitment. While these benefits look like a pension benefit and can be put into a pension plan, they operate fairly nicely as part of a flexible benefit program.

Another alternative, and this is something that Pillsbury did, is provide a lump sum benefit to people at retirement. It has a formula to determine exactly how much money somebody will get based on their length of service and then the retiree has the option to convert it into a temporary annuity to age 65 or convert it on a lifetime basis or a combination of the two. He can either pick a single or joint life basis of doing it.

The other plan that I wanted to briefly mention is a defined contribution plan which is now transferring not only the health cost inflation risk just like a defined dollar benefit, but it also transfers to the employer the risk that poor investment results will limit his benefits. This approach limits the liabilities of the employer dramatically. In fact as long as he is making his contributions on time, an employer can't be in a position where he will have any unfunded liabilities.

MR. TIMOTHY R. GARMAGER: I am approaching the topic of postretirement health benefits from, perhaps, a slightly different perspective. As I am the only nonactuarial consultant on this panel, I will bring to my discussion a bias that I have with regards to health cost management: for an employer to control his costs, it requires what we call strategic health planning, a long-term planning process that is based on the individual needs of a corporation. Thus, the thesis that I am working off of is that employers who are reacting to rising retiree health costs should adopt a strategy that mirrors the goals and objectives of that employer and is tied directly to the corporation's overall business plan, human resource plan, and its culture. I can't overemphasize its culture. I am going to speak a bit about the need to plan for controlling retiree health care costs and some of the considerations and obstacles involved in that planning. I am also going to talk about different approaches and cultures that I've dealt with and with which I am familiar. Specifically, I'm going to talk about the Quaker Oats Company and Whitman Corporation, both based in Chicago, and the planning they did to control postretirement health costs. I think they represent distinct cultures and styles in how they handled their retiree health programs. Finally, I have some brief remarks about some future considerations in retiree health planning.

As you are all aware, most American companies have yet to develop, I think, serious long-range plans for their active or retired programs and they tend to react, of course, to the general marketplace and what other companies are doing. In typical fashion, as the Financial Accounting Standards Board (FASB) passes its exposure draft into the marketplace, employers are reacting to the retiree health costs and are watching to see how others react. I believe most employers who are serious about managing health costs, and who have been working with those costs for years, started thinking about their retiree health care costs long ago, and aren't simply reacting to the exposure draft today. I also believe that simply reacting financially to the FASB exposure draft, and focusing solely on the company's liabilities and attempting to reduce those liabilities over time, is not the appropriate response for every company.

Depending on its culture, a company may be very willing to accept an appropriate level of liabilities accruing on its balance sheets, and treat it as another cost of doing business in the manner that has made them successful. It is time, I believe, not only for companies to begin to look long term at how they are going to manage those costs, but how they're going to manage those costs in a manner that doesn't violate their corporate culture, and their long-range plan for human resource planning and retirement planning in general. I don't think you can separate a company's philosophy for retirement planning from its attendant philosophy for retirement health planning.

Pensions, and any other kind of deferred compensation plans, are tied integrally with where a company should be going with its retiree health program. We suggest our retiree health clients set some overall objectives and goals for the company. We ask questions like: Why are you offering a retiree health program in the first place? Or, why should you offer a retiree health program? Why are you offering a health care program for active employees, and should there be an extension of that program for the retired group? What are the employer's objectives and goals regarding the appropriate level of health care expense and reimbursement? A corporation's culture will very much drive whether or not the active employee or retiree should share the burden of these costs.

An employer, typically, does not seriously think about what its tolerance is for expense or risk, so we try to get those kinds of issues on the table and articulate the corporation's objectives and goals regarding how much expense it is willing to absorb and how much reimbursement should be given to the employee, whether based on a program that varies by years of service, or a program simply designed to protect retirees from catastrophic costs. We then focus on the sources of the highest health costs that the employer must tackle in their active or retired programs, and what can be done to control those costs in the next three, five, and ten years. For example, what's going to happen to Medicare? What's going to happen in medical technology? What's going to happen with the aging of the population? All these are issues that a company needs to deal with in its long term planning, as much for its business as for its health programs.

Finally, and most importantly, how does a company measure those changes over time? Most of the "knee-jerk" reaction that we have seen in the marketplace over the last five or ten years stems from borrowing the "best" ideas from other companies and adopting them, whether or not they fit the company's objectives, and discovering two or three years later that they didn't control costs a whole lot; and then, because they lack meaningful measurement tools, try to determine what real effect a particular cost management program had on their health costs. We stress very strongly in our long-range cost management process to put in place, today, those data analysis tools, or those data reports that are needed long term to continuously monitor where the program is going and where its successes have been. No business can control its expenses when it isn't continuously planning its long-range goals for health cost management.

There are several cost control solutions that have been alluded to regarding plan design, including sharing of the cost of health care with retirees and more directly managing the utilization of care and price that's provided to those retirees in the marketplace. Just as companies are trying to manage their active life health care costs, and have reached into the marketplace and have begun working with providers on delivering efficient and effective health care services (through managed care, HMOs, PPOs or other risk sharing techniques), they should similarly explore the managing of retiree health costs and potential prefunding for those expenses.

The issue of corporate culture is critical, as we will see when I get into a discussion of the Quaker Oats Company and Whitman Corporation. Looking at corporate culture is not easy. I can identify with both Quaker and IC Industries, which is now Whitman, because I was employed at both companies for a number of years managing corporate health care programs and benefit programs in general; so I understand their cultures and am able to draw the distinctions between the two. I think that the strategies they've individually adopted are illustrative of those cultural distinctions.

It is more difficult as a consultant to walk into an environment that you are unfamiliar with and try to determine what the culture is of that organization, but a lot can be said, and a lot can be derived from looking at their current benefit programs and spending a lot of time with management as well as middle-management, to determine where they have been in their benefit planning, where they intend to go as a business, how important human resource planning is to that business . . . whether it's a service industry or a manufacturing industry . . . where they see their population of employees going and the needs of that population. How do they want to appear to their employees? How do they want to motivate them? Issues of productivity should surface. All of these things are part of a corporate culture that will drive whether or not a corporation should maintain its current retiree health program, devise new ways of providing that benefit, or, eliminate those programs altogether.

Communication and education, to me, is critical to whatever a company does in its retiree health planning. An employee who has gone through a series of cost management changes during his career when covered under the active benefit program, should be reasonably prepared for what he

is going to be getting into when he gets into his retired years. However, most companies are still struggling with long-range retiree health communication. A lot of companies have retiree planning seminars for employees. I think, typically, we would like to see companies begin to educate their employees about retirement when they are in their 50s, including: what Medicare is all about; what it is actually going to provide to them; what the company is going to provide for them long term; and, how much the company is going to provide them either through reimbursement or through some other retiree health funding vehicle. I think employees are better equipped and better able to cope with the retiree health expense that they are going to endure, if they have been prepared for a long time by the company. Critical to planning is a knowledge of Medicare. As was mentioned earlier, a company doesn't want to provide an awful lot of outpatient incentive for the Medicare-eligible retirees, since inpatient care is more highly reimbursed under Medicare. However, if the employer believes strongly that outpatient care is less intense and is better for the employee or retiree long term, it may in fact provide generous outpatient benefits for the retiree, simply because of its cultural ethic or its philosophical beliefs about health care services.

## OBSTACLES TO PLANNING LONG RANGE -- LEGAL ISSUES

Several cases, ranging from contract law cases to collective bargaining constraints, define how much an employer can change the design of his current plan structure. It's probably less important (again, it goes back to my own bias) for an employer to deal necessarily with the program that he has in place, as much as what program he wants to have in place in the future. So, changing the current program is sometimes very difficult and employers have not been very good about conveying to their employees that they have the opportunity to change that program at a particular point in time. And, of course, as corporations by-and-large go through mergers, acquisitions, or bankruptcies, flexibility to change is becoming more and more constrained by law. The bankruptcy code, as you know, has changed in the past year, in response to the Ling-Temco-Vought (LTV) case that precludes employers, in bankruptcy, from eliminating their health obligations.

Retirees are very vocal -- another obstacle. Depending on the kind of corporation that you are, and changes that you put in place for your retirees, you typically will receive a very strong reaction, particularly if you are a larger company with lots of retirees. The most mail that Congress received in the last five years was received from retirees in the last several months regarding the premiums that retirees will have to pay on their Medicare catastrophic coverage. They are screaming! We have made some changes just in claims administration that affected retirees for several of our larger clients, and the group you always hear from are the retirees, because they are the ones who are using health care services the most and they're the ones who want reimbursement the quickest due to their fixed incomes. Any changes in the plan design will initiate enormous outcries by retirees. Again, it goes back to the issue of communication and education. As long as you keep your retirees informed about what you are doing and the cost that you are absorbing, the more reasonable the retiree might be about change.

## DIVERSE POPULATIONS IN GEOGRAPHY

Another obstacle to effective retirement health planning is geographic dispersion. Typically, retirees are all over the place, although you might be surprised with some from the major employers, how many of them stay close to home or to where they worked. So, trying to find effective solutions through HMOs or PPOs is quite difficult when your retirees are spread all over the United States. If they are spread in small populations all over the United States, it is very difficult to find leverage in the health care marketplace to effect any real cost management technique.

## UNION PRESSURES

We are currently helping a large client who is in the midst of negotiations with a major union. There is no language in the bargaining contract with regard to retiree health. Although retiree health is not traditionally bargained by the union, our clients are afraid to raise the issue of changing the current benefit program for retirees simply because that will potentially alert the union that this should be a bargaining issue. So, they would rather remain silent on the whole issue, hopefully make some subtle changes over time in the current retiree health program. A large number of unions, of course, have bargained their retiree health benefits and they have a very strong vested interest in those benefits. It is very difficult to get any kind of cost sharing through the union in today's environment. In the last two or three years, and what I perceive in the next two or three years in collective bargaining, there won't be any strong opportunity to alter or shift any costs to retirees when they are under union contract.

Finally, management's personal considerations, whether we like it or not, are a powerful factor in retirement health planning. Management has its own vested interests, mostly personal, when it comes to retiree health benefits that they expect to receive, and some of that will become more evident as I talk about Whitman and Quaker Oats.

**QUAKER OATS AND WHITMAN CORPORATION**

Quaker Oats is a highly regarded, well-known company that is over a hundred years old and has a very family-oriented structure; each employee is referred to as a Quaker. It provides (an overused phrase) essentially "cradle-to-grave" benefits. It has a typically very long-service workforce. I believe the average length of service at Quaker is over 15 years. Some of their employees stay up to 50 years until retirement. Their population is spread geographically primarily throughout the Midwest and East. They typically have a very strong, loyal, and vocal retiree group. They have always bargained retiree health benefits and general health benefits for the last 40 years and they gave away a lot of benefits back in the 1970s, as a lot of corporations did, in lieu of direct wage increases. They continue to provide very generous health care benefits, though now constrained by certain incentive programs and cost management techniques for the active population. By and large, their culture demands that the retiree continue as a Quaker in retirement. The company has directly and indirectly assured them that they will take care of high medical expenses, and thus they have put into place, in the recent two to three months, a defined contribution (DC)-like program for their retirees.

The interesting difference between what we've already seen demonstrated as a defined contribution approach (placing some defined amount of dollars in an account every year while actively employed) is that Quaker is continuing to maintain its current retiree indemnity program, so that the bank account that is being collected for those retirees will essentially be used to offset some of their premium costs, as well as deductibles and copays. So, the company continues to absorb the bulk of health care expense, and in particular continues to absorb the catastrophic expense of health care for the retiree. (Although it is capped, it is a fairly significant cap.) There was, I understand, little resistance from Quaker management for that program, as it seems a natural adjunct to their current programs and a typical Quaker-like program that fits neatly into their culture. The monthly premium for that program for retirees, by the way, is based on years of service and so is the contribution to the program. So each year a Quaker employee will get a flat dollar amount in an account set aside for him based on years of service ($12 currently for each year of service). Whether or not that amount changes over the years, I am not certain. Quaker's culture would allow us to predict that it probably will. Premiums can change, but there is a limit on the dollar premium increase that Quaker will put on its retirees, limited to 5% increase per year after 1991 or 1992. I don't know, since I didn't consult with them on the project, what kind of considerations they gave to long-term assumptions of cost. It implies, however, that Quaker is willing to continue to accept a good deal of that liability as time goes by. It is difficult to tell whether the bank accounts that are being set up will be enough to cover some of the catastrophic expenses or cover enough of the expense a retiree will have to endure outside of pensioned income. Thus, Quaker continues as it always has and its culture has always demanded to provide most of the expense coverage for its employees as well as its retirees.

Whitman Corporation, which was IC Industries until December, is a financially driven holding company; "financially" meaning "bottom-line-oriented." Their programs have been quite consciously designed over the years to encourage an entrepreneurial attitude among employees. In other words, they expect employees to plan for themselves, and therefore they cashed in pensions, 401(k) balances, and employee stock ownership plans (ESOPs) (plus the increasing value of the stock held in the ESOP) to pay their retiree health expenses. Whitman will no longer subsidize the retiree health program for future retirees and will only subsidize those who are in the grandfathered retiree health program. In a sense, it is forced retirement planning. It is very consistent, however, with Whitman's philosophy regarding the entrepreneurial employee and it very much acknowledges Whitman's culture. For Quaker and Whitman, their new retiree health programs, I think, very deeply reflect what kind of corporate cultures they represent.

My final consideration for employers is that demographic studies show we are going to have a dramatically aging population. I have already alluded to merging retirement planning with retiree health planning. Again, Whitman has merged that very neatly into one package. It is not just retiree health, but the whole issue of how we take care of our aging population over time. I think most importantly, companies must consider what kind of workforce we are going to have in the

next century. We are going to have an older work force, obviously, and probably a much shorter serviced workforce than we have today; that trend will continue. We'll have different reward structures for employees in the next century and it will require a good deal of nontraditional human resource and employee benefit planning. That planning should begin today. If I were to qualify the program which is probably more responsive to what may be needed in the next century, I think Whitman's probably is . . . as it probably prepares the employee more adequately today for handling higher health costs in the future.

MR. CHARLES E. DEAN, JR.: As Tim has pointed out, an employer should develop a philosophy of employee benefits, retirement benefits and retiree medical benefits. And with that philosophy, they can identify objectives to be met in providing retiree medical benefits, and then develop a strategy for meeting those objectives. As Bill discussed, that will involve a thorough review and potential redesign of the retiree medical benefits program consistent with the company's philosophy in order to meet their stated objectives.

If you think about it, companies should have been doing that all along. They should have done that 30 years ago. Did they? Practically no one did. It is only in very recent years we are starting to see this kind of activity.

Something's happening that is going to crystalize this, courtesy of the Financial Accounting Standards Board. FASB's Valentine present to corporate America is an exposure draft on new accounting treatment for these benefits.

It has been estimated that there is something like a $500 billion obligation for retiree medical in the United States. It is a huge number. The impact on large employers could be as large as 25% of net profit. This is an overall average of some of the largest companies and is certainly worse than that for some. FASB's new accounting treatment is a very major issue that will direct the attention of chief financial officers and other corporate decision makers to retiree medical benefits.

What I would like to do now is review briefly some of the high points of the exposure draft. I don't think we need to dwell on this and there is no way that anything I could say could be substituted for reading the exposure draft or some good analysis of it. We will then look at a case study with an actuarial valuation of this liability in accordance with the FASB rules and forecasting. What is going to happen to retiree medical expense and to the obligation over periods of time and their impact of funding?

An article in a business magazine late last year, "The First Thing We Do Is Kill the Accountants," described the forthcoming exposure draft on retiree benefits with a lot of scary numbers as to what this was going to do to companies. The key message is that there is a great deal of concern about this and that concern is going to translate into looking at the financial aspect of retiree benefits, and that in turn, is likely to trigger plan redesign as companies find out the costs and liabilities they have.

Our clients now think and have been acting as if the company assets and net worth belong to the shareholders. In reality, though, when they see these new numbers they will see that a good part of the company belongs to retirees in the form of the company's obligation to provide retiree medical and life insurance benefits. The basic problem can be summarized as there are more retired employees. They are living longer, they are consuming more and different medical services, the cost of those services are increasing faster than any other component of the economy, and the government is attempting to shift the cost of these services to the employer. Now we've seen a temporary blip on that tendency in the catastrophic coverage amendment to Medicare, but it's still anticipated that the long-term trend is going to force more and more of the cost of these benefits onto employers.

FASB's interest in this subject dates back to at least 1981. There was the discussion that ran along this topic, including pension accounting changes in 1982. In 1984 the issue of retiree medical and life insurance benefits, which at that time was called other postemployment benefits (OPEB) was spun off in order to facilitate the pension accounting statement. In 1985 Statement 81 was issued and is in effect today. It simply requires disclosure of what the cost of these benefits is and what accounting treatment was used.

Key ideas in this statement are to provide comparability, so that readers of financial statements can compare the costs of these programs on a reasonable basis. The dollar amounts are material and they shouldn't be ignored any longer. The proper way to account for them is on an accrual basis -- not cash, and there should be a matching of expense to revenue -- which means that the cost of this should be accrued during the working lifetime of the employee. Also, an important concept, and this is a philosophical debate, FASB says "Companies should expense for the benefits they are providing without regards to whether they have the legal right to terminate that plan or substantially modify it." In other words, you are expended for what you are doing, and the fact that you don't have an absolute legal commitment to continue with it indefinitely in the future does not change that accounting rule.

We have both pension actuaries and health actuaries here. I think the best advice I could give you is if you are a pension actuary, find a health actuary to help you with this; and if you are a health actuary find a pension actuary to help you with it as well, because the problem certainly has both aspects, and I think it's essentially an unsolved problem as to how to best treat this. In contrast with pensions, retiree medical and life insurance benefits have a much higher, relative cost for earlier retirement, because of the Medicare effect. The benefits are different. We're reviewing the design of these benefits, as Bill has pointed out. Dependent coverage is very common. Critically these benefits are fully indexed. How many companies provide pension benefits that are automatically indexed to the CPI or something that's the highest component of the CPI? I don't know of any, but companies do provide this automatically indexed benefit for retiree medical coverage. There is a great deal more uncertainty in estimating these numbers. We can make assumptions, but our certainty in the assumptions is much less in this area than it is for pension plans and the sensitivity of the results is very high, higher than in typical pension calculations.

FASB is requiring, or the exposure draft requires, that these benefits be expended in a pension-like way. There is a very close analogy between the requirements for postretirement benefits and the requirements for pension plans. Some of the terminology is even the same or very similar. The expense for a year is the result of several components. One component is called the service cost, which is like a normal cost in a pension plan calculation, but interest on the actuarial liability is less than the return expected on any assets that exist to fund this program, as long as those assets are segregated and legally dedicated to paying these benefits, not other types of benefits. To that is added amortization of the initial unfunded obligation plus amortization of any plan amendment effects, plus amortization of any gains and losses due to experience outside that defined corridor. The result of all those pieces is the expense for these benefits.

One of the starting points is the obligation as of the start of 1992 for the calendar year. This represents the present value of benefits for retired employees and for all employees who are eligible to retire and receive these benefits, plus a service proratable share of the present value of benefits for active employees. This service proration is usually just a straight-service-type calculation. But if the benefits are defined in such a way that they depend on service, the accrual pattern would be followed. This initial obligation is to be amortized over the working lifetime of the employees, where that working lifetime is limited to the age at which the employees are fully eligible for the retiree medical or life insurance benefit. As an alternative, the employer can use fifteen years for the amortization. I have an illustration here of how the calculation is made for an active employee with $20,000 present value of benefit. Multiplying by one year's service and divided by their total potential career, provides the service cost of $800. Multiplying their $20,000 present value by the ratio of past service to all career service provides the accumulated benefit obligation for actuarial liability, if you will, for this employee. And then that amount is amortized over fifteen years. One of the interesting effects, at least to pension actuaries, is that the service cost, or normal cost under the FASB approach, is accrued only up to the age at which the employee is eligible for full benefits. For example, if that would be age 55 there is a service cost up to age 54, but there is no service cost after that. There is an interest cost which represents interest on the actuarial liability, or accumulated benefit obligation, as it's called by FASB, and that would continue all the way into retirement, as would the amortization of any initial obligation. The disclosure that a company must make on their financial statements is very similar to the disclosure that is required for a pension plan. Its terminology is also similar but not identical. The additional items that must be disclosed are the health care cost trend rate that is assumed in the calculation, and there has to be a calculation of what the impact on the overall results would be. There is the actual expense for the year and the accumulated benefit obligation if that trend

cost were changed by 1%; so this is a kind of required sensitivity analysis in the accounting statements.

In making the calculations, certain assumptions are required that are similar to pension-plan-type calculations. A discount rate for measuring obligations, a salary scale which may apply depending on the provisions of the plan, and employee turnover are important. Retirement age is particularly important. It is more important in these kinds of calculations than it is in typical pension plan valuations. It's perfectly acceptable, generally, to use an average age in a pension valuation and some actuaries do that rather than use probabilities of retirement at different ages. But I think it is more important in these calculations because of the front load effect of the benefit obligation of those people who retire before age 65. So in doing this work, it would be important to have as much information as possible about the retirement pattern and actually use the pattern and not some sort of average age. Dependency status is needed and of course mortality. In addition though, there are other assumptions that are required that are not needed in a pension valuation. The incurred claim cost is the critical one and the trend of future claim costs is a vital assumption. There also must be implicitly or explicitly some assumption as to what is going to happen to certain kinds of provisions of the plan, such as deductibles -- things that might be expected to increase on a long-term basis in proportion with pay or with cost. And of course Medicare benefits must also be projected.

It's a real challenge to pick an assumption for the long-term trend in health care claim costs. One approach is just to look at what happened last year, the last two years, and what is projected to happen next year. Crudely, it might be anticipated that the increase in claims is going to be a very big number. It may be 20% for a particular plan. That kind of a projection, though, on a very long-term basis, is unrealistic and unreasonable. The kind of analysis that has been done is to look at the impact of long-term trends in medical costs compared with the GNP. For example, we are currently spending on acute care approximately 11% of the GNP. That would remain level if the long-term trend in medical claims cost is exactly equal to GNP growth. If the trend in claims cost is greater, the percentage of the economy that is devoted to health care will increase and the increases over a period of time are very sharp. For example, the 11% of GNP would increase 18% in fifty years if there were simply a 1% differential between the claims trend and GNP growth, and if there were to be a 3% differential you arrive at 44% of the economy being devoted to health care costs. This kind of analysis shows that in the long term you cannot make assumptions that are going to result in unreasonable percentages of the GNP being devoted to health care. Since that logically cannot happen, you've got to adjust your assumptions for some kind of reasonable result. This is probably a more productive way of choosing the long-term claim cost trend than trying to look at what's happened over a few years.

Another important assumption in the calculations is to recognize that the cost of medical claims is a function of age. This is partly a utilization issue, but there is a definite pattern that claim costs increase with age. Let me mention a technique that can be helpful here because often you will just not have the kind of claims data that you can use to prepare very exacting assumptions. One powerful technique is to look at the actual claims cost weighted by the number of retirees at each age table of age factors, and use that to adjust and create a new table for a particular plan.

One study that I'll mention was done before FASB issued the exposure draft. We are denoting it as the ABC company, but this is an actual employer. However, it anticipated most of the significant changes in FASB accounting. The steps in this study were to look at current benefit plan provisions, develop assumptions for forecasting future costs, obligations, assets, all the key measurements of the program, the current liabilities or obligations of the retiree medical and life insurance program, and forecast cash flow expense and the accumulated benefit obligations. To do that, based on several alternative scenarios (optimistic, pessimistic and best estimate), the next step was then to develop something that does not automatically come from the new accounting treatment. That is what is the long-term level percentage of pay that will actually support the plan and eliminate the timing effects of the new accounting treatment. Finally, look at funding alternatives for this plan.

For this particular plan, which is quite generous, before age 64 about 70% of the cost is actually provided and paid for by the employer plan, and after age 65 less than 25%, or about 20% of the cost is paid for by the employer.

The assumptions that were used in this forecast were to look at three levels of inflation; low, best guess and high. In this case it was 2.5%, 4.5% and 7%. These are numbers selected in part by the company, so certainly they would sign off on these. Another kind of demographic assumption similar to what's used in the pension plan was a medical cost trend assumption on a best-estimate basis of 8% with a 1.5% differential for Medicare representing cost shifting. It was also assumed that the key plan feature, such as the out-of-pocket maximum and the deductible and life time maximum would be adjusted or indexed to the medical claim cost trend. The discount rate used was 9%. Now this forecast is a forecast of an open group and we'll see that in a moment. It's assumed that the total population of the company would be increasing by 5% a year for a few years and they would be level thereafter.

The long-term inflation under the best-estimate scenario was assumed to be 4.5%; additional medical inflation on the longest term basis was an extra .5%, plus 3% more for the effect of technology and the increase in utilization over time. So the total medical cost trend was assumed to be 8% on the very long-term basis, and 1.5% less for the cost shifting of Medicare.

The pay is assumed to be increasing by 6% under this assumption and effectively a GNP level would be on the order of 6% or 6.5% nominal rate.

The differences are very significant, and the results are sensitive under the low, medium and high scenarios for the value of the present value of benefits for retirees and then for all of the employees as a whole. For example, the impact of the 1% decrease in the discount rate, everything else remaining equal, is about 9% for retired employees and about 35% for active employees. For this particular population, about 65% of the present value of benefits is related to the employees currently under age 50. Based on the assumptions used, the best-estimate assumptions, the relative present value of benefits for employees of different age groups can be determined and it ranges from $8,600 for employees under age 50 to $25,000 for retired employees under age 65, who are not yet eligible for Medicare, and $11,600 for those retired employees who are eligible for Medicare.

Now this being an open group forecast, we are forecasting what is going to happen to the employee group. In this particular case, the number of employees was increasing from slightly under $50,000 to more than $63,000 over a twenty-year period with the increase concentrated in the early years. The percentage of the retired employees who represent the active group is increasing very substantially from 13.8-25.7%. So this company was going to see more and more retirees over this period of the forecast. The first item that was projected would be the actual cash flow from benefit payments, and separate calculations were made for medical benefits and life insurance. These amounts are projected over the twenty-year period based on dollar amounts, and then related back as a percentage of pay. The increase in the cash flow requirements for the retirees' medical plan over twenty years was from .4% of payroll to 2.8% of payroll under the high assumptions scenario, 1.2% under the medium, and .6% under the low assumption scenario. Now with this information, the expense under the FASB rules can be calculated; for the medical and life insurance components looking at the retiree medical component, the service cost was about $18 million interest was about $19 million and amortization was $14 million for a total expense of almost $51 million. The cash flow in the same year was about $6.3 million, so there is a very high multiple between what the company would be expending before using the new accounting treatment and what they would have to expense afterwards. There is a multiplier of about 8 and when forecasting the expense as a percentage of payroll over the twenty years it increases from 4.1-7.4%, compared with the cash requirements of only .6% of pay to 1.4%. Now one thing that is notable about this kind of forecast is that we have an expense that is much higher than the cash requirement. Ordinarily you expect this kind of accounting difference to reverse. This is verified in other studies, and I haven't seen an example where they do reverse other than a closed group of retiree projections that were done. This is a very important concept, and something that I think we need to realize, and that employers need to be advised of. There is a long-term and perpetual distinction between the higher expense under the new accounting treatment and what their cash requirements will be.

Now in the forecasting, of course, you are developing all of the key items that are shown by the Financial Accounting Standards Board of the accounting treatment. Something that is not part of the accounting treatment is a concept that is referred to as a target cost. It's actually calculated as two different amounts; it represents the level percentage of pay that would have to be set aside or accrued in order to meet a long-term targeted obligation at the end of the twenty-year period. It

was some measurement of the economic liability of the plan and if this number is calculated using the same 9% discount as is used for FASB calculations, 2.3% of pay on a level basis would be needed to meet that funding target, which is substantially less than the expense developed under the new accounting rules. So, it can be argued that if all assumptions are met, these new accounting rules will front-end cost compared with the long-term percentage of pay that is actually required to maintain the plan. A calculation was also made of the target cost with no interest discounted at all, 0% discount, and that required 4.5% of pay. Finally in this particular study there was a comparison of the prefunding alternatives. Those that were looked at were 501(z)9 funding and 401(h) pension-type funding through the pension plan. Our key differences are the limitations on these two approaches and the fact that the investment earnings in the 501(z)9 trust are subject to income tax where they are sheltered under the pension plan account funding.

We'll illustrate forecasting of a funding method with 401(h) pension-plan-type funding using a projected unit credit approach and 9% of investment returned; 8% medical cost trend, 6% pay increases plus merit scale and amortization over thirty years.

The funding requirements range from 2.8% of payroll dipping down slightly and then coming back up to 2.9% of payroll at the end of twenty years. This is a very different pattern of expense because now the plan has assets, now there's an expected return and an offset to the overall expense of the plan, so the balance sheet accruals for this company are going to be much smaller, and in fact by the end of the period, the contribution on this basis is almost exactly equal to the expense. This particular calculation did not include the effect of any 25% limit; it was assumed that the full amount could be funded on this basis.

I should mention to you there is a private letter ruling that came out on March 23, regarding 401(h) plan arrangements and if you are interested in that topic this ruling can be described as being very favorable. It answers the question that a lot of us have had about what happens to a 401(h)-type arrangement if a pension plan is at the applicable funding limit and the company cannot make a contribution because it's not allowed. In the private letter ruling, which of course is supposed to apply to those particular facts and circumstances, although they seem quite general in nature, the answer was there would not be a limit to the contribution that could be made for the retiree medical benefits. That contribution would be 25% of the cost of the pension and the cost would be determined on a projected unit credit cost basis with assumptions written into the document independently and without regard to a full funding limit.

MR. JEFFREY P. PETERTIL: On this new private letter ruling, and what it has opened up in the way of 401(h), it does maintain as always with 401(h) that the medical plan is subordinate to the pension plan. Does anyone have any idea what that means as far as vesting requirements? Is there any speculation on that?

MR. REIMERT: Well, if you want speculation, I can give it to you and that is that there isn't a vesting requirement. My answer is just that -- speculation. I don't know of any vesting requirement because this is not the pension benefit; it is an ancillary benefit and there is normally an eligibility requirement that you want to have for those kinds of benefits.

MR. HARRY L. SUTTON, JR.: First of all, has anyone looked at the long-term trend of interest rates for discount purposes versus medical inflation rates? When I do it, I tend to have an inflation rate slightly higher than the interest rate, but I honestly don't have any long-term look at what the trend of ongoing interest rates is relative to the medical inflator or projected claim costs. Whenever I've seen discount factors being used that are higher than the medical inflation rate, I tend to think the costs are going to be estimated on the low side, at least the way things have been lately. A twenty- or forty-year trend might be different.

Second regarding IC Industries not providing any retiree benefits and letting the people save 18% of income or something like that, I have a client who doesn't have a retiree plan past age 65 and they offer an employee-pay-all plan, so at least retirees could get the administrative costs paid for. But, only about 50-60% of the retirees buy it and the costs rose sharply, probably due to the antiselection for those who were willing to pay the premium versus those who weren't. Not offering a vehicle for retirees to have coverage and pool their experience like through an employer group or some other mechanism, or pushing them on buying medi-gap policies (which I don't have an awful lot of brook for), seems to me they're still leaving the employees out in the

cold unless they provide a mechanism and almost force them to universally buy coverage through some kind of a pool which they sponsor even though they don't pay any money except maybe administrative costs.

MR. GARMAGER: This is in response to the second point; it's a very good point. One of our clients, another Chicago-area client, is putting in a second defined benefit program to cover its retiree expense and a much smaller pension benefit than their main program. They are not providing any kind of vehicle for the employee to buy into when they retire, eliminating completely the retiree health program. Compare that to the Quaker program, again accepting the risk long-term because it's maintaining its indemnity program for its retirees, and that cost will continue. So while some companies are trying to walk away, others are maintaining it.

MR. REIMERT: I'd like to address the first question, but just one other comment: I mean, some companies are trying to walk away and some companies are trying to address it and some companies are trying to get the federal government to take it over, which is what the auto strategy seems to be these days.

On the first point, I didn't do anything exactly as you described, trying to look at the relationship between discount rates. The way we looked at it was per capita, trying to get a per-capita growth in health care cost. I really wonder what would come out of it if we did. Say you just went back to the turn of the century -- which is what we do in looking at per-capita health care cost growth and what was happening to GNP. If you go back, the most common economics statistic on discount rates and total returns and so on, are Ibbotson-Sinquefield data, which go back to 1926. I think the world was so different back then. You see it just looking at asset return numbers. But try to think of what was happening during the depression, when discount rates were down in the 2% area, and in fact, return on short-term money was negative, I believe, for a while. Think of what was happening in the growth of health care costs at a time when insurance wasn't available, and think that somehow we can extrapolate out of periods before certainly the 1950s, when companies started providing health insurance, or the 1960s, when the federal government got into the act and started throwing more money at doctors and hospitals. I have some doubt about trying to look at that data and using it to extrapolate what's going to happen in the future. Also trying to get carried away of what's happened since the 1960s up until now when companies, employers and the federal government have been throwing a lot of money at the people who provide health care services in the form of insurance or Medicare or Medicaid. Trying to extrapolate what's been happening in the last 20 or 30 years and thinking it's going to continue, I also think is really dubious, which may be just a cop-out way of avoiding what might be a very valid analysis.

MR. DEAN: Let me make a plug for Bill's book. The 1989 EBRI book, *Retiree Health Benefits: What Is the Promise?*, has some well-thought-out examples and models and it addresses specifically this point of the long-term trend in claims costs from the standpoint of looking at the GNP. I think you've got to hinge on that because it is very fundamental to the economy. The whole cannot be greater than the sum of its parts. You cannot spend more than 100% of what you produce on health care. In fact, it has to be limited to some reasonable amount that the population will stand for. So I don't think looking at short-term effects is the appropriate way to pick these long-term assumptions.

On the other hand, if you start making the comparisons year-to-year, it's just nothing but scary. You may want to look at the kind of analysis where you're saying that your claims trend is going to start out much higher and grade down to something that could be supported in the long run, and that's probably what's going to happen in the real world. You've got an issue doing valuations -- some kind of a practical issue -- do you want to use secular rates that vary or do you want to try to approximate it with a single rate on a long-term basis?

MR. GERALD R. SHEA: I was interested by the open group projection which showed the expense soaring off into the heavens while the cash requirements stayed more or less level. I think you mentioned that the workforce was assumed to be growing, and I was wondering if you get the same kind of result on a more stable workforce projection. Have you done that kind of calculation?

MR. DEAN: Yes, that is a very good question. In the particular example, the workforce was growing but only for a few years and then it was level. The results really didn't depend on that. That was not the significant factor. In more projections you're going to see exactly that. It almost

takes an extreme case to not see that -- to see an actual crossover. The only time I have seen it is for a closed group of retired employees where new active employees were not going to receive the benefit, and even then it was out when the crossover occurred. So I think it's a very real effect.

MR. REIMERT: I think what you're saying is that under the FASB rules, as the liability is growing, if the plan is not funded, every year an interest cost is charged under the plan. That may sound ludicrous but if you think about it, if a company is not funding its plan and it could, it's retaining the cash inside. Certainly the stockholders hope and pray that money is being invested and earning a return. So when you think about the net bottom line, although the expense charges look really weird, if the company is retaining the cash internally, somehow the return on that investment should be flowing through to the bottom line. So you should expect that this expense charge should have to be shooting up to offset it to get to the same net operating gain that you would get if you took the money outside and invested it and earned a comparable rate of return. Now that ignores tax effects and pretends that what you earn internally is similar to what you could earn in a trust and those are very dubious things, but I think it's the investment thing that is driving that.

MR. DEAN: Bill's point is absolutely correct for the pay-as-you-go forecast. In the very last forecast, where we had funding, the two lines came almost together, that was assuming we had no 401(h) cap and pure pension-plan-type funding with no tax on investment income.

MS. FESHBACH: Yes, I was just thinking that if you had started your forecast with a plan that was funded at this point, that you might get crossing or get something that looked a lot more like a pension plan.

MR. THOMAS M. MALLOY: I was just going to throw two cents more into that discussion. Another thing that is happening in your forecast with a growing population and your inflation assumptions is you've got an additional artificial growth here which is putting off the point of crossover. I find it useful to take your results and discount it to real dollars rather than the nominal forecast inflation dollars. Your results start to fall back into where you would expect to see them, and so your basic overall inflation assumption exacerbated by the high medical trend rates tends to put off the point of crossover because you're just building and building and building.

MR. SUTTON: I would think part of this would be that you've got a population that isn't mature yet. With a mature retiree population, maybe it would close out after 20 years. But your example has an active population growing for ten years, but the retiree population will be growing for 30-40 years so you don't have a constant retiree population for another ten years beyond your projection. I would think that if the inflation and the discount were the same at some point, the present value of the cost would be constant for the total retiree population.

MS. FESHBACH: That's an interesting point. Chuck, you didn't tell us whether, except for this expected growth in employees over the next five years, you had already attained a stationary retiree population. I'm guessing not and Harry is guessing not.

MR. DEAN: No, it wasn't. I just want to emphasize the power that is in that relationship -- that is: you don't fund. It wasn't the fact we had a group that was aging -- that wasn't the key driving force -- it was the nonfunding. And this interest effect was not really drawn on a dollar basis. We're looking at real effects and they are surprising. They're not what the CFO is going to expect and they're not necessarily what an actuary expects until you actually do a bit of it. But there is something quite strong -- there is a very strong effect in there and it's due keenly to the fact that we may have a benefit that's on a pay-as-you-go basis. This benefit is indexed and you've got the claims trend factor. So, with no assets and an increasing benefit, and this particular way of accounting that has the interest cost built into it, you see a pattern that's just nothing like a typical pension plan pattern of asset and liability forecasting.

If you start to fund the plan, then the world changes a lot. Now, the cycle will close at the end of the existence of the corporation but on some of these forecasts, you're led to believe that the thing it would take for the expense line and the pay-as-you-go funding line to cross would be bankruptcy or liquidation of the company, or cycling down to a very low level of activity. Other than that, if things are even in a steady state, you never see a crossing.

MS. FESHBACH: Or at least these aren't going to happen while these are our clients -- maybe our children's clients.

MR. REIMERT: I'd like to turn the tables and ask a question. I don't know how many of you have read the announcement about Ameritech setting up a VEBA. At least in the "Getting the Jump on FASB Ameritech Starts Retiree Health Fund," *Pension and Investments Age*, (February 20, 1989, pp. 1,47) article, they talked about having done some projections, and if I remember correctly, within the next ten years. Their projections indicated that the average duration of those liabilities is four years as opposed to the average duration of the pension liabilities. The explanation I've been able to dream up for it is that for some reason in the next ten years they're expecting a tremendous number of people going out at 62-63 years old with a tremendously expensive plan before Medicare eligibility, and then a sharp cut-back. Is there anybody who is familiar with that plan or who has done those sorts of projections and can add anything to that?

MR. DEAN: I can't add from lack of knowledge but by projecting early retirees you might wind up with a projection that the average length of coverage prior to retirement is four years depending if it's humped toward 62-63. But it would seem to me that would ignore the liability past age 65.

MR. REIMERT: Yes, and it seems to me with the kinds of trend assumptions that most of us are using (which is close to the discount rate or certainly not very far below it) even though there is a sharp drop at age 65, then for the remainder of the life expectancy, there is additional payment . . .

MR. DEAN: I agree. It's weird. Another possibility is that since they have to comply with DEFRA, maybe they're saying it's an inadequate funding that is going to run out very quickly because they can't put inflation into DEFRA, so that may not have anything to do with reality but rather with DEFRA.