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POST-RETIREMENT HEALTH BENEFITS: EMPLOYER AND EMPLOYEE VIEWPOINTS

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- o Discussion of the practical problems involved in evaluating post retirement benefits
- o Case study illustrating the differences between employer and employee viewpoints

MR. DAVID B. TRINDLE: I am a consulting actuary with the QED consulting group. Our panel will focus on evaluating retiree health benefits in an environment of conflicting employer and employee perspectives. The panel will present a real-life case study illustrating some of the practical considerations that face actuaries in this type of situation. We are privileged to have three fine panelists: Gordon Trapnell of Actuarial Research Corporation, Dan McCarthy of Milliman and Robertson and Steve Meskin of the Martin E. Segal Company.

The subject of retiree health continues to get increasing public attention: In February 1989, FASB issued its exposure draft aimed at establishing accrual accounting for retiree health benefits. It would require that retiree health be treated as deferred compensation for accounting purposes. As such, benefits would be considered an obligation to be recognized on the balance sheet based on services rendered.

Recently, the first round of public hearings on the FASB exposure draft was held in New York. About 60 organizations and companies testified. The testimony focused on the hardships that would be created for employers. The National Association of Accountants (NAA) was one of several groups calling for FASB to allow more time to gather information and to implement the new accounting procedures. They felt the burden would be especially difficult for smaller companies. Also, their organization has commissioned a study to determine the "enormity" of the problems. Continental Can asked FASB to extend the implementation dates by at least two years because of the "monumental task" involved in compiling historical and cost data.

FASB has received about 500 letters on the proposal, including many from companies seeking ways to lower their liability under the new rules. The next round of public hearings is scheduled for November 2 and 3 in Washington, DC. FASB plans to present its final draft sometime in 1990.

The financial impact of FASB on the employer is dramatic:

- o Experts have estimated the total corporate liability at $0.5-1.0 trillion. This translates to $25,000-50,000 per covered worker.
- o On an ongoing basis, the accrual could shrink corporate profits by as much as 25% every year.
- o Company debt-to-equity ratios would be increased, possibly causing the companies to violate terms of their debt agreements.
- o Because of restrictions on the recording of deferred tax benefits, a portion of the accrual may not receive any tax benefits for financial statements.
- o At this point, there are limited provisions for current tax deductibility of corporate contributions to prefund retiree health plans.

- The impact of FASB on an employer's financial status would depend heavily on the employer's plan and demographics of the group. Some companies will be hit much worse than others.

Employers are taking action to reduce the liability:

- More than one-fourth of employers have made changes in their retiree programs within the past two years. Another 10% plan to make changes before 1990.

- In a survey of large employers conducted by the Washington Business Group, 47% of respondents described themselves as "very committed" to providing retiree health benefits, whereas 50% were "committed only to the point where program costs are not excessive."

  -- The survey also showed that FASB would triple the average retiree health benefits cost from 2.5-7.9% of payroll.

  -- Fifty-one percent of respondents said they would probably reduce health care coverage for current and/or future retirees should FASB require a balance sheet liability.

  -- Forty percent of respondents plan to switch to a "graduated benefit plan" based on years of service. Fifteen percent plan to switch to a defined contribution plan. Other plan reductions mentioned are as follows:
     - Increase years of service required for eligibility
     - Switch to a defined cash benefit to be used to purchase coverage at retirement
     - Increased deductibles
     - Elimination of dependent coverage
     - Managed care and wellness programs

- A recent survey of multiemployer plan trustees showed that 55% have already taken specific measures to reduce the liability. Another 25% anticipate similar changes in the next few years.

- Several large employers have already taken action:
  -- Ralston Purina announced that after a transition period it would stop subsidizing medical care premiums for future retirees.

  -- The Whitman Corporation also said it would no longer subsidize medical care for future salaried retirees.

Retirees are increasingly taking action to protect their benefits: In August, salaried retirees filed a class-action suit against General Motors (GM) seeking to restore health benefits that the company had reduced last year as part of a massive cost-cutting program.

I will read the specific statements made by each side because they so clearly describe the dilemma of retiree health:

- The suit charges that GM violated ERISA by failing to establish and maintain a planned program of lifetime health benefits. It charges that GM broke a promise to provide those benefits at no cost to retirees or their spouses. According to the group's lawyer, "The point of our suit is to show employers that when they made promises of long-term health care as an incentive to keep employees, they can't later renege on those promises under technicalities in the federal law."

- GM representatives see it differently: "We are confident we have not disadvantaged our retirees. Benefit packages change with the times. If they didn't, many of our long-time retired employees would have considerably fewer benefits than they had at the time they retired... the GM salaried retiree package is among the very best of the Fortune 500 companies."

Traditionally, courts have ruled in favor of companies' rights to amend retiree health plans when the rights were clearly outlined in a plan document: In overturning a lower court ruling on a class action suit, an appeals court said American General Corporation could alter retiree health care

benefits because plan documents state it has the right to make plan changes. The right to cut retiree's health care benefits -- if spelled out in plan documents -- preempts "oral statements" participants may have received.

Retirees of Grand Trunk Western Railroad failed in their class action suit against the company for increasing cost sharing on their health plan. The court ruled that pension benefits are protected under ERISA, but health benefits usually are not.

The developments in the field of retiree health present a challenge to the actuarial profession. Over the past few years employers, employees, politicians and lawyers have gradually become more attuned to the enormous liability incurred in providing retiree health benefits. The FASB debate is a reflection of this and has, itself, further heightened the awareness level.

The financing of retiree health benefits is emerging as an important social and political issue. As employers face the ever-more-immediate impact on their financial results, the situation promises to become even more volatile.

The actuarial profession is on the forefront of this issue. It must approach the problem from a position of knowledge and integrity. The reputation of the profession will gain or lose from our performance in this extremely visible area.

We are going to have both a general discussion of employer/employee issues and a specific discussion of an actual bankruptcy proceeding that our three panelists have played roles in. Our first speaker, Gordon Trapnell, is president of The Actuarial Research Corporation, a consulting firm located near Washington, DC. Dan McCarthy is a consulting actuary with Milliman & Robertson in New York City. Dan is on the Board of Governors of the Society and currently serves as treasurer of the American Academy of Actuaries. He has been involved in several retiree health valuations related to bankruptcy proceedings. He will introduce the case study and provide some insight into the actuary's role in representing the employer's viewpoint. Steve Meskin is vice president and senior health actuary with the Martin E. Segal Company in Washington, DC. He serves on the Retiree Health Committee of the Actuarial Standards Board (ASB), the Society's Education and Examination (E&E) Committee, the Academy's Health and Welfare Committee, and is currently the Chairman of the Health Section Research Committee. Prior to joining Martin E. Segal, he served as the chief Medicaid actuary for the Health Care Financing Administration (HCFA). In the Spring 1987, Steve presented the SOA seminar on Retiree Benefits. He recently published an article in *Compensation Benefit Management* on Medicare catastrophic coverage. His firm represents both employers and employees in cases involving retiree benefits. He has provided advice and expert testimony in four class action suits involving retiree benefits. Steve will explain the views of the retirees of the Allis-Chalmers plan. He will describe the actuary's role in representing the employee viewpoint.

MR. GORDON R. TRAPNELL: The case history that is going to be presented involved establishing the value of the claims of retired workers to post-retirement health insurance in a bankruptcy proceeding. It was brought to my attention by two colleagues, each of whom has referred some business to me, who were representing opposing parties in the legal proceedings to resolve the claims of creditors of the bankrupt company and were looking for an arbitrator if they couldn't agree on the value of the claims of these employees.

This struck me at first as a "Mission Impossible" because I expected them to be miles apart on most of the important actuarial assumptions, given the different perspectives that they represented. On one side was the representative of the corporate owners and creditors, who wished to minimize the amount of the available assets that would be diverted from paying creditors' and owners' claims. If they had to actually pay for the services involved, their position would be similar to that of an employer funding a pension plan, (i.e., he is liable for future benefits promised and wishes to make prudent provision for them). This is the perspective of the pension actuary in advising an employer concerning amounts that are prudent to set aside and deduct from present reported earnings to fund pension benefits. The crucial question is what a prudent businessman would do, which is neither the highest amount that may be needed nor the most optimistic, but something in the middle, perhaps with an eye to everything that might go wrong. (I always like to think that one of the most distinguishing features of the actuary compared with other social scientists is that the actuary prepares to be wrong; the one result that he regards as a certainty.) In recommending a method of valuing liabilities, pension actuaries describe a range of possibilities and recommend

a degree of conservatism in taking into providing for them. This perspective leads to setting assumptions that are in the middle range of those possible, perhaps the maximum likelihood of the Bayesian distribution of possibilities.

On the other side was the advisor to the employees, whose position was fundamentally different. From the perspective of the employees, the amount should be such that payment for the benefits promised would be assured beyond a reasonable doubt. The position of the actuary representing the employees is that of a fiduciary and more like that of the valuation actuary, who has the task of determining a reserve basis that assures that the funds are adequate to actually pay the benefits. This position implies a much larger degree of conservatism than that of the prudent businessman who can adjust the funding path if events show the value assessed to the liabilities is insufficient. The retirees cannot adjust if the money runs out.

Given these fundamental differences in perspective and the very different degrees of conservatism implied, I thought the parties could never agree on the assumptions required. Further, the actuarial assumptions needed involve some of the most difficult and controversial areas of actuarial practice. At the heart of the problem is the expected rate of increase in the cost of health care for decades into the future. Those of you who have worked in health care know how impossible it has been to forecast with any accuracy for a year or two, much less 20 or 30 years. When faced with this sort of controversial assumption, my expectation was that one actuary would extrapolate the rates of increase over the last 10 to 20 years to continue indefinitely into the future (implying an ultimate proportion of GNP devoted to health care in excess of 30%) and the other to insist that the U.S. would not be willing to let the proportion of GNP devoted to health care to rise above some relatively reasonable magnitude such as 15%. Either position could be correct within what is really known about the future of health care costs in the U.S.

Further, over this span of time there could be similar divergence in other crucial actuarial assumptions. The interest rate used to value the claims has a dramatic impact on the present values. Changes in the Medicare program that shift costs to private payers could well occur in view of the looming funding crisis in the Hospital Insurance program. Mercifully, for all concerned, the work was completed before the passage of the Medicare Catastrophic program, so it was not affected by the expansion or current movement to curtail it.

I guess you might think that one would have to be crazy to accept the responsibility of arbitrating a situation like this, because it is highly likely that he would make at least one and perhaps two colleagues angry. (I may still manage that if I keep talking.) But it sounded like an interesting experience, and the one thing that I have really feared since my first year in the insurance business as an actuarial clerk calculating settlement options to ten full digits was boredom. Further, with the prospect of more and more of this type of dispute being settled by arbitration, I thought it would be beneficial to get the insight into what is involved that only experience can give.

The most important variable to be considered is the proportion of GNP that will ultimately be devoted to health care. There are really two questions: How far and how fast? How far doesn't matter if it is far enough into the future. For a closed group of individuals to whom certain benefits have been promised, 40-50 years should do it. If the group consists entirely of retired employees, most will be dead within 20 years. But if there are substantial numbers of young employees, there may be many still alive and using services after 75 or 100 years with the continuing decline in mortality rates.

There is a school of analysis that claims that it is not reasonable to project a continuation of health care inflation at the present rate since ultimately the entire national product would be devoted to health care. This logic has a very familiar ring to it. When I arrived in Washington and wanted the Social Security Administration to project hospital costs to rise at 4% per year beyond the increase in average wages (the average rate at which hospital costs had risen since World War II) for the full 25-year projection period, I was told that this was impossible for the same reason. Since hospital costs could not rise indefinitely at a rate higher than wages, it was assumed that future increases beyond wages would be limited to 15%.

The problem does demand an analysis of what the world would look like if varying percentages of national product are devoted to health care. For each ultimate percentage, there would be a corresponding limitation on other flows of goods and services, and an implied national

input-output matrix. But to my knowledge, despite the urgency and importance of this problem, no one is analyzing what these flows would have to be to see what sorts of sacrifices would have to be made in other aspects of national life to judge whether the pressures involved are highly likely to lead to measures that would constrain the cost of health care.

Such analysis, as I have seen, involves arbitrary dates on which costs are not allowed to rise further, except perhaps for demographic changes. For example, if the rise for other reasons besides basic inflation and the aging of the population were to end in the year 2000, the proportion of national product would be around 15%, and ultimately would rise to around 19% by the year 2025. This is the basis of the projection by Dave McKusick that underlies the projections of future health expenditures by the Office of the Actuary in the HCFA.

Other groups looking at this problem have reached still higher percentages. A Coopers and Lybrand presentation to the Conference of Actuaries in Public Practice included alternate projections that ranged from a low of 19% to a high of 35%, with a consensus estimate of 25%. It is important to recognize that these are exercises in the manipulation of numbers without any accompanying analysis of the feasibility of the economic and social environment that is implied. But the absence of thorough analysis does not give much comfort to an actuary whose responsibility it is to make a projection that involves this type of estimate as an important parameter.

I also recall with great discomfort the arguments presented by economists and other social scientists that the proportion of the GNP devoted to health could not rise above 5% or 6% since the dislocations to the economy would be too great. (One particular influential advisor that I remember, who was the Social Security Director for the AFL-CIO, claimed at a meeting of the Health Insurance Benefits Advisory Council of the Social Security Administration that the pressures on resources would "make geniuses of hospital managers" since they would have to produce all those hospital services we projected for the aged with the limited income that the tax bases would make available to them!)

Another observation is that Medicare has continued since its inception to grow at a rate 3-4% in excess of the cost per capita in the nonaged population. (Aging by itself can account for only 1% of this.) This may simply reflect that between Medicare and Medicare supplements, this is one of the most comprehensively insured groups in the population, and that a rise of this magnitude should be expected as a result of the insurance. It may be just what should be expected to occur under our present system of paying for health care in which the providers decide what is needed and how much it should cost.

At any rate, it seemed impossible to me that my colleagues would agree on either the how far or how fast questions. From the perspective of an employer providing for the funding of such benefits, the prudent course would appear to be that the HCFA projections would be a reasonable basis, and that if after five or ten years it had not slowed down, then it might be reasonable to project a somewhat higher percentage.

But from the perspective of the employees, provision for at least the Coopers and Lybrand intermediate scenario of 25% by 2025 would be demanded for prudence, and to be really safe, an ultimate of 30% or more would be required. So I thought they would never agree.

Another actuarial assumption involved that always leaves me schizophrenic is the interest rates to assume in the longer run (after 10 or 20 years). When I project from the perspective of a prudent businessman providing for the future, I expect the interest rates to rise on the average over time, reflecting the inflationary implications of the huge burden of paying for the social insurance programs, unfunded governmental pension programs, interest on a growing national debt, the huge and rapidly growing budget debt and other hidden liabilities (e.g., savings and loan losses), and perhaps long-term care. I have a hard time envisioning how this can be paid for without an Argentine or Brazilian inflation rate, and hence sharply higher interest rates. For those interested, I suggest looking at the reports made by John Wilkin and myself on work done for the Subcommittee on Social Insurance in which we tried to add up the obligations of the federal social insurance programs; it came to a total of 33% of payroll or 22% of GNP as measures of their eventual cost -- without a federal long-term care program. Thus, it is difficult to believe in lower long-term interest rates.

On the other hand, when I have to put on a fiduciary hat for some specific beneficiaries, the implications of a drop in investment income are so catastrophic that one winds up projecting a decline in interest rates. Further, the U.S. insurance industry has survived periods in which many companies were really near insolvency as a result of depressed interest rates, and the memories are still embedded in the collective experience of actuaries.

An intermediate perspective is given by the observation that the term structure of interest rates implies what short rates are going to be in the longer run. For example, the rates available on zero coupon bonds with 25-year and 30-year maturities imply the precise rate at which a 5-year zero will sell in 25 years. How can an actuary representing a fiduciary interest argue with the pronouncements of the marketplace? The present term structure implies relatively constant interest rates around 8% for three decades to come. In fact, the liabilities for each future year could be invested in zeros of the appropriate duration, thus removing all investment risk.

The relevant variable for the retiree health costs is, of course, not absolute or even real interest rates but the interest rate relative to the average cost of health care. Since the inflation rate is a major component of each, there is some offset for the problem at hand. But the correlation between inflation rates and either interest rates or health care costs is not smooth and predictable. Further, the historical relationship depends on what period is averaged, and each period includes events that are unlikely to be repeated. The future, of course, will have its own nonrecurring events, for which nothing in the past provides a basis for forecasting.

Still another variable that really worries me in making projections of retiree health care benefits is the stability of the Medicare program. The twisting fate of the Medicare Catastrophic program has highlighted the possibilities. But this is just the latest and most spectacular revision to the program in a process of annual ominous changes through "omnibus" bills. Each of the annual reconciliation bills has contained literally dozens of amendments to the Social Security Act that have revealed that the Congress will make most any type of change that seems expedient for political or budgetary purposes, without more than a superficial examination of the consequences. The passage of the Catastrophic Act itself, with the income tax surcharge on higher-income aged to support benefits primarily enjoyed by other aged, and a large transfer of financing responsibility from employers to taxpayers, was itself a monument to ineptitude that has led to an entirely predictable revolt by the prospective taxpayers. The point here is that the actions of the Congress over the last eight years have demonstrated that no feature of the Medicare program can be counted on to last beyond the next Congressional budget crisis.

Further, some of the prospective changes would have the direct and intended effect of shifting cost to private insurance programs. For example, in response to the query, "How can we get more money from employers to pay for part of the cost of Medicare?," I personally advised budgetary officials in the Department of Health and Human Services (DHHS) concerning how to capture up to $500 per claimant from employer-sponsored group programs (a proposal that quietly died this time around, but that may well be resurrected if budgetary pressures are great enough). (I would like to add that I am not in favor of such modifications to Medicare for reasons of equity, stability and efficiency. But I have not noticed that budgetary officials involved in the process that leads to many of the middle-of-the-night-from-nowhere amendments that appear in reconciliation bills are motivated by these considerations. Worst, most are ill-informed of the consequences of proposed changes and few seek advice from those who could advise.) Thus, I am not sanguine about the Medicare program continuing to pay over future decades the same share of the services typically covered by employer programs that it presently does.

MR. DANIEL J. MCCARTHY: Gordon mentioned that in the case that I will describe, he was the person agreed upon by both sides as the actuarial arbitrator if the two of us were not able to agree as to assumptions. He also mentioned that he expressed surprise subsequently that we did manage to agree. I will tell you that one of the things that perhaps lurked in the back of our minds as we agreed was that Gordon insisted at the outset on clarification that if, let us say, on a particular assumption or the entire range of assumptions one party was at point x and another party was at point y, Gordon was not to be bound by x and y. He reserved the right to be outside either end and that scared the heck out of both of us, and that was perhaps a factor among others in causing us to reach agreement.

I'm going to set a framework of the case study that we are talking about. I will then give a brief background of two prior cases that shed some light on it in one way or another. I will also talk a

little bit about some of the various interested parties, including one that hasn't been mentioned yet, and I'll discuss some of the assumptions that we debated. Steve Meskin will pick up on that latter topic. The case in question was the bankruptcy of the Allis-Chalmers Corporation. The bankruptcy was filed as of the end of June 1987, and the process was completed 18 months later at the end of 1988 which, by the way, is a very rapid time period for a bankruptcy process of that type.

Before I discuss Allis, I want to talk about two predecessor instances. One of them is particularly relevant, because as Steve pointed out to me in our preparation for this session, many of the same parties were involved advising one or another entity. That was the earlier bankruptcy, about 1980, of the White Motor Corporation. One of the interesting things about the White Motor bankruptcy was that a case grew out of it called the White Farm Case. This was a case in which a court held that a promise, in a collective bargaining agreement to provide benefits that appeared from the wording of the agreement to carry beyond the period of the bargaining agreement, was a valid promise and could be upheld. Thus, in White it became clear as a result of litigation that those people had a promise to a benefit. Furthermore, it became clear in that case that the nonbargaining employees of White were protected in effect by what I'll call a "me too" clause. That is to say, the company had operated for years on the clear understanding, pretty well communicated in its literature, that it would treat salaried employees the way it was treating bargaining employees in that regard. So that in White there was an issue at first as to whether coverage existed in bankruptcy, and it was resolved that it did.

In Allis that was not an issue, partly because of the White precedent. A third case that I will refer to along the way was not bankruptcy related and has one other difference which is also important. That case is the breakup of AT&T. In the breakup of AT&T and the establishment of the regional holding companies, there was an agreement in the documents that set the stage for that breakup. The agreement stipulated that retiree health care costs (and retiree life insurance costs for that matter) for existing retirees would be shared over future time by AT&T and the newly formed entities in prescribed ratios as defined in the agreement. The agreement went on to say that if actuaries working for the two parties could reach agreement as to the present value of those benefits, then those present values would be the basis that would be used for the sharing and the whole thing would be resolved. If they could not agree then the sharing would take place as the actual cash costs of those benefits materialized year by year. This is different from the bankruptcy situation; in the case of a bankruptcy, the court has an obligation to establish the value of the claim of each creditor and one way or another one must get to a number.

In the AT&T instance there was always an escape hatch; there was no pressure to get to a number because there was an alternative, and so, although the difference between the parties as a percentage based on the detail estimates of each was no wider than in the bankruptcy cases we are going to be talking about, the gulf was never narrowed. In a bankruptcy, on the other hand, you have to have a number, even if it takes an arbitrator to get that number. Let me turn now to the interests involved. The interest of the employer has already been mentioned, but of course in a bankruptcy, particularly where it's anticipated that a bankruptcy will be followed by liquidation, the interests of the employer and the shareholders whom the employer represents are not quite as persuasive as in the ongoing situation. Those people aren't going to get any money anyway. Another interested party or collection of interested parties is the other general creditors -- in bankruptcy, bondholders for example. Every dollar by which the retiree claims are increased is just more liabilities into the pot and hence a lower settlement, and consequently fewer cents on the dollar for the bondholders. So the general creditors have a very important role in this process.

In fact, we first became involved in the White bankruptcy because we were retained by the general creditors. They feared that representatives of the employees would state an inflated claim and that the employer had no particular reason to oppose it. Therefore, the general creditors retained an actuarial advisor in their own interest. The same thing happened in Allis along the way. So, there are interested parties who will come into play in bankruptcy who would not necessarily be present in the same way in an ongoing situation.

Now there are really two issues once you've got the parties lined up. The first is, What is the value of the claim? The person is a claimant just like a bondholder or anybody else. What is the value of that claim? The perspective is not that of, let us say, a valuation actuary who is trying to set provisions that will, with some high percentage of probability, be sufficient as regards the obligation. In law I am told (I'm not a lawyer but all the lawyers tell me) no matter which side

you are on, the objective is to get your best estimate. That is to say to arrive at a number which will with 50% probability or on a mean value basis discharge the obligation. So it's a somewhat different perspective from trying to arrive with a high degree of accuracy at an amount that will be sufficient with regard to the discharging of the obligation. Another thing that is different from the pension funding example that Gordon mentioned is that here what ultimately will happen is that one number will be fixed and if there is money awarded that's all the money that will be awarded. There will be no ongoing contributions to be made. There will be one lump sum of money awarded at one point in time and that is it. That causes me to turn to the second issue that arises in a bankruptcy of this sort.

In theory, each of these retirees appears before the court as a separate creditor and that person has an entitlement, unless the court decides otherwise, to the present value of his or her own claim. (In fact, in White, calculations were actually done to determine those present values for employees of different ages and dependency situations.) Now the court may well decide, and in the cases we are talking about here the court did decide, that a fair way of dealing with the situation was not to make individual awards but rather to tell those employees that their entitlement in bankruptcy would be received by them if and only if they elected to join a trust fund. Money would be given to the trust fund which would provide benefits for the employees. As we will see, one of the things that happens is that some employees do that and some don't and there is always some question, in contemplating the benefits that the trust fund will provide, the extent to which you should handicap for that ahead of time.

So we have two different issues -- how to establish the value of the claim at bankruptcy and what happens afterward. I'll come to the "what happens afterward" later, but let me turn first to the value of the claim. In the case of Allis-Chalmers, there were essentially two agreements reached among the parties. The first one set out a very broad framework in which claims would be calculated. It defined, for example, different subdivisions of employees. There were different unions involved, United Auto Workers (UAW) and United Steel Workers of America (USWA); there were salaried employees; there were employees who were employed by subsidiaries with vastly differing benefit plans, etc. So it was agreed that all of these people would be placed in any of six categories referred to in some of the notes you'll see as "stipulation groups" because they appeared in the stipulation to that extent. Calculations would be done separately for each of those groups. That initial stipulation also prescribed an "as of date" as of which calculations would be done and would be effective, and it further said that calculations would be done on the basis of the Medicare program as it stood on the "as of date." That was something that became very significant as we went on.

The agreement was written before the Medicare Catastrophic proposal became law. The "as of date" was after the Medicare Catastrophic proposal became law. The difference in this case was approximately $100 million; that is to say, in the final numbers we came to, the present value was estimated to be $550 million for all benefits before Medicare Catastrophic and about $450 million afterwards. It also caused a lot of scrambling when the Medicare Catastrophic provisions got cast into law and Steve and I and others spent a lot of time arguing about niceties and how to make these adjustments.

I think it's helpful to talk now about some of the assumptions shown on a document that some of you may have received. This is a copy of a public document (Figure 1) in the Allis case, and it is a matter of court record. I want to talk about a couple of the assumptions that are made here and I want to talk about them not so much from the point of view of their substance as from a point of view of process. Take mortality first. We say we will use a 1983 group annuity (GA) table with probabilities of death multiplied by various numbers, and if you look at some of those numbers particularly for hourly retirees it may strike you that those scaling factors applied to the 1983 GA look very, very high. With this assumption, as with many, the process of resolving differences began on kind of an iterative basis. We said, "Well, we think it's probably in the nature of x," and Steve or someone else would say, "Well, we think its probably in the nature of y."

Of course neither of us had any evidence and so that naturally led us to say, "I guess we ought to do a study." In cases like this, where large amounts of money are involved, typically every effort will be made, and data will be provided and a study will be performed. The factors that you see here resulted from a detailed mortality study and I think it is correct to say that at least for hourly retirees these factors were outside the original range of "guesstimate" that we made and that Steve and his colleagues made; in short, it turned out that being an hourly employee for

FIGURE 1

AGREEMENT AS TO ACTUARIAL ASSUMPTIONS
FOR COMPUTATION OF THE PRESENT VALUE OF
AMOUNTS DUE FOR POST-CONFIRMATION
RETIREE BENEFITS WITH RESPECT TO
ALLIS-CHALMERS CORPORATION

1. Mortality:

Starting level: the 1983 Group Annuity Table, with probabilities of death multiplied by:

for salaried employees and their dependents and surviving spouses: 1.2, for ages 65 and under,and 1.1 for ages 90 and over, with linear interpolation for intermediate ages.

for hourly retirees: 1.65 , for ages 65 and under, 1.55 at age 75, 1.45 at age 80, 1.3 at age 85, 1.1 for ages 90 and over, with linear interpolation for intermediate ages.

for dependents and surviving spouses of hourly employees: at each age, a factor which is the mean of the "salaried retiree" factor at that age and the "hourly retiree" factor at that age.

Future adjustments for mortality improvement:
In accordance with Projection Table "H" as published in Transactions of the Society of Actuaries Volume XXXV(1983).

2. Interest or discount factor.

9% per annum, net of investment expenses. Claims assumed to be paid 3 months after the date incurred.

3. Medical Claim Assumptions:

Starting level:

Calculated, separately for each of the following categories, as the ratio of incurred claims for the period September 1, 1986 - August 31, 1987 to the claims that would be expected for the same period using the population (determined as of March 1, 1988, but using ages as of the experience period) and the claim costs set forth in the Milliman & Robertson, Inc.Health Cost Guidelines. The categories are:

FIGURE 1 (CONTINUED)

Medical-dental-vision coverage for each of the five "stipulation groups", separately for persons 65 and over and persons under 65 years of age.

"Par" prescription drug coverage in the aggregate (most of this coverage is applicable to stipulation group (i)).

NOTE: Incurred claims for the indicated period were determined as the claims incurred during the period and processed prior to December 31, 1987, multiplied by the following "completion" factors:

for "under 65" claims: 1.092
for"65 and over"claims: 1.200

for "par" drug claims, incurred claims were taken as those estimated by the claims processor, Aetna Life & Casualty Company.

Adjustments from the experience period to the projection period: The per capita, age-specific claim rates determined as above are adjusted for overall inflation trend(but not for aging) and for Medicare deterioration by applying the following multiplicative factors:

	Factor for period indicated	
Coverage category	3/1/87-2/29-88*	3/1/88-2/28/89*
Medical,under 65	1.18	1.143
Medical,65+	1.16(1.175)**	1.138(1.153)**
"Par" drug plan	1.16	1.138

* The periods indicated represent the midpoints of experience years.

** The figures in parentheses, which are the ones to be used in actual calculation, provide for the effect of Medicare Part B deterioration.

Effect of aging: The age scales of the Milliman & Robertson,Inc., Health Cost Guidelines are to be used; the pattern from age 77 to age 82 is to be extended through age 85; at that point, the annual factors are graded down linearly so that the factor representing the increase in cost from age 90 to age 91 is 1.01; the 1.01 factor is used for all higher ages.

FIGURE 1 (CONTINUED)

Other adjustments during the projection period:

Basic trend factors and Medicare Part B deterioration factors: as shown in Schedule A, attached.

Adjustments for the effects of maximum benefits, deductibles, out of pocket maximums, and drug copayments: reflected based on projected claims distributions, using the Milliman & Robertson, Inc., Health Cost Guidelines, after the other increases (for general trend and for aging) are applied.

4. Administrative and insurance company expenses:

9% of incurred claims in each year.

5. Retirement age.

Persons eligible for retirement but not actually retired as of the calculation date are assumed to retire as of the confirmation date.

Thomas D. Levy, MARTIN E. SEGAL COMPANY

Daniel J. McCarthy, MILLIMAN & ROBERTSON, INC.

David Hirschland, UAW SOCIAL SECURITY DEPARTMENT

SCHEDULE A
TREND FACTORS BY YEAR

DURATION	MEDICAL		DENTAL	PRESCRIPTION DRUGS	DETERIORATION IN MEDICARE PART B
	UNDER 65	65 & OVER			
1	10.40%	11.00%	8.40%	11.00%	1.50%
2	10.45	11.15	8.60	11.15	1.50
3	10.50	11.30	8.80	11.30	1.50
4	10.55	11.45	9.00	11.45	1.50
5-23	10.60	11.60	9.20	11.60	1.50
24	10.28	11.08	9.16	11.08	1.20
25	9.96	10.56	9.12	10.56	0.90
26	9.64	10.04	9.08	10.04	0.60
27	9.32	9.52	9.04	9.52	0.30
28 and later	9.00	9.00	9.00	9.00	0.00

Allis-Chalmers was hazardous to your health. So as that process went along we next debated mortality improvement, and ultimately picked a scale. Interestingly, I have been told by SOA's Research Director Mark G. Doherty that it has turned out, over the past few years at least, in the Society's studies, that group pension mortality is improving at a more rapid rate than projection table H. The study will be available in the context of some materials that the Society expects to circulate over the next year. In any event, that was the best we had to go on at the time and we picked it. I'm going to skip the discount factor for the moment and come back to that. You have to have a way, assuming you have starting claim costs, to project for aging into the future. Our firm has a set of scales that we've developed over time and we naturally said we think those are the right scales.

Not unreasonably, other people who hadn't participated in those developments said, "Well, what makes you think those are the right scales?" and that led to a study again. Get the claims, age by age, divide them by the expense, age by age, do a bunch of calculations, and see what happens. In the end we concluded that, except for some grading that needed to be done at the highest ages, those scales were adequate. There is a reference to a 9% interest rate, and in schedule A, there are trend factors that relate to that 9% interest rate. We did in fact focus, as Gordon indicated, on the fact that the relationship between the two of those factors is more important than either one. If you go through the calculations, as we did over time, to look at health cost as a percentage of the GNP implied in these numbers, it turns out that we tracked out through the year 2000 at the Social Security estimates. That is to say, at about 15% of GNP, and we wound up with an ultimate number between 17% and 18%.

For a group of retirees the ultimate ratio is less significant the further out you go as Gordon pointed out, and there was some debate as to whether we should or should not scale down to a fixed percentage. We finally concluded that it didn't matter very much and that we would do that. The ultimate came out to be somewhere between 17% and 18%. The schedule also has the provision for deterioration in Medicare part B that was something we felt we had to deal with. In fact, Medicare part B has intended to cover consistently a lesser and lesser portion of medical fees over time and we could agree on that; then the question is, What deterioration do you assume and how long will that be allowed to continue and how do you phase it out? Here one couldn't do a study; it is just a question of exchanging estimates and trying to figure out what they mean and working down finally to a bottom line. What we arrived at is that we did not assume any deterioration in the Medicare part A. As was mentioned previously, these factors have a lesser significance when you are talking about a group all of whose members are retired or retirement eligible than they do for a population which includes active employees.

Both in the case of Allis-Chalmers and the other two cases I mentioned, if you take all of the detailed assumptions that the two groups of advisors have developed at the outset, do a calculation, take the average, and then look at that average and say, "How far are those two separate numbers from the average." The answer is that they'll tend to be perhaps 10-15% away in either direction. On the other hand, if you do this for a population of active employees as well as retired employees and take into account variations in assumptions about turnover and assumptions about retirement age, which is the most important single assumption, your range in variation will be far wider. I have seen calculations which differ by a factor of six or eight.

One of the things that happens in these numbers that I want to point out in particular is that it heightens what Gordon said about not mattering too much what you assume in the very long term; that is, that a very sizable portion of the total present value that we are talking about here occurs between the current ages of these people and age 65, at which time they become eligible for Medicare. A very, very high portion is the pre-Medicare portion of the entire cost and that will run off during a relatively small period when you have a group of people who are already eligible for retirement. In the case of White, for example, after that bankruptcy a trust was established and, in fact, that trust still exists. Most of the people who entered are now older than 65 years and our estimate of the future liability for that trust as of today in constant dollars is less than .33 of what it was when the trust was established eight years ago and we had to deal with a very sizable pre-65 portion of that cost.

That will bring us back to the final thing I want to mention which is this question of what happens afterward? As I said the first goal is to get a present value which enables the court to make an award in bankruptcy. Now since the essence of bankruptcy is that there aren't enough assets to cover the liabilities, that award will not be sufficient to provide those retirees with

benefits of the type that they have previously been promised. In the case of White the settlement was about 40% on the dollar; in the case of Allis-Chalmers it was closer to 20% on the dollar, so at that point you have to develop a new plan of benefits and inevitably you will need contributions of some sort. Since there is money there, by and large, that will be a better plan of benefits for the dollar than somebody would be able to go out and buy. Issues of cross subsidies become very important. To what extent do you favor the persons younger than 65 years who are bearing the greatest burden of cost because Medicare isn't there? To what extent do you look at the long term? How do you balance concerns about overall generosity now versus overall generosity 25 years from now, because there is no more source of money other than altering member contributions as you go along? These are very difficult issues to deal with in a trust of this sort.

Two things happen that are important. First, as I mentioned, a surprising number of people won't join; particularly among the younger eligible people. I assume that some of them get other jobs and that some of them have duplicate coverage. I don't know the reasons for all of them. We attempted to study that in the case of White, but in any event the fact is that many of them will not join. Now they were in the population for purposes of calculating the present value so if they don't come into the trust you have a fudge factor to work with there. The second thing that happens, and the dynamics of this become very important as you go on, is that one of the things that is driving the cost is that you are dealing with a closed aging population which means it is really good if you can get some of those people into a pool which is freshened by other lives. In the case of White, for example, the trust has campaigned actively to get those people to join HMOs and to subsidize heavily from the trust their participation in those HMOs. Because you are then operating on the bases of community rates that aren't driven by the aging of this closed group alone, but rather by a group that will be freshened over time. The leveraging of that phenomenon is one of the things that have made the White trust work over a long period.

I think that covers most of the things that I wanted to talk about; Steve is going to talk about a little more of the process that led to some of the exploration back and forth and some of the verifications that went on in the process. As Gordon said, we had to reach agreement or else Gordon was the arbitrator, so we did reach agreement on the settlement basically and explaining to people that this is what it is going to be and working with it. Representation by competent unions is very helpful when they have been brought into the process so that they will go out and sell it to people. Also, the former senior executives of the company who are now retirees are often very convincing with the nonorganized retirees.

MR. STEPHEN A. MESKIN: When it comes to health care, retirees want their benefits to remain unchanged. They feel they deserve them -- regardless of how costly they are to provide. As a result, the actuary's first task when dealing with retirees in litigation is to tell them how much it will cost to preserve their benefits and, after they pick themselves up, explain to them why it will cost that much. And, that's no easy task.

Usually, retirees are represented by a committee and a lawyer who have been certified by a judge to represent a broad class of retirees. The committee may contain retired former executives, senior professionals and union staff people who were previously involved with employee benefit issues. However, the committee may also include professionals who are not familiar with employee benefit issues, e.g., a patent attorney. Moreover, the committee will usually contain and may be composed entirely of rank and file former employees. In the Allis-Chalmers bankruptcy case, the committee included all of these.

No matter who they are, the committee members are going to be deeply interested and involved, not only for their own benefit, but also for the benefit of their friends and acquaintances and all the retirees and widows who call them at home at all hours of the day and night.

Once the actuary has explained to the retiree committee why the cost of preserving benefits is so high, it is then the lawyer's and/or the accountant's task to explain to the committee why there may be a reduction in benefits. These are issues which revolve around the profitability of the company, the value of the company's assets and other liabilities and case law. They are issues upon which we, as actuaries, are not qualified to give advice.

It is important that the lawyer and the accountant have a lot of trust in their actuary. The actuary, to build up that trust, may want to provide the lawyer or accountant additional, more detailed explanations. I have found that the lawyers who get involved in this kind of litigation

are very smart, they ask good questions and they often make useful suggestions which may improve the validity of the valuation. Their suggestions on how to work with the retiree committee and the professionals hired by other parties to the litigation are also useful.

The second main task of the actuary, in these circumstances, is to help the retiree (hereafter when I say retirees I mean the retiree committee and their lawyer) evaluate alternatives. These may be company proposals of a cash settlement or a reduction in the company's contribution. The retirees will want to know what benefits the settlement will buy, how much they will have to contribute to preserve their benefits, and how the value of the new company contribution compares with the old.

The actuary will also be called upon to evaluate proposals by the retirees. If a proposal involves retiree contributions increasing over time, the retirees will want to see how high the contributions might be at various points in time and the corresponding expected number of retirees.

Since the actuary will probably be more familiar with alternative plan designs than the retirees, he or she may be relied upon for benefit design suggestions. It is important, however, to be very sensitive to the wishes of the retirees. It is far better to discuss a number of alternatives with them and get their feedback than to come in with your own solution no matter how brilliant it is.

From my experience, the main concern of retirees is access to health insurance for the rest of their lives, even if they have to pay for it. After that they are interested in minimizing near term changes, especially in their own contribution level. The rationale for some retirees is a hope that eventually their needs will be taken care of by the resolution of the National Health Care Crisis. Others think that they don't have very much longer to live. Our task here is not to decide what is best for the retirees, but to help them decide. And that process, the retirees' decision-making process, takes time and cannot be rushed. It is important to keep in mind that the retirees have to live with their decision; we don't. The third task of the actuary, because of his or her experience with health benefits, is to evaluate the benefit details of proposed settlements. Here, it is important to make the retirees aware of things that might be missing from a proposed settlement, e.g., a provision for a grace period for the retirees' contribution, or which party is responsible for run-out claims. The actuary might point out provisions of the agreement which are beneficial to the retirees and which are not. For example, which party gets the benefit of retirees' dropping coverage if retiree contributions are implemented or increased.

This is not a process which relies heavily on actuarial calculations, but rather it relies on the ability to understand the benefit aspects of a legal document and knowledge of employee benefit plans. Because of this, the actuary may be asked to draft or revise language for the proposed settlement. The actuary may even get directly involved in negotiating some of the benefit issues, and if a settlement is reached, he may assist in its implementation. Thus, the actuary may serve the retirees as a general consultant on health benefit issues.

In other circumstances, the actuary may get involved in calculations unrelated to benefits. With Allis-Chalmers, a very complex method was proposed to distribute the proceeds from asset sales. We modeled it for the negotiators. Another task was to write a program to help prepare bills for retiree contributions, which included optional life insurance. Dan McCarthy described how we came to an agreement with respect to the assumptions and the methodology which was to be used in the valuation. When it came to actually doing the calculations, we explored the possibility of saving the client some money by relying on Dan's firm to do the calculations. It was also felt that if the calculation were not contested, it would add to its acceptability by all parties. The retirees, however, wanted us to certify that the calculations were done correctly. The question was how to check that a calculation has followed the methodology and assumptions, as we understood them, without redoing that calculation. How do we check so that we can certify that the calculations were done correctly? One member of the retiree committee was very suspicious and we had to try to satisfy him.

Clearly, it wasn't sufficient for us to check their test cases. We had to do something more. We took a number of steps. First of all, we had to have a copy of all the data that were going to be used so that we could check anything we wanted. Second, we made sure that the initial number of lives were correct by category. Third, where it was easy to do, we redid the calculation. Fourth, we made rough estimates to see if the numbers they came up with were reasonable. Finally, and most importantly for our certification and for the very suspicious member of the committee, we

went through what I will call, for lack of a better term, a reverse checking process. We started where they finished and worked our way backward step by step. At each step we asked for details and selected, sometimes randomly, sometimes intentionally, a few pieces to check further. In this process we worked our way back to the starting point along quite a few paths. There were a few points where our understanding differed from theirs or where they had to use judgment. We discussed these and after a few minor modifications were made, we were satisfied. We certified the calculation; the suspicious member accepted our approach, but I'm not sure if he was totally satisfied.

In terms of the technical issues, the main goal was to determine the present value as of September 1, 1988, of retiree life and health benefits. For voting purposes, we also had to determine the present value per retiree or surviving spouse for each of the five subgroups: UAW, USWA, salaried retirees prior to March 1982, salaried retirees after March 1982, and all others. When an employee retired, his or her health plan was frozen. The salaried retirees were split into the pre-March 1982 and post-March 1982 groups because on March 1, 1982 the company had changed from a base plus supplementary major medical plan to a comprehensive major medical plan and the deductible had been increased over time. The computation for each group was done in the following steps: adult medical; adult drug; adult dental/vision; handicapped children; other children; surviving spouse contributions; HMO enrollees; a subsidiary with a substantially reduced benefit level; not yet retired but eligible; soon to be eligible; outside board members; life insurance; part B contributions; retiree contributions; a contested subsidiary; and expenses.

The calculations were done on an incurred basis and an adjustment was made to compensate for the claim lag.

Within each of the five groups there were a number of plans. Expected claim costs were developed for each group separately for those younger than 65 and those older than 65. This was done using manual rates by age, sex and plan. The expected claim costs were compared with the corresponding actual insured claim costs for the year ending September 1, 1987 producing 10 ratios for the two age bands in each of the five groups. The manual rates were multiplied by the ratios, trended forward and applied to the expected population by age, sex and plan. Expected cash flows were developed by plan within each group. The present values of each were computed and then added together. This process was completed in July 1988, just as the Medicare Catastrophic Coverage Act was signed. We had to adjust almost all our computations for that (not Life, Part B Premium which was fixed, or Retiree Contributions which were fixed). This was done by modifying the trend rate.

We were able to come to a resolution because we approached the calculations in a cooperative manner with a common professional background in an effort to determine the facts as best we could. There was also pressure from our principals to come to a resolution. Since the retirees' benefits represented almost 80% of the unsecured debt, to get a 1% change in the retirees' distribution, a 6% change in the present value was needed. Moreover, it was to everyone's advantage to come to a consensual agreement and avoid a Chapter 7 liquidation of the assets and a long drawn-out litigation.

MS. ANNA M. RAPPAPORT: I've got several questions: one concerns the kind of work that you did in connection with retirees' medical litigation. Does that have application in other kinds of litigation and do you know of situations where actuaries may have been involved where there is some kind of health problem in trust fund set up later? I know there have been other kinds of litigations that involve trust funds. I think, for example, Agent Orange might be an example; I know that there has been such litigation but I don't know whether actuaries have been involved and I was wondering if you knew if there had been or whether there might be some parallel lessons.

MR. MESKIN: On the Agent Orange situation I suggest that you give Tom Levy a call; he has been involved in that; I'm sure there have been.

MR. TRAPNELL: In general, I would think that arbitration problems would be a growth issue for actuaries because of what I see as the trend toward the business establishment avoiding the courts as much as they can to avoid both the enormous expense and unpredictability of the judgments. One area that has struck me is in reinsurance contracts for long-term care insurance. A typical contract will have cancellation clauses that permit either the insurer to "recapture" business or

allow the reinsurer to "retrocede" it back to the issuing company under certain sets of conditions (e.g., cancellation of the basic contract, refusal to go along with a rate increase, etc.). This problem stems from the long-range and experimental nature of this coverage and the uncertain level of utilization. I have seen contracts that specify that each side will pick an actuary and those two actuaries go pick another actuary. If they can't agree on the third actuary then each side will supply a list of three. The other side will knock two off and then if they still can't agree, then they pick one of the remaining two randomly. I had to think this through for a client, and I recognized that the key issue to the protection offered by a reinsurance contract was how the liabilities would be valued at cancellation. The latter would depend in turn on the beliefs of the three actuaries chosen as arbitrators. The question then becomes which proportion is more optimistic than I am and do I really want to put one of my clients into this process? But I can easily see this situation being replicated again and again. I speculate that this might be manifestation of a general trend for business generally to see how much it can avoid the court system, which has characteristics that are undesirable from the point of view of enforcing contracts.

MR. MCCARTHY: I guess another set of examples arises from the fact that over the past decade the Department of Labor (DOL) has, with increasing frequency, brought actions against trustees, particularly those of multi-employer plans. Some of these actions concern broad situations that don't necessarily suggest actuarial input but others are on judgment questions. Actuaries have participated in some of those discussions where there was a potential for litigation. There is a fair amount of activity that has been going on there and the DOL has been kind of stiffening that up over a period of time.

MR. TRAPNELL: And using some sort of process like this?

MR. MCCARTHY: Well not necessarily because the issues there aren't usually so much long-term funding for the future as they are propriety of actions taken at a particular point in time. In one, for example, an advisor was sued for recommending a settlement between a trust and an insurance company; to a number of people who looked at it, it was obviously a worse deal than just letting the contract that was in place run its course, and the question was, was that neglect on the part of the trustees, was it inappropriate advice on the part of the advisor and that sort of thing. There is a fair amount of that going around and some of it has actuarial application.

I presume that both of you are doing valuations and therefore insurance companies and or employers are involved. To what extent do the assumptions that you are using for other purposes cause you to get into any kind of knots or into litigation or create any special issues with regard to the litigation?

MR. MESKIN: Yes, every time I go on the stand the lawyer brings up the last time that I was on the stand and I say, "Well, things change."

MR. MCCARTHY: No, but there is a consistency issue over time and I think that is an excellent question and that goes in my thinking to expert witness work of any type that anyone does over a period of time. You have to have a framework in which to deal with these things and if your views change you have to be prepared to support them. In the case we are talking about here there was no testimony; it was all just negotiation. However, in the White Motor case there was testimony. One of the things that happens in these bankruptcies, in general, is that you have a filing for bankruptcy at a certain date; in Allis-Chalmers, for example, it was July 1, 1987. Typically, as of that date, the first thing the court will do is to say, "Until we straighten all of this out, keep paying the benefits that you were paying before." That's a cash strain on a bankrupt company and also what it means is that if you continue to pay 100% benefits and let's say that the ultimate settlement is a 50% settlement, all of the benefits paid from the date of the filing onward come out of the settlement amount so all you have done is mortgage the long term for the short term so you get into negotiations then about whether there will be a stand-still or interim reductions agreement. In White there was a very colorful court hearing that was held in Cleveland, Ohio. The UAW packed the court with union retirees who didn't want to stand still at the time and who wanted benefits to continue to be paid, and those of us who were testifying as to the financial effect of "stand still or no stand still" were greeted to a kind of Greek chorus of hundreds of voices in the background that would swell or wane depending on their sense of what we were saying and how it affected their benefits. So these things become rather interesting and intense in litigation for the reason that Steve talked about. People obviously are still at that point

in the stage of saying, "Somebody promised me benefits and something went wrong and I haven't figured out why but I want the benefits."

MR. JOHN M. STENSON: I noticed that there are adjustments made for expected deterioration in Medicare part B coverage. According to the FASB exposure draft the plan's statutory changes (e.g., Medicare Catastrophic Act) cannot be used in developing future assumptions. However, my understanding of the draft is unclear. We are supposed to use Medicare as it now stands?

MR. MESKIN: Well, there are really two issues. In some sense the way Medicare part B is designed, there is a cap on what it will pay, so that there is some natural leveraging on the amount in excess of what Medicare will pay. So you have some deterioration arising from the program as is. I think the other issue is how you interpret what FASB says. The interpretation depends on whom you talk to at FASB. Some will say you can assume that and some will say you can't and I think when you come in November and hear the Academy's presentation to FASB we are going to bring that issue up and try to nail them down. It isn't a black and white issue; you can interpret FASB's exposure draft as allowing you to take into account trends in Medicare that have existed in the past.

MR. MCCARTHY: The other point that I would make is that this was not a FASB calculation; our obligation here was to produce the best estimate on the facts as we saw them.

MR. TRAPNELL: I'm not sure that Steve made it clear that the kind of cap that he's talking about is the cap on reasonable charges. In other words, many of the plans were carved-out plans so that they paid up to whatever they recognized as reasonable charges which are generally higher than what Medicare recognizes. So there was no projection of a change in the law in the deterioration factor.

MS. PHYLLIS A. DORAN: With respect to your assumptions on the medical cost trends and the discount rate and their relationship, I noted that you assumed they were equal. I just wondered if you would comment on your rationale for that and how it fits into your assumptions about medical care as a percent of GNP?

MR. MCCARTHY: Well that is consistent long term with the assumption of leveling of Medicare medical care cost as a percentage of GNP and that was what we were trying to get out to in a "no growth" situation in the very distant future. We considered by the way, and actually used in White but not in Allis, select and ultimate interest rate assumptions on the theory that if you received a bunch of money at a particular point in time and invested it at that time, even if the economy changed it would take a while for those investments to turn over. In the context of Allis-Chalmers, the two sides together concluded that was true but difficult to explain to the audiences we were dealing with, and we tried to pick a set of equivalent assumptions that didn't have that nicety in them.

MS. DORAN: Does your comment imply then that ultimately you would expect interest rates also to level out at the rate of general inflation or at the rate of growth in GNP?

MR. MCCARTHY: No, I would say at the rate of growth plus a constant delta. We assume that interest rates and the rate of medical care inflation will be the same long term; that is not quite the same as the rate of general inflation because you can tolerate a delta over that. The delta was assumed to be equal to the growth in the economy long term. That is what kept medical care long term constant as a percentage of GNP and we linked the interest rate also to be inflation plus growth in the economy.

MR. MESKIN: I thought the questions on the trends would be at the beginning and why they went up first and then down.

MR. MCCARTHY: I was going to let you do that one.

MR. MESKIN: Since it hasn't been asked, I will give you the answer anyway. What happened is we did sit down and come up with select and ultimate interest rates, and then developed our trend rates, and then looked at the differential, and then kept that differential after we flattened the interest rate. So what's happened is the differential increased and decreased over time rather than our expectation of inflation.

FROM THE FLOOR: I guess Gordon mentioned that you tried to focus on the percentage of GNP the health care system can absorb and he had mentioned a few studies done by governmental entities with the global economy. Most other countries right now may be in the 6-8% range and is the 11-15% range really realistic and is the 18% reasonably realistic? I have read some studies by Uwe Reinhardt discussing how far it can go up. You get into that doomsday scenario. Obviously 100% is definite doomsday, but how far do you go before you have a reasonable versus an unreasonable estimate?

MR. MCCARTHY: We did feel that in the context of looking at a selection of projections that showed that relationship building to slightly more than 15% in the year 2000, and that being the most authoritative projection available, and that was the mid-range projection. Both sides gravitated towards that as something that we could accept intellectually even though it might not have been our own. It was available in public print, and it covered the years that had most of the effect on the calculation we were dealing with. We then agreed after that to grade it down and go beyond that and ended around 17.5, but frankly we used the HCFA projections as something of a crutch for the shorter range by which I mean the first 12 years.

What are your thoughts on the long-term relationship between medical inflation, interest rates, and the GNP?

MR. TRAPNELL: I can still remember the arguments of the economist in 1965 that 10% was absolutely impossible according to the science of economics.

MR. MESKIN: Let me just mention that, as Dan pointed out, we relied on the HCFA study. However, when we sat down together to come up with these things, we each came armed with boxes of articles supporting our own view of what the future would be. We traded them and looked them over and this is what we came up with. We needed to have something that was supportable, something that could withstand attacks by the other unsecured creditors, and we looked for whatever we could.

MR. RICHARD E. ULLMAN: I am still puzzled by the trends. I would think there is an underlying real rate of return in the absence of inflation of, say, 5%. Therefore, if you have a long-term investment assumption of 9%, there is an underlying general inflation of 4%. If you expect medical care to stop increasing as a percent of GNP, then medical care would ultimately have to come down to a rate of an increase of 4%. I would think you are assuming a 5% annual increase in medical care of over and above general inflation forever.

MR. MCCARTHY: First, I would think that the long-term rate that is supportable without causing a further increase in GNP is equal to, depending on how fancy you want to get, the sum of the inflation rate and the growth rate in the economy not just the inflation rate itself. So that gives you that number of whatever points of inflation you got plus a long-term growth rate which I believe we got down to about 2.5%. Steve, is that right? Right. I think that we didn't assume a 5% real rate of return. In fact, I think that I would be very hard pressed if somebody asked me if 5% were my best estimate for real long-term rate of return to say yes. I think it is implicit of what we have here that 2.5% is the real long-term rate of return. In other words, the real projection of basic inflation in the economy was like 6.5%? That is correct.

MR. MESKIN: And the reason they came out equal is sort of serendipitous.

MR. MCCARTHY: That was serendipitous but the estimates were close enough so it was easier to deal with the whole thing having them equal than having them marginally different.

MR. ARTHUR L. BALDWIN, III: If I understand correctly what you have done, you have an estimate of future costs which are then funded at 20% on the dollar and you make up the difference by some combination of plan changes and contribution levels. My question to you is that obviously the assumptions that you have made are not going to come to pass. What's the mechanism of the future for bringing things back into balance?

MR. MCCARTHY: Very important question and best illustrated not so much in Allis-Chalmers with the trust still relatively new but in White where the trust has been running for nine years. We have always described that to the trustees as a process of continuing mid-course corrections because you always have more data as some people who are entitled to the benefits didn't commit

to the trust. Encouraging people and subsidizing them to join HMOs also saved money because in effect we got them off the aging curve of the closed population and got them into community-rated populations. All of these things have had benefit for people in the trust. It was also nice to get lucky. One of the things in White that the trust got was some stock in a survivor corporation that nobody thought was worth very much. It turned out to be more than anybody thought so that the 40% settlement that people originally thought they had in White actually turned out to be a 50% settlement when all the assets were converted to cash. It is an ongoing course correction; all the things that Steve talked about dealing with the retiree group apply in this instance. You've got an ongoing group of retired trustees representing their fellow retirees and then you do projections periodically and talk to them about the alternatives. They ask very hard questions and then they reach the decisions which they update every year, not just the benefits, contributions and whatever else will happen. It is a very important part of the process.

MR. MESKIN: Let me second that about the stock. In another settlement in which I was involved, Uniroyal, there was a liquidating trust benefit set up. It sold some business just recently and the value of that was much higher than originally thought. The retirees who settled for a piece of that action did very well. So, I think retirees have to try to get a piece of the corporation, no matter what is left because ultimately their future is best served by the future profitability of their equity in what remains of the corporation.

MR. STEVEN BLAND: I had a question about setting your assumptions for determining the number of people who would not participate in your trust. How did you do that?

MR. MCCARTHY: For purposes of the present value, first of all, we didn't because everybody was entitled to benefits and the present value was based on that. Where the percentage who would not come in was concerned was in setting the benefit plans for the trust which was originally thought to be sustainable by the corpus of the trusts. In the White case we made no such assumption; we assumed 100% of the people would come in and in fact about 75% did. Armed with that experience in somewhat parallel groups of people, in designing the original plans and benefits with the trust that were set up in Allis, a cut was made to the population assuming people would not come in. It also turns out, as I mentioned before, that it tends to be the younger ones who don't come in. They have more alternatives open to them; they are the ones who carry the highest present values of benefits. So, frankly it is helpful from the point of view of the remaining people if some of those don't come in.

MR. RALPH J. BRASKETT: How do you deal with the situation in which the retiree committee is going in there looking for 100% when in fact they are going to be getting maybe 20 to 30 to 40%? I guess the question mostly is to Steve.

MR. MESKIN: It is really not the actuary's role to deal with that issue. The lawyer has to counsel the retirees on what the alternatives are. In a bankruptcy it is a lot clearer than it is in some of the other litigations that I have been involved in. In a bankruptcy you can get the accountant to sit down and say this is what the company is worth; this is what is going to have to go out to the senior creditors, and this is what is left over for the junior creditors, and you are x, of the junior creditors and this is a range of values you are going to get. This is fairly simple. When they put that against the present value you've computed there isn't much of a choice. In another situation and other litigations, the lawyers have to make some kind of estimate of what the likelihood of success is in litigation to maintain their benefits. If a large corporation has decided to cut the retirees' benefits in half or eliminate them and the retirees are suing, there is a question, what is the case law, what is the likelihood of success? It also depends on what circuit you are in and all those things are things that you as an actuary are not going to be able to be much help in. It is a hard job for the lawyer in that situation. The retirees are often hard to convince. We just had a hearing recently on this and we thought we had a settlement. It was about a 50% settlement; retirees were getting 50% of their benefits. We thought we had the retiree committee outside, but they came in and they started telling the magistrate that they were unhappy, asking very pointed questions and saying they don't agree, it was a bit of a circus. It's a tough area.

MR. MCCARTHY: It is very helpful in a case like that to have employees who are represented by a good union. I would give tremendous credit to the UAW and USWA organizations, the two cases I have been involved in, for going out and selling.