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POST-RETIREMENT BENEFITS OTHER THAN PENSIONS

Moderator: GEORGE J. ROCCAS
Panelists: HARVEY SOBEL
RICHARD E. ULLMAN
Recorder: ELLIOTT I. COBIN

- o Retiree health and life insurance plan design
- o Retiree cost sharing arrangements
- o Cost containment alternatives
- o Trend considerations
- o Funding assumptions for self-insured arrangements
- o Single premium insurance pricing considerations
- o FASB draft update

MR. GEORGE J. ROCCAS: We're going to talk about a number of topics, which are listed in the book, including plan design, cost sharing arrangements, cost containment alternatives, trends and so on. We'll start off with Harvey Sobel, who is a Principal in the New York office of William Mercer, where he consults for employers, Blue Cross/Blue Shield plans and HMOs, in all facets of health and group insurance. He has consulted for numerous employers and corporate buyers in the area of post-retirement life and medical. His projections of the cost associated with those programs have been so warmly welcomed by the investment banking community that he is affectionately known as the Darth Vader of the merger and acquisition field.

Richard Ullman is with Equicorp, although Equicorp may cease to be Equicorp in the near future. He is V.P. for Managed Care Consulting. He's a part of MultiNational Account (MNA), of which Harvey is the Darth Vader, since Equicorp has been sold to Cigna. Currently in New York, Richard works in managed care and indemnity consulting. He has authored an article on group dental insurance and he works with clients in the areas of marketing, expense, and underwriting.

Elliott Cobin who is with TPF&C in Philadelphia, consults in the area of health insurance, including post-retirement medical benefits.

MR. HARVEY SOBEL: I'm going to start off by qualifying my talk. We're very decentralized in Mercer, and, therefore, what I'm going to say primarily reflects my views. We don't have an official Mercer set of trends or approach, so this is rather my own evaluation and my own opinions.

I have a very ambitious agenda. I'd like to touch briefly on all of the following four items: benefits and plan design, retiree contributions, a brief actuarial evaluation, and then thoughts about what employers are doing, as a reaction to some of the horrendous numbers.

In the area of benefits and plan design, I think we first have to look at post-retirement benefits other than pensions and consider what we're talking about. Most of us tend to think of medical care, but we also have a number of other post-retirement benefits, such as life insurance, and, in many cases, post-retirement dental, which typically cuts off at age 65. The next three items, prescription drugs, vision, and hearing, could be thought of as postretirement medical, but sometimes there are separate stand-alone plans that you need to consider. Finally, what's often overlooked is the Medicare part B premium. There are many employers that will pay for the retiree, and, in some cases, the spouse's Medicare part B premium. So that would be also a post-retirement benefit other than pensions that we would want to value. For the rest of this presentation though, I'm going to really limit my comments to the medical benefits, because that's where the dollars are.

I'm going to take a look at one company, the famous XYZ Corporation. Before we get into the retiree medical, we have to understand a little something about the medical plan for this company's active employees. This is really based on a real life company, which was a spinoff from a very large corporation. The active plan for this company is base hospital, which provides 100% coverage for the first 365 days of care, and then there's a wrap-around major medical plan that pretty much picks up everything else. All other expenses are reimbursed at 80% after satisfaction of a $200 per person or $400 per family deductible, and expenses are capped off at $1000. We're talking about a pretty rich plan, with base hospital and relatively low out-of-pocket. Also covered are prescription drugs. Now there are certain exceptions to the 80/20 coinsurance, such as outpatient psychiatric, alcoholism and substance abuse, and there's an optional mail order prescription drug program. Pretty much everything else, with the exception of base hospital, is covered at 80/20.

Now let's turn to retirees. The XYZ Corporation, like many employers, requires that to be eligible for retiree medical, the retiree must have been in the medical plan as an active for some period of time; in this case, five years. In addition, to be eligible for post-retirement medical, the retiree must be either age 65 or age 55 with ten years of service. There's the ability of the retiree, if he or she is between 50 and 55, to be eligible for benefits, but at a COBRA rate provided that his or her age plus years of service is greater than or equal to 80. That rule allows long-service employees to retire and have a bridge period before they go into the retiree medical plan.

Now, as far as the actual benefits, it's pretty straightforward. Retirees younger than age 65 get the same benefits as active employees, which is very common. Once the retiree hits age 65 and over, he or she gets the same benefits as the actives with a Medicare carve-out. In the Medicare carve-out situation, the employer plan benefits are determined without regard to Medicare and then Medicare reimbursements are subtracted to produce a net employer benefit. At this point, I'm not going to go into other types of integration with Medicare, because Dick will pick that up later.

Looking at retiree contributions, or contributions in general, we found that contributions generally cover less than 25% of the cost of the plan. Now employers are talking about changing this, but my experience has been that, at least currently, retirees do not pay a

very large share of the cost. Contribution rates may differ for early retirees versus those 65 and older.

My next bullet indicates to be careful of plans that require retirees to pay a certain percentage of the cost. I have that in there because more often than not, the employer is saying that retirees pick up 50% or 25% of the cost of the plan. For early retirees, employers are equating this percentage with the average active rate, and most actuaries know, particularly for early retirees, where there's no Medicare offset, those retirees are costing the employer two to three times that for the average active employee. So if the employer is saying that the retiree is paying half the cost, it's usually less than half the cost, and that's been my experience. I've had such discussions with employers and said, "Well, if you're going to continue this policy, why don't you at least change the percentages and talk about what you're really giving the retirees?" But there continues to be the perception that the retiree is worth the same as an active. I think that will probably change over time. Finally, if the employer is going to drastically increase contribution rates, as many are talking of doing, then the actuary has to be careful about anti-selection, because that's going to affect the projection and it's going to affect the cost. Now, if we look at the XYZ Company, they are charging a very modest $10 for the retiree and $30 for the dependent, and not varying it by age.

What I'd like to do now is walk you through you a sample valuation since I've given you a little bit of background about this fictitious company, the XYZ Company. In general, the steps are pretty straightforward. We project the retiree population, and that includes not only current retirees but future retirees, and we also have to project out the number of eligible dependents. We have to estimate the per capita claim costs for providing coverage to these people, and then, if you multiply the two, you get your cash flows, which get discounted to your valuation date.

In the process, we're going to be making a number of actuarial assumptions. For the pension actuaries here, you're already making a lot of these assumptions. Things like mortality, retention costs, withdrawal rates, retirement rates, and interest rates are assumptions you're making all along. In doing a post-retirement medical valuation, however, there are other assumptions to make. In the area of medical care, two very critical assumptions are your starting or initial claim cost level as well as your medical care trends which can drive the calculation -- I spend a considerable amount of time on the initial claim cost when I do my work.

One of things that makes retiree medical different is the dependent situation. We have to make assumptions about who is covered for dependent coverage -- spouses. There could be children covered to perhaps age 19, or, in some cases, up to age 25. Many times we know something about the dependents. If we do the pension valuation, we may know something about the spouse's date of birth, and number of children, but more often than not we don't. And even if we know something about the retirees, we may not know something about the actives; and, if we do know something about the actives, it may not be applicable to when they retire. We're in the process of doing a valuation where less than 50% of the group is married. This employer has a very young group of 30-year-olds; and, so the fact that 50% of the group is married today doesn't mean that 50% will be married when they retire.

The other thing to consider is that I'm going to be doing pretty much a static valuation; I'm not going to assume any plan changes. Dick will be talking a little more about the effect of plan changes on the valuation. If you do make changes, if you do want to assume either plan changes or contribution changes, then you have to rethink your assumptions. As I mentioned, anti-selection can affect your starting claim costs and some of your other assumptions may be affected by changing either the plan design or contribution rates.

FROM THE FLOOR: What did you mean by retention?

MR. SOBEL: I'm sorry. Retention refers to the administrative expenses and profit margin of the insurance carrier, if it's an insured plan. If it's a self-insured plan, you have to consider employer administrative expenses.

As I mentioned, I spend a lot of time on the development of the initial claim cost, and the way I see it, there are really three basic approaches to developing the starting claim cost. One is, if you have a large credible employer, you may be lucky enough to get actual retiree experience; and, better yet, it might even be broken down by age. In some cases, your group is not credible -- it doesn't have a credible retiree population, but it has a credible combined group population, so you may want to infer what the retiree costs are based on the active costs adjusted for the demographics. Finally, if nothing is available, if you don't have any credible experience, then you really have to look at some sort of manual or tabular approach. You may have to look at the experience of employers in comparable industries, but, obviously, the job gets a lot tougher.

Now, there are really two starting claim costs: there's your gross employer cost and then you have to consider the effect of Medicare on your starting claim costs. I'm not going to go through the full laundry list of the Medicare program, which covers hospitalization and physician expenses. I will point out some of Medicare's "gaps," and I put gaps in quotations because whether you consider it a gap really depends on your belief about what the government should and should not be paying. Currently, the Medicare program does not pay for long-term care which is, obviously, the most costly item. There's no coverage for dental. There was to be coverage for prescription drugs, which was, obviously, repealed; and then, there's a list of some other items which the employer plan would tend to pick up.

Now, even for hospital and physician charges you need to understand your data. Every carrier plan is different in terms of how they're capturing data. In the case of hospital, the Medicare Diagnostic Related Group (DRG) is going to be less than the hospital's usual and customary charge, in most cases. For participating physicians, who agree to accept the Medicare allowance as payment in full, that allowance is going to be considerably less than the doctor's usual fee. And, finally, for nonparticipating physicians, those who do not accept Medicare as payment in full, there's a hidden provision in the current Medicare code; basically, there's an item in an obscure section of the Medicare code that says that physicians, even if they're nonparticipating, are not permitted to bill beneficiaries in excess of the maximum allowable actual charge or MAAC. This has been in effect since January 1, 1987, and we found out that carriers are currently adjudicating claims differently as well as coding them differently.

Let me give you a true story from the case files of Mercer. We have a New York City ophthalmologist whose usual fee is $115. This doctor has been both, participating and nonparticipating, on different occasions. As a participating physician, he accepts $60 as payment in full. He gets the 80% from Medicare and 20% from the beneficiary or the employer plan. When he's nonparticipating, his allowance is cut by 5% according to the Medicare program, so that the Medicare program would adjudicate his claim based on $57. His MAAC is $76. He is prohibited from charging the $39 in excess of the MAAC, which is a precursor to the ban on balance billing.

So this raises the question, "How is the carrier adjudicating the claim?" If they adjudicate as a participating physician, there's no problem, it's $60. But if it were nonparticipating, is the carrier adjudicating based on the $115 or the $76? I believe there's mixed practice out there. I have an HMO client that's currently ignoring the MAAC, and actually, with what their usual fee is, could be doing something totally different.

Medicare reimbursement rears its head in selecting trends and there are two trends. There's the trend in the employer cost as well as the trend in Medicare payments. If you read the FASB exposure draft, which George will be talking about later, it really talks about considering only Medicare as enacted today and not to consider future changes. So some actuaries have interpreted this to mean that you should not have cost shifting and that, in fact, you should have the same trends on the employer plan as for Medicare. I believe differently. I think that one could support the interpretation that, to the extent that the Medicare program has built-in cost shifting and that it can be demonstrated that trends have been and will continue to be different, different trends should be taken into account in the valuation process.

In fact, we've all probably read about the Medicare Physician Payment which is going to be starting next year. There are three major pieces of this reform. You have a resource based relative value schedule, or RBRVS, and that's going to be phased in over five years starting in 1992. You've probably all read about the controversy over that. In addition, part B will change to have a volume performance standard where reimbursement to physicians in future years will be adjusted based on whether the expenditures come in under or above the targeted amount.

But I think the most ominous feature of the physician payment reform is the ban on balance billing, which is going to strengthen the MAAC provisions that I just discussed. Basically, nonparticipating physicians are going to be unable to bill enrollees a certain percentage in excess of the Medicare allowable, which would start at 25% in 1991 and phase down to 15% in the year 1993. I think this is the most ominous feature of the physician payment reform. My prediction is that we're going to see a lot of physicians who will actually drop out of the Medicare program and Medicare will start to turn into another version of Medicaid.

Whenever actuaries talk about trends, they need to consider what their trends imply about medical care as a percentage of the gross national product (Exhibit 1). If we check the statistics, we can see that in 1965 the national health expenditure or NHE was 5.9%. It's climbed steadily: 1988 and 1989 are still preliminary figures, but it looks like it's up to 11.5%, so the 12% figure we heard earlier seems to be good (Exhibit 2). I

EXHIBIT 1

SAMPLE MEDICAL CARE TREND FACTORS

Year	Private Insurance Pre-65	Medicare & Private Insurance 65+	Medicaid & All Other
1991	15.0%	14.0%	13.0%
1992	14.5%	13.5%	12.5%
1993	14.0%	13.0%	12.0%
1994	13.5%	12.5%	11.5%
1995	13.0%	12.0%	11.0%
1996	12.5%	11.5%	10.5%
1997	12.0%	11.0%	10.0%
1998	11.5%	10.5%	9.5%
1999	11.0%	10.0%	9.0%
2000	10.5%	9.5%	8.5%
2001	10.0%	9.0%	8.0%
2002	9.5%	8.5%	7.5%
2003	9.0%	8.0%	7.0%
2004	8.5%	7.5%	7.0%
2005	8.0%	7.0%	7.0%
2006	7.5%	7.0%	7.0%
2007 & later	7.0%	7.0%	7.0%

EXHIBIT 2

PROJECTED NHE AND GNP

	National Health Expenditures								
	Private Insurance		Medi-	Medi-	All		Non-		Medical Care %
Year	Pre-65	65+	care	caid	Other	Total	NHE	GNP	of GNP
1989	3.4	0.2	1.9	1.1	4.9	11.5	88.5	100.0	11.5%
1990	4.0	0.2	2.1	1.3	5.5	13.1	93.9	107.0	12.2%
1991	4.6	0.2	2.4	1.4	6.2	14.9	99.6	114.5	13.0%
1992	5.2	0.3	2.8	1.6	7.0	16.9	105.6	122.5	13.8%
1993	5.9	0.3	3.1	1.8	7.8	19.0	112.1	131.1	14.5%
1994	6.8	0.3	3.5	2.0	8.7	21.4	118.9	140.3	15.2%
1995	7.6	0.4	3.9	2.3	9.7	23.9	126.2	150.1	15.9%
1996	8.6	0.4	4.4	2.5	10.7	26.6	134.0	160.6	16.6%
1997	9.6	0.5	4.9	2.7	11.8	29.5	142.3	171.8	17.2%
1998	10.7	0.5	5.4	3.0	12.9	32.5	151.3	183.8	17.7%
1999	11.9	0.6	5.9	3.3	14.1	35.7	161.0	196.7	18.2%
2000	13.1	0.6	6.5	3.6	15.3	39.1	171.4	210.5	18.6%
2001	14.5	0.7	7.0	3.8	16.5	42.5	182.7	225.2	18.9%
2002	15.8	0.7	7.6	4.1	17.7	46.1	194.9	241.0	19.1%
2003	17.3	0.8	8.2	4.4	19.0	49.7	208.2	257.9	19.3%
2004	18.7	0.9	8.9	4.7	20.3	53.5	222.4	275.9	19.4%
2005	20.2	0.9	9.5	5.1	21.7	57.4	237.8	295.2	19.4%
2006	21.7	1.0	10.2	5.4	23.2	61.5	254.4	315.9	19.5%
2007	23.3	1.1	10.9	5.8	24.9	65.8	272.2	338.0	19.5%

would just caution you that the employers are not the sole culprits because Medicare, which was enacted in 1966, has heavily influenced these numbers. If you break up the figures, -- I have some pretty good figures going back -- and you look at 1987, you can see that private insurance is really about a third of the pie -- 32%. There's a big category, "other private," which includes claimants' out-of-pocket payments directly to providers. It includes deductibles and coinsurance. It includes things like nonprescription drugs and certain long-term care payments -- and that's a pretty big percentage. Then, even within the 41% of the national health expenditures that are governmental, Medicare and Medicaid are pretty big percentages. But there's a 15% other government share, which I did a little digging into, and it turns out it's a real smorgasbord. You have the Federal Employees Program in there, Worker's Compensation, payments to cover medical care of the Indians on the reservations, and an item that's really State Grants to health care facilities. So, there's really a whole slough of things in "other government." After studying the data for some time, I've come up with private sector trends starting at 15% and grading down to 7%, for this employer. If one assumed that the medical care trends of 15-20% that we're currently seeing were to continue, you end up with medical care greater than 100% of GNP. I should point out that these trends are independent of aging; we have a separate set of aging trends. Then I've estimated that, as a result of the physician reform, as well as past Medicare practices, Medicare trends will run about 1% less than the private sector trends. Even though I've not used it in my actuarial valuation, I do display a Medicaid and all other trend, which is even running less than the private sector and Medicare trends. My trend assumptions ultimately imply a 19.5 medical care percentage of GNP. This is assuming GNP is going up at 7% annually in all years.

Now moving into the actual valuation, this might seem like a small group, but it's actually, as I said, a spinoff of a quite larger group. We're talking about looking at 80 actives and 20 retirees (Exhibit 3). The 20 retirees currently have 18 spouses. The actives have around 12 years of average service, and I'll display, in a summary form, some of the major actuarial assumptions (Exhibit 4). We've assumed a 9% interest rate, which is sort of the current interest environment. You'll notice that we have starting claim costs, which are at age 65 since that's really the way our Mercer software operates. We have to plug in a specific claim cost and the software will adjust the starting claim cost either up or down based on the retiree's actual age. The aging factors, are .5-5% per year. We've studied the aging -- there's a wealth of material out there, but there's some Medicare statistics that indicate that around the 55-65 year-old range, aging can add 4-5% a year; but that tapers off as the retiree or retiree's spouse hits the 80s. So I've not assumed, as some actuaries will, a flat 2 or 3% on the aging. You'll also notice it means that I'm going to take a claim cost, which is an age 65 claim cost and, if I'm trying to project a 66-year-old's expense, I'll take an aging factor, which could be anywhere from .5-5%, and I'll multiply the 65-year-old starting claim cost by 1.05. On the other hand, if it's younger than 65, I'll divide by 1.05. You'll also notice that I have a separate assumption about what the claim costs are for Medicare eligibles versus non-Medicare eligibles.

The reason I've complicated things by doing that is that I'm trying to reflect the effects of some of the things I've talked about before. The fact that the hospitals are reimbursed based on DRGs and the fact that physicians are not receiving their full charge

EXHIBIT 3

XYZ CORPORATION CENSUS

	#	Average Age	Average Service
Actives	80	39	12
Retirees			
Pre-65	16		
65+	4		
Total	20	59	
Retiree Spouses			
Pre-65	17		
65+	1		
Total	18	55	

EXHIBIT 4

XYZ CORPORATION POST RETIRMENT MEDICAL — ACTUARIAL ASSUMPTIONS

Item	Assumption
Discount Rate	9%
Mortality	GAM 83 (0,-6)
Starting Annual Age 65 Claim Cost — Non-Medicare Eligibles	Male $3,602 Female 2,834
Starting Annual Age 65 Claim Cost — Medicare Eligibles	Male: Gross $3,422 Medicare (2,738) Net $684
	Female: Gross $2,692 Medicare (2,154) Net $538
Aging	1/2% to 5% Per Year
Medical Trend — Non-Medicare Eligible Claim Cost	15% Grading to 7%

means it's actually cheaper to cover 65-year-olds when they're Medicare eligible than when they're non-Medicare eligible. And, of course, I have a very hefty offset for Medicare, so that a 65-year-old man who's Medicare eligible is costing the employer $684 as opposed to $3,602 if he's without the benefit of Medicare. And here are some of the other assumptions. I'll call your attention to the percentage married. We actually knew the current ages of the retirees' spouses, but we had to make an assumption about the percentage of married for the actives, because as I mentioned, that's going to change. And we've assumed in this valuation that the plan will stay static: no changes in deductibles or out-of-pocket limits, and that the retiree contributions will continue at the same flat monthly single/family $10/$30 amounts (Exhibit 5).

I'm just going to briefly show you some of the output. We have the 80 actives declining to 26 by the year 2008, with the retirees and retiree spouses going from 38 up to 60; and, if we take it out to the end of the 35-year period that our software shows us, we're down to two actives and 58 retirees and retiree spouses. You'll notice that the widow population grows quite sizably. Our computer software goes beyond 35 years, but it does not spit it out; it keeps the calculations internal. And our cash flow for this company goes from $74,000 in the first year all the way up to $1,066,000 by the year 2024, so it's just a steadily rising pattern. Now, when you discount the cash flow at 9% interest and sum it, we end up with a $3.7 million total liability, and you'll notice that the first 35 years comprise to around 84% of the present value. There's still a very large present value in the tail and that would vary depending on your active/retiree mix. But not all of that $3.7 million has been earned or incurred. If you go through the FASB exposure draft, it defines two terms. The expected post-retirement benefit obligation or EPO, and the accumulative post-retirement benefit obligation or APO. The EPO is pretty much the full present value; the APO is the pro-rata share that's been earned by retirees and actives to date. In the case of a retiree, they're one and the same. For an active who has worked 20 years and in five years will be eligible for full retirement, the APO on his behalf would be 20/25ths of the present value. So, for this group, we're talking about a $2.7 million liability to the employer, which represents around 72% of the present value. And, if you run through the exposure draft, in terms of what it says for a 1990 expense, we have three pieces. We have an $86,000 service cost. Then, the $2.6 million APO gets amortized over the greater of the average future working lifetime of the active employees, or 15 years. The employer can use a 15-year safe harbor, so we've chosen the 15-year amortization $176,000. And then finally, that unfunded APO is accruing with interest at 9%, so that gives a $234,000 addition to expense. If you total the three pieces, you end up with $496,000, which represents 6.7 times the pay-as-you-go cost, and you've all read about the horrendous multipliers that employers are seeing which varies all over the lot depending on the industry. George is going to talk more about the FASB rules later, so I won't go into that anymore.

I did want to do a little sensitivity testing. I went through and I picked what I thought were the six actuarial assumptions that might affect the answer the most, and I looked at the affect that a 1% change in each assumption would have on the results. I did it in such a way that I either increased or decreased the decrement by 1% depending on which way it would produce an additional cost (Exhibit 6).

EXHIBIT 5

XYZ CORPORATION POST RETIREMENT MEDICAL — ACTUARIAL ASSUMPTION

Item	Assumption
Medical Trend-Medicare Eligible Claim Cost	14% Grading to 7%
Withdrawal	Actuaries Pension Handbook Table T-3
Retirement	55-59 5% 60-64 40% 65 100%
Percent Married (New Retirees)	Male 80% Female 50%
Incease in Deductibles and Out-of-Pocket Maximums	None
Monthly Retiree Contributions	$10 per retiree $30 per dependent unit
Increase in Monthly Retiree Contributions	None

EXHIBIT 6

XYZ CORPORATION EFFECT OF CHANGE IN ACTUARIAL ASSUMPTIONS ON 1/1/90 APO (IN $1,000s)

	Amount	%
Best Guess APO	$2,640	100%
Increase Due to 1% Change In:		
Medical Care Trend	$522	20%
Discount Rate	469	18%
Withdrawal Rates	103	4%
Retirement Rates	36	1%
Starting Claim Costs	30	1%
% Married (New Retirees)	9	0.3%
Total	$1,169	44%
All 6 Assmptions Together	$1,418	54%

So, for example, medical care trend, which is obviously the greatest one, a 1% increase in the trend increased my liability by 20%. A 1% decrease, in the discount rate, going from 9-8%, threw off 18% more liability, and so on down the road. You can see retirement rates, starting claim costs and percentage married really did not affect the results as much as the first two items. All totalled, a 1% change in each of the six items, individually, would add 44% to the valuation results. But, if we were to make a run with all six assumptions changed together, we pick up an extra 10%, so that the $2.6 million liability goes up 54%.

When we do valuations, we like to show our clients not only a best guess result, but also some sensitivity testing and an indication of where there's a high and where there's a low. We try to say what this implies about medical care as a percentage of the gross national product. It's a real challenge to do this because you don't want to have too much of a range -- employers are not paying you for a wide range. So you really have to walk a fine line so as not to lose credibility with your clients.

The post-retirement medical numbers are pretty horrendous, as George mentioned. I don't exactly have numbers that are welcomed by investment bankers. I have been involved in some merger and acquisition deals, and the lawyers and the investment bankers are all set to go. Then I come along and can kill the deal because these numbers are very real and buyers do want to negotiate or adjust the sales price to reflect this liability and/or leave current retirees with the seller.

So, what are the employers doing about these liabilities? Well, one of the obvious things that is taking place is that employers are raising and instituting employee contributions. That's really not a surprise. And notice the second item: increasing deductibles and out-of-pocket maximums. Again, that's happening on the active plan. What is probably different for retirees is that we're seeing more interest in varying employer contributions by length of service. So that a retiree who has 30 years of service may get 100% subsidy, whereas somebody with only 10 years of service would get perhaps a 25% subsidy, i.e., rewarding the long-service employees. And the last bullet is eliminating subsidies for retirees abroad. I do have a client that has retirees abroad; and, if the retiree incurs medical expenses outside the United States, unless the retiree is living in the United States and on vacation, Medicare will not cover it. The wording in the retiree plan is very loose. It basically says the employer plan will pay whatever it would pay less whatever Medicare pays. Well, we pointed out that if Medicare pays zero, it's creating a very large liability to the employer plan. So this employer is in the process of modifying the plan to say that they will pay what Medicare would have paid. The claim would be adjudicated as if Medicare had paid it and the employer plan would only pay the difference. The employer has decided they're not going to subsidize retirees going to Italy or France.

Some employers are expanding coverage, and here are three actual examples. I'm currently involved with an employer that has purchased a company and they're going to let the employees of the new company into their medical plan, which has post-retirement medical. The subsidiary company does not have this coverage, and they're going to be de facto granting them post-retirement medical. They've been alerted to the cost of this

and we've done work with them, but they decided to make this decision for other reasons.

Now another example of liberalization is that there are unionized companies that have employer pay all retiree coverage for basic hospital and basic medical-surgical, but major medical is 100% employee pay all. And, over the past few years, the employee pay all major medical rates have gone through the roof. It's caused the unions to press for the employer to pick up some of the share and some employers have granted 50% coverage. It's a huge liability, but they've done it to keep labor peace.

Finally, there's a situation where we have a client with a retiree medical plan that says, if the retiree dies, the retiree medical plan will allow the spouse and children to continue on by paying the COBRA rate. The employer believed that they should allow the spouse to stay on at the subsidized retiree contribution rate. So that's another example of a liberalization that I've seen. After I put these three things together, I found it hard to believe that despite the environment we're in, with some very horrendous numbers, that we are still seeing examples of employers actually liberalizing.

MR. RICHARD E. ULLMAN: I'm going to talk about what Equicorp is doing in the post-retirement market. For those few of you for whom Equicorp may not be a household word, I will give you a brief introduction to Equicorp. We were formed on October 1, 1986 as a joint venture of the Equitable and the Hospital Corporation of America. Last fall there were rumblings of a sale of Equicorp to another company; that other company was Cigna. The talk of the sale proceeded from last October through March, and on March 29, the sale actually closed. Because of anti-trust regulations, Cigna could find out all it wanted to know about Equicorp, but we could not find out anything about Cigna. So I know very little about Cigna other than what all of you already know. Since I've been out of the office for several days (I've only been in the office for two days subsequent to the closing of the sale), almost everything I'm going to say is about Equicorp's plans for the future prior to the sale.

In the post-retirement market, we do single sum life buy-outs. We quote these frequently. These are the single sum valuations -- single sum costs of providing death benefits subsequent to retirement. We handle life continuance funds. These are like pension funds except the benefit is life insurance rather than pensions. We are the investors of the funds, and we also do the actuarial work. Some of these plans are very over-funded. Prior to the 1986 Tax Reform Act, some large companies used these funds as tax shelters and the result was over-funding. We generally decline single sum health. Most insurers generally decline this. There is one insurer that has written one case. I'll get into some of that a little later.

Equicorp's clients occasionally ask for a valuation of post-retirement health benefits and we do these request.

We've had several requests to do full-scale studies and full-scale presentations to companies, with significant post-retirement health liabilities, who want to get out from under them, or restructure their plans to reduce the liabilities.

Single Premium Life is very desirable business except for statutory surplus strain problems. If the insurer is not concerned about statutory surplus strain, then it's very good business. This is because mortality is reasonably predictable. Post-retirement mortality is reasonably predictable. AIDS is not a factor at all for retirees. What I've left out is that actuaries and insurance people have been predicting investment for more than 100 years, so the prediction of investment return is also not a very risky business.

Retention consists of state premium taxes, cost of claim settlement, cost of policy issue, miscellaneous overhead, and profit, which is also rather easily predictable.

There is an employee tax problem if the employer buys single premium life insurance for its retirees because the present value or the cash value of the permanent insurance becomes taxable income to the employee. For example, suppose there's an employee who retires at age 65 with $50,000 of paid up life insurance and it's worth (say) $20,000, the employee has to pay an income tax on the $20,000, which is not a very desirable situation. Finally, one reason that the business is desirable from the insurance standpoint is that face amounts surely decline after retirement, which is the opposite of health where the liability continually increases with double digit trends.

We have one single premium health case on the books. We quoted another case on a very conservative basis. That group had a low lifetime maximum -- something like $25,000 lifetime for Medicare supplementary benefits. That case was won by another insurer and we're not that unhappy about it. We are no longer in the single premium health business. One major concern that we all always had about single premium health is that Medicare will go secondary. Medicare has already gone secondary with respect to active lives over 65. There's always that chance, however small, that the political environment will allow Medicare to go secondary with respect to retired lives. That would certainly upset the apple cart with any insured program, as well as upset the apple cart of corporate America by vastly increasing post-retirement liabilities. Significant other concerns are, even if Medicare would not go secondary, that there would be gradual cost shifting, inflation and technology, which makes the prediction of post-retirement health costs very difficult to insure.

I'd like to talk about post-retirement health benefits supplementing Medicare. Basically, there are four kinds of benefit plans that supplement Medicare. There are coordination of benefits (COB), carve-out, a supplement (Medicare acts as a base plan with a corridor deductible and a major medical on top of the corridor deductible -- a supplementary major medical, if you will), and then a gap-fill (it fills the gaps of Medicare).

Here is a claim example which will clarify just what these terms mean (Exhibit 7). Let's say you have a claim of $10,000, $5,000 in the hospital, $4,000 for physician services and $1,000 for drugs. Medicare will pay all the hospital bill less the $592 deductible, or $4,408. Of the $4,000 doctor bill, 70% would be -- I estimate 70% would be the Medicare allowed charge and Medicare would pay 80% of that 70% or $2,240. Medicare would pay nothing of the drug bill, resulting in a Medicare benefit of $6,648. In any decent comprehensive health care plan for someone younger than age 65, the benefit would be more than $6,648, and so COB just kicks in the balance of $3,352, so that the $3,352 plus the $6,648 produce the entire $10,000 of expense, leaving the Medicare

EXHIBIT 7

CLAIM EXAMPLE

Hospital Stay	$5,000
Physician Services	4,000
Prescription Drugs	1,000
TOTAL	10,000

→ **COB**

MEDICARE PAYS

All of HOSPITAL BILL less $592 deductible	$4,408
80% of 70% of PHYSICIAN BILL	$2,240
0% of DRUG BILL	0
	$6648

COB BENEFIT $3,352

→ **CARVEOUT BENEFIT**

.80($4,000 − $250) + 1.00 ($6,000) - $6,648 $2,352

→ **SUPPLEMENT**
.8 ($10,000 - $6,648 − 250) $2,481.60

→ **GAP-FILL** $592 + .2×.7×$4,000 $1,152

beneficiary with no out-of-pocket health care costs. Under carve-out benefits, which are really the same as COB on a benefit-to-benefit basis rather than expense-to-expense basis, Medicare would pay 80% of the first $4,000 less a $250 deductible; and, assuming a $1,000 out-of-pocket cost for the member, 100% of the next $6,000. Subtracting off the Medicare payment, we're left with a balance of $2,352. Under the Medicare supplement, we have the total bill of $10,000, less the Medicare payment, less the cash deductible, times 80%, gives a benefit payment of $2,481. Finally, the gap-fill would fill in the deductible of $592 for the hospital and the 20% coinsurance on the physician charges, and that comes to $1,152. So, clearly, COB and the benefit payment of $3,352 is the most expensive form of supplement. The gap fill, with a benefit payment of $1,152, is the least expensive form of supplement, and the carve-out and supplement flow in between.

COST CONTAINMENT

There are four ideas for cost containment. One is premium cost sharing on defined benefit plans; a second is claim cost sharing; a third is managed care; and fourth is to define the contributions rather than the benefits.

Premium Cost Sharing

One is to tie the premium to years of service. Harvey has already mentioned this. Instead of the employer paying the entire cost for all retirees, the employer might pay the entire cost for long-service retirees and gradually scale it down -- scale down the employer contribution for shorter service people. A second idea is to have the employee pay for his dependents while the employer pays for the employee. A third idea is to have for a duration of benefits the employee pay all, either pre-Medicare from early retirement up to age 65; or, at age 65 and later.

Claim Cost Sharing

There are also four approaches. One is to increase the deductibles; another is to increase the coinsurance; and a third is to redefine reasonable and customary, or as some of you might call it, usual reasonable and customary, UCR. Most employer plans have defined usual and customary between the 80th and 90th percentile. Medicare is the 75th percentile, except that there are so many other cost constraints, it is really much less than the 75th percentile. One way of restraining benefit plans for supplementing Medicare is to reduce the typical 80th and 90th percentile to something lower. Finally, one can consider elimination of peripheral coverages such as vision and dental. Vision is almost a dollar swap coverage for people 65 and older. Almost everybody older than 65 years has glasses and has ophthalmologic or optometric examinations, and so you're really just taking the dollars of the Medicare beneficiary and giving them back to him or her. And dental, while not quite as much a dollar swap as vision, is also a peripheral coverage at advanced ages.

I'm now going to go through three illustrative groups, two of which Equicorp was intimately involved with in advising the client to restructure his benefit plan; and a third one, which we were not intimately involved, but more peripherally involved. I'll call this illustrative group A, which is a large financial services industry company.

The high retiree health plan was the same comprehensive plan as for active employees, including dental and vision. The deductible was based on 60% of final salary: approximately 1% of 60% of final salary. There was 80% coinsurance, and a $1,000 out-of-pocket stop-loss limit. The plan for retirees older than 65 years was the same as the pre-65 plan, except for a Medicare carve-out. Including dental and vision, there were no employee contributions, except that the retiree payed the cost of Medicare part B. Eligibility to get post-retirement health benefits was age 65 or age 55 or older with 10 or more years of service, or a job abolished with 25 or more years of service.

Now we have a very interesting bar graph showing the relativities of pension benefits, life benefits and health benefits (Exhibit 8). The pension benefits are the top part of the bars, the diagonal lines. The life benefits are the next thin sliver, about 2 mm. So a little sliver of this bar is a life benefit, the rest of it is the health benefit.

Now, if we look for a person who's 65 years old with 30 years of service, we see that the pension benefit is significantly bigger than both the life and health benefits. Nevertheless, the life benefit is still a good portion of the pension benefit. At the opposite end of the scale, for a person age 55 with 10 years of service, the pension benefit is a relatively thin sliver and the health benefit is about four to five times the pension benefit. So the benefits manager for this employer, in talking to top management, told them that the pension and the health plan are just out of kilter, at age 55 and 10 years of service, where the employer is paying five times as much for health benefits as he is for pensions. And, of course, in between, there are all kinds of gradations.

As a result, this company was presented with six alternatives to its current plan (Exhibit 9). The "A" was to limit benefits to the retiree, and have the retiree pay -- in other words, the retiree pays the cost for dependents with the employer paying the full cost for the retiree. Alternative "B" is to have the company pay benefits only before age 65, with the employee paying the cost after 65. "C" is the reverse, having the employee pay before 65 and the company pay after 65. "D" is to require 20 years of service and direct retirement from the company before the company pays for anything. "E" was more stringent, requiring 30 years of service and direct retirement from the company for company paid benefits. Finally "F," is to have company-paid coverage starting at age 60, with cost sharing for service less than 30 years. Harvey has already alluded to that option of reducing the company contribution and increasing the employee contribution for years of service less than some benchmark, like 30.

Here is alternative "F" in some more detail. After age 60 and 30 years of service, the company would continue to pay the full cost of retiree health. Up to age 60, the employees would pay the full cost of coverage for each year of early retirement prior to age 60. Now is the cost sharing formula. With 30 or more years of service, the company pays in full. With fewer than 10 years of service, the employee pays in full. With 10-19 years of service, it's 50-50. With 20-29, the company pays 75%, with the employee picking up the balance of 25%.

In the actual actuarial work, the FASB valuation showed these kinds of cost reductions for each of the six alternatives. Let's look at the biggest one first. If the company is going to pay before age 65 and pay nothing after 65, 75% of the cost is knocked off, a

PANEL DISCUSSION

EXHIBIT 8

ILLUSTRATIVE GROUP A

VALUE OF POST RETIREMENT LIFE, HEALTH AND PENSION BENEFITS/CURRENT PLAN — RETIREE EARNINGS $30,00

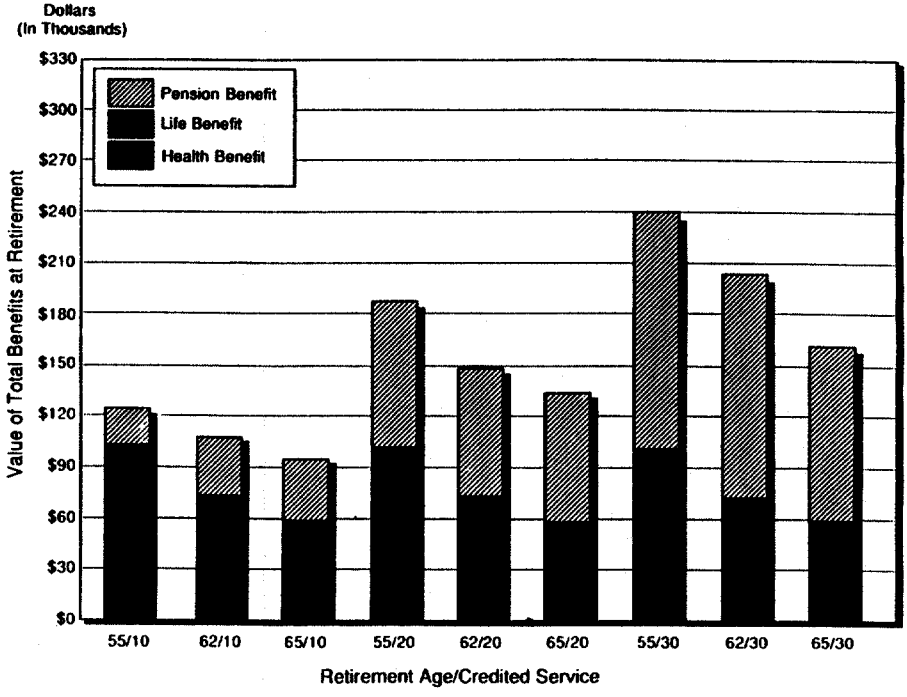

EXHIBIT 9

ILLUSTRATIVE GROUP A

COMPARISON OF COST REDUCTIONS FOR POST-RETIREMENT HEALTH BENEFITS ALTERNATIVES

Alternative	Active Employees % Reductions from Current Plan Cost
A) Limit benefits to retiree (retiree pays cost for dependents)	55
B) Provide company paid benefits only before age 65	75
C) Provide company paid benefits only after age 65	25
D) Require 20 years of service and direct retirement from the company for employer paid benefits	20
E) Require 30 years of service and direct retirement from the company for employer paid benefits	50
F) Company paid coverage starts at age 60; cost sharing for service less than 30 years	20

very, very big reduction. The second most dramatic reduction is alternative "A." Have the retiree pay for his dependents -- the employer pays only for the retired employee -- that knocked off 55% of the cost. And, third, is to require 30 years of service before the employer pays for anything, that knocked off 50% of the cost. "C," "D" and "F" came in at approximately the same percentage reduction, 20-25%. Company-paid benefits only after age 65 yielded a 25% reduction. A 20-year service requirement had a 20% reduction, and the graded reduced company contributions to insure them 30 years of service was a 20% reduction. The company finally adopted alternative "F," giving them a 20% reduction in cost. That's it for illustrative group A.

Here is illustrative group B. This is a group in somewhat of a smokestack industry with a large population of retired people and with a very high liability. Their problem was how to reduce the liability, i.e., how to reduce benefits on existing retirees, a very knotty problem.

Equicorp is aware of the ever increasing costs of retiree health plans, Medicare cost shifting in the form of deductibles, coinsurance, reduced allowable charges, and Physician Payment Reform. Even though it's financially neutral for Medicare, Physician Payment Reform will probably result in shifting some costs from Medicare to the non-Medicare population, and some of that would go to the population from 55-64 that is retired. And, finally, the medical CPI, the ratio of the medical CPI to the overall CPI, was at an all-time high, as it has been for the last several years. That ratio is around five times -- general inflation is running around 4 or 5% and most insurers trends are running 20-25%. This was Equicorp's analysis of the problem for this employer. There are two problems: current retirees and future retirees. And, finally, another dimension, the pre-65 age mix for the actives is very heavily weighted toward all the people, so when they retire, they're going to have expensive benefits. This leads to the complex legal issue of whether the Government will continue to increase support of retiree rights legislatively, judicially, and through regulatory agencies. Court decisions to date have not been favorable. Finally, we said that short-term confrontational approaches have been counterproductive. We suggested a voluntary approach, with inducements that increase the likelihood of success and acceptance.

Let's do group B. This is the Equicorp approach to a solution. I'm going to change the retiree plans to shelter the company from increasing medical inflation and continuing government cost shifting. We want to develop a fixed cost program using flexible (flex) benefit plans. Retirees can choose an additional plan on a fully contributory basis to supplement a low cost employer provided base. At age 65, there's a one-time choice at retirement. For the early retiree, he chooses his benefits from 55-64 at retirement and then at Medicare eligibility he chooses again as to what he or she wants as a Medicare supplement. The increasing costs are passed on to the retirees based on the plan chosen. Greater increases to richer plans.

And, as solution, we proposed: All plans will have to have strong utilization management features, disincentives, cost sharing, cost containment features, and a modular design flexible benefit package which I'll describe. The employer contribution covers only the low cost module. Inflation and cost shifting are passed on as employee contributions in an annually determined premium. For pre-65 plans, we recommended

coordination with any other employer as primary, if the retiree is an active full-time employee. That's a very important provision. Many people who retire at 55 years get other jobs, and having the health insurance plan of that second employer as being primary, saves the employer we're concerned with a good deal of money. Modules are based on the active employee plans with deductibles and coinsurance that vary from the active employee plan. Finally, for people older than 65 years, the retiree is required to elect a Medicare supplementary plan, unless he's an active employee with another employer.

We recommended modular designed flexible benefit plans, to be chosen only once at retirement. Of course, there are elements of selection, and, as an insurer, we were going to be the underwriter for these plans. Since a larger part of it is employee money, we wanted the employee to choose once at retirement and not choose again and again. The post-65 plan would be based on the Medicare supplement type plan. For future retirees, for salaried retirees, and for current salaried employees, the plan would be put in place immediately. For unionized employees, we were advising the employer to negotiate quickly, while a wind of opportunity were still available. We said a short-term financial inducement may be necessary for current retirees to enable the employer to get out from under this killing liability. First, we said it had to be voluntary. We would use the existing liability to provide financial inducement, one-third to the retiree, one-third to fund the base module, and one-third to reduce company liability. So if the approximate liability for a retiree is $30,000, the cash inducement was to be $10,000. We'll give you $10,000 to get off this plan and we'll take a second $10,000 and buy a base module. The final $10,000, will reduce the company liability.

Here are the four options we proposed (Exhibit 10). These are all Medicare supplementary options. Option one is the basic employer pay all plan. Options two, three, and four are the three supplements, the low-cost supplement, the medium-cost and the high-cost supplement, that the employee may elect. The biggest feature is the deductible: option 1 was $500, then grading down $100 from option to option. A second very big feature of the cost is the private duty nursing lifetime maximum. For option 1, the basic module is $10,000 and for option 2, it's $50,000, then $100,000, and for option 4 it's $150,000.

Other features of the plan design include the part A deductible and copays for parts A and B. Under options 1 and 2, the deductible is not filled in at all. Under option 3, we proposed half the deductible be filled in; and, under option 4, all of it. The part A coinsurance that's from the 61st to the 90th day has a very relatively low cost because of the infrequency of such long stays. We recommended that these copays always be filled in. For the copays beyond the 90th day to the 150th day, no, on option 1; and, yes, on each of the other three options. Finally, the part 4 coinsurance will always be filled in, except for option 1 where the copay for high-frequency low-cost office visits would not be filled in. The annual charge is $300 for the lowest cost, $600 for the highest cost.

What are the advantages? Well, first of all, the legal problems are avoided for a voluntary program. The employer is not taking unilateral action in stepping down benefits. Instead, he's offering a financial inducement to retired employees to take $10,000 and choose one of these plans, and pay part of it out of pocket and we'll pay the

EXHIBIT 10

ILLUSTRATIVE GROUP B

MEDICARE SUPPLEMENTARY OPTIONS

	Option 1	Option 2	Option 3	Option 4
Part A Deductible	No	No	50%	Yes
Part A Coinsurance	Yes	Yes	Yes	Yes
Hospital Days in After the 150th	No	Yes	Yes	Yes
Part B Deductible	No	No	No	No
Part B Coinsurance	Yes, except physician's office visits	Yes	Yes	Yes
Major Medical for Non-Medicine Coverage Services, E.G.,				
Physician Charges in Excess of Medicare				
Private Duty Nursing				
Prescription Drug				
Deductible	$500	$400	$300	$200
Coinsurance	75%	80%	80%	80%
Private Duty Nursing Maximum	$10,000	$50,000	$100,000	$150,000
Stop Loss Limit	$2,000	$2,000	$2,000	$2,000
Annual Charge	$300	$400	$500	$600
Monthly Charge	$25	$33	$42	$50

rest of it. We'll provide six reduced company liabilities over the life of the plan. It's not a one-time only change and the cost savings do not evaporate over time. The positive inducement that works is the immediate advantage to the retiree. It is also a deferred increased cost to the retiree. The big disadvantage to the employer is a large immediate pay-as-you-go cost -- $10 thousand to each retired employee who elects to step down from his fully employer financed benefit to one of these modular options.

We believed that communication of the benefits is very important, at least as important as the benefits themselves. Lewis Harris Associates said, "In winning the acceptance of employers to changes in the design of corporate health care plans, communications seems to be almost as important as the detail of the changes made." Then our communications people went into action and talked to this account in the following manner. For active employees, the goals are as follows: to maintain employee morale and good will; have positive acceptance of the new flex plan; have employees understand the flex concept, the plan, and the utilization of cost containment features; and establish and maintain channels of benefits communications. The message is, we care about you now; and, after retirement, a new plan for new times. Select the benefits that suit your retirement lifestyle and be a smart consumer of health care. The vehicles for communicating these ideas are home mailers, a planning ahead quarterly newsletter, a workbook and enrolling materials for the pre-retiree, a telephone hot-line, and retirement counseling.

For retired employees, we also have a strong communications aspect. The goal is to buy into the flex plan with smooth implementation, utilization of cost containment features, communication channels, and all resulting in good-will toward the company. The message, again, the company cares about your welfare. Select the plan that suits your lifestyle. Convert benefits you don't need to cash. Be a smart consumer of health care. And, again, the vehicles are the home mailers, the workbook, the telephone hot-line, and the choice years quarterly newsletter.

Well, the result of all this tremendous sales effort and this presentation Equicorp made to this company was that this company was bought out by another firm and the whole thing died. But it was an interesting exercise. I regret to say that, but it was an interesting exercise. I think we came up with some good ideas. This prospect was very interested for awhile. The company was very interested up until the time of the buy out, and I think it was worth talking about it to this group. I guess I just don't have stories with the best endings.

FROM THE FLOOR: Did you get paid?

MR. ULLMAN: Well, we all got our salaries. I don't know if we got paid.

Finally, illustrative group C. This employer wanted a rather unique, sort of a Draconian kind of solution to its problem. This is a heavy manufacturing employer with 47,000 employees. The existing retiree health coverage is for employees age 55 with 10 years of service. The employer pays the full cost of the benefits.

This employer's solution to its problem was to virtually eliminate and discontinue all post-retirement health benefits. For employees 50 and older, the employer offered additional pension credits in exchange for the total elimination of retiree health. I believe the additional pension credits were worth about $35,000 in terms of present value, which is very close, indeed, to the present value of a good retiree health plan; or, lesser additional pension credits, with limited number of years of retiree health. I think it was one to five years of retiree health provided by the employer in exchange for pension credits. For employees younger than age 50, additional pension credits based on age in exchange for total elimination of retiree health. For new employees, the employer offered no retiree health benefits at all. Essentially, this employer is looking for an insurance carrier provided benefit purchase options. It's a funding vehicle and investment vehicle for employees to save during their actively working lifetime, and then three or four options to choose at retirement, which would be on an insured basis. Well, there were problems with this. A lot of these employees are blue collar employees and the average salary is $25,000. So the affordability on an employee pay all basis, especially for relatively modest income staff, was a big question mark. For people earning $25,000, at age 45 or 50, or 55, to put away several hundred dollars a month for retiree health is not the easiest thing in the world to do. And, finally, there is the taxability of the investment income. Until the United States deems it advisable -- a social tax policy to encourage savings for retiree health prior to retirement -- the taxability of the investment income would be a big problem.

Actually, this employer was not concerned with the taxability of investment income on the retiree fund. They believed that they had to go along with having full taxability of the investment income so long as the employees had a funding vehicle for savings for their health needs after retirement. However, the question was, would Equicorp as a carrier -- now Cigna is the carrier -- go along with a product that over the years would build up significant investment income, say $4,000 or $5,000 of investment income a year, to low-income employees who never received that investment income and have a tax liability with no income to offset it? It's not at all clear at this point whether Equicorp will want to associate itself with such a product, even if the employer would want it. Again, this business has not closed, we're still in discussion stages.

MR. ROCCAS: Before I start, how many people practice in the pension area, that is, are familiar with FAS 87? A good number of you. Because I think the update and the discussion on the exposure draft will be very familiar to you, if you're familiar with the FAS 87.

Let me just say that FAS 87 has been with us -- I should say the exposure draft has now been with us -- more than a year, because it was published February 14, 1989, and it's kind of lived up to its billing. It's been controversial to say the least, and I'll come back in a little while with the FASB's latest schedule on what they plan to do over the next few months and when they plan to come out with what would be, I guess, a pronouncement, with respect to the exposure draft, the expense part, which is probably not the most onerous part, but it's certainly a good deal of it, would start for fiscal years after December 15, 1991. So, effectively, for all your calendar year employers and sponsors, you're talking about an effective date of January 1, 1992, unless that date is moved back, which is always possible. The minimum liability aspect, which is the other, maybe in

some ways, more onerous part of the pronouncement, becomes effective for fiscal year starting after December 15, 1996, or, again, for calendar year plans, January 1, 1997. So we can see that, with regard to the minimum liability aspects of it, we're a long ways away.

Small nonpublic employers would not go under the pronouncement, as far as the expensing aspects are concerned, until December 15, 1993, I believe, which is essentially 1994. For those of you who were at the session with the speaker Alain Enthoven, I think he mentioned just briefly that this exposure draft has created a great deal of heat from corporate America, particularly in the sunset industries. Many of these companies will see a tremendous increase in expense, as well as, probably, end up having to put some of this liability on their balance sheet. Because of this, some companies have talked about national health insurance, and they have talked about other ways in which some of this liability could be, I guess, taken off their books -- that's essentially what it comes down to. There's even been talk about trying to prefund it. As you probably are aware, there are some suggestions to allow pension plan surplus to be switched over into plans to back up the liabilities in post-retirement medical.

The scope of the exposure draft is fairly wide. I put up the two major benefits that will be affected. Health care, of course, which everybody knows about, but for those a little less familiar, life insurance will definitely be affected. Some other post-retirement benefits, such as vision and dental care, will also end up under this. Some post-employment benefits will not. For example, severance pay at this point under this exposure draft will not end up being in this pronouncement.

One of the big problems with this whole exposure draft is the measurement of the obligation. Keep one thing in mind about accounting -- what accounting is all about, really, is trying to measure your costs and trying to match up your expenses, as accountants would categorize them, with your revenues, which would essentially be whatever you got from sales and investment income. So, essentially, what the accountants are trying to do is put these benefits on accrual accounting, which is, essentially, the accounting that matches your expenses with your revenues. Well, as you can probably appreciate, up to this time in the post-retirement field, that has not been going on for the overwhelming majority of corporate America. Essentially, the major employers, as well as many small employers, have been on pay-as-you-go. That is, whatever was being disbursed was what your expense was. And, in the accounting profession's eyes, that was not a proper matching of expenses with revenues.

Within recent years, the rules in the accounting profession, as set forth by the Financial Accounting Standards Board, which is a private agency -- not run by the government in any way -- have shifted over from income statement emphasis to what we would call balance sheet emphasis. So they're now maybe more concerned about assets and liabilities than they were in the past, and the income statement has taken a little bit of a back seat to this. This is also evident in pension accounting -- FAS 87 -- in that what they would have like to have done was put your pension plan's assets on the balance sheet, put your pension plan liabilities on the balance sheet, and then the changes from year to year would end up in your expense. However, that was not something that would work or they even thought would be practical considering the long-term nature of these

obligations. So they decided to come up with some type of compromise approach, which was, essentially, recognizing some of this cost immediately and bring in the rest of this cost over time; in particular, unfunded obligations were going to be brought into the balance sheet over time.

Well, this whole concept is carried over into post-retirement medical benefits, except there's one major problem; namely, there are no assets, at least for 99 and 44/100% of the plans. So, essentially, what you would end up doing would be putting on the balance sheet a whole host of liabilities and there wouldn't be any assets, which would just not be acceptable to corporate America or to stockholders. So that is the reason why this whole pronouncement is more unpopular than the pension pronouncement. In the pension situation, there were assets, and assets presumably would have gone on the balance sheet if they had taken this balance sheet approach.

Well, so what they did was, they carried over a lot of the concepts into the post-retirement exposure draft, and the measurement of the obligation is probably the single biggest controversial issue. Because of the different options you have or the ways it can be measured, big differences in terms of the numbers, the bottom line so to speak, can be demonstrated. Generally, what they're saying is that you're going to measure your obligations based on current plan provisions and, I'll come back to this later, because there has been some talk about making this a little less rigorous.

The whole concept of accrual accounting requires that you recognize liabilities and expense not only for your current retired group, but you also recognize it for your current active group. The benefit measurement approach that they seem to favor is what they call the benefit over the years of service method. Those of you who are familiar with pension terminology will recognize that as, essentially, being a projected unit credit cost method. One big difference is how you do what they would call the attribution, that is, how you would spread the liabilities. Well, in the pension world, essentially, you spread them over an individual's working career. They made one big difference with respect to this approach, as far as post-retirement benefits, they said, no, don't spread it over their entire working career, spread it from the time they're employed to the time they are first eligible to retire. So, if you're in a situation where employees retire at age 65, but they're eligible to retire as early as age 55, then instead of spreading these costs from hire to age 65, the current exposure draft rules require them spread from hire to age 55. And this does push up these liabilities and, when you do that, they're higher than they would be if you measured them at age 65.

Again, with regard to assumptions, they took the approach that the assumptions should be explicit; that is, each assumption should stand on its own, be realistic on its own, and you shouldn't couple less realistic assumptions together even though the results may be the same as using realistic assumptions. We've had a number of people talk about health care trend, I think, in one form or another. Essentially, what they're saying is, that whatever baseline cost you come up with, which is, again, going to be a problem in itself for many employers, your trend factors project them out into the future. In Harvey's example, I think, the trend started pretty high. I think it goes around 12 or 13% in the early years and dropped off, I think, to about 6 or 7%.

MR. SOBEL: Down to 7%.

MR. ROCCAS: Yes. Basically, I think a lot of work that's being done in this area is being done on that kind of assumption. I think they initially wanted the discount rate or the interest rate, as we call it, to be a rate at which the obligation could be settled; that is, you could go out to an insurance company and purchase some type of program which would have the insurance company pay these benefits or pay these costs in the future. Well, as Richard has told us, at this point that ain't gonna happen. There's no insurance company that you're aware of, I guess, that's doing this; or, if there are, they're certainly very few. So I think, from that point of view, it may be unrealistic to say that we're going to use a settlement rate. So they kind of backed off a little bit on that and they said, well, why not use a rate that's inherent in high quality fixed income investments, like 30-year bonds and things like that, or what they would consider high quality fixed income investments.

Another approach, in terms of this measurement of obligation as I mentioned, is this minimum liability or how much of this liability has to go on the balance sheet. What they, essentially, are proposing is, that the liability for all retirees would go on the balance sheet and a proportional liability for those people who are eligible to retire but are still working, would also go on the balance sheet. So that's not quite everything, but it's certainly a large part of it.

Let's get down into some of the details, with respect to the expense components. Essentially, the components in this model are the same as in pension accounting: the service cost, which is, essentially, the expected increase in your liability from one year to the next; interest cost, which is, essentially, your increase in your liability due to the passage of time; and expected return on assets, that's, essentially, what you think your assets will earn in the coming year -- it's more of a long-term rate as opposed to a spot rate or a one-year rate. As I mentioned before, there aren't many plans around with assets, so asset return is likely to be zero for most purposes.

Prior service cost represents amortization of any benefits changes that occur subsequent to the time that you go under the pronouncement. Gains and losses represent experience deviations; that is, if you assume that your trend factor is going to be 13% and it's actually 20%, then at the end of that year you're going to have what we call an actuarial loss. Your liabilities will be higher than you would have expected them to be. These losses or gains, for that matter, also have to be recognized and there's a pronouncement that anticipates the use of a corridor and some smoothing. And then, finally, the transition obligation, which is, essentially, the obligation that exists at the time that you apply the accounting pronouncement for the first time. The obligation gets amortized over a period of years, which can be 15 years in some cases.

These numbers were from Harvey's example. Our assets are zero, the liability is, I guess, $2,640,000; right Harvey? Service cost was $86,000. The interest cost is nothing more than 9% of the $2,640,000; that's, essentially, how they define interest cost and you can make adjustments for benefit payments. There are some modifications, fine tuning, if you want to call it that. The expected return is obviously zero since there are no assets

in this plan. The amortization was over 15 years and that's, essentially, the $2,640,000 divided by 15. As you can see, the cost comes out to be around $500,000.

Now I think Harvey mentioned that the actual payout was somewhere around $70,000 or $80,000, wasn't it?

MR. SOBEL: That's about right.

MR. ROCCAS: Now what happens in accounting is, if you have an expense which exceeds your cash payment, the difference ends up being a liability and it goes on the balance sheet. Now this is a different liability than the minimum liability and so these liabilities start compounding and they get bigger and bigger. Some of the things that the Financial Accounting Board is thinking about are going to affect some of these relationships. I think Harvey also pointed out that at this time, the expense number is about six or seven times what the benefit payments are. There are some companies in which this relationship can be as low as two and three. I mean, if you get some real heavy smokestack industries where the benefit payments are just tremendously high, the expense number might only be two or three. You get into some companies which are young, high-tech companies, say, where there may be only two or three retirees, if that many, you can get a relationship of 40-50. These relationships are going to be all over the ball park.

What's on the FASB's mind, so to speak? A lot of people would like to know that. They're subject to a lot of pressure. They're subject to, I think, the feeling that maybe they're being a little bit too zealous in this area, but they have been deliberating a great deal about issues which do need to be resolved before the pronouncement comes out. The major issue, I think, facing them is the measurement of the obligations themselves. There are some people around who say that because you can't measure the obligation too precisely you shouldn't measure it at all, and, therefore, there's no need for this pronouncement. They're just not going to buy that argument. In fact, that's dead, it's not going to happen. They're saying, in effect, that accrual accounting is going to apply and it's just a question of how we apply the accrual accounting concepts.

The FASB is wrestling with what is the definition of a plan. I think all of us know that, particularly in medical insurance, some of the things that go on are not that well documented. Plan documents, as we know them, don't generally exist, and I think that what constitutes a plan, whether it be a written plan, whether it be a summary plan description, or whether it be a practice, is going to be an issue which they're going to clarify in the future.

I think one of the things we're having some trouble with is getting claim costs. Some small companies, I think, are going to have problems getting claim costs, which are age specific or retiree specific, and I think that some of these issues will have to be addressed in terms of what can and can't be done.

Projecting health care costs is another issue. I think some of the practitioners would say that, in projecting health care costs, you ought to look at baseline costs; maybe even look at baseline costs by specific service and then project those services out using trends that

vary by the service. For example, projecting hospital room and board at a different rate than drugs. I think that they're aware of these issues and they may come up with some rules that may simplify this process or give some more latitude to what can be done. Another issue is future plan changes, and how these plan changes should be reflected in costs and liabilities. The FASB has been spending some time on that lately. The feeling seems to be that certain plan changes will be acceptable and can be reflected in future costs and liabilities, while other plan changes may not be. They seem to be leaning toward allowing types of changes that have some historical evidence. For example, if employee contributions are raised every year to meet a specific percentage of the cost, they seem to be favorably disposed to that type of change. They do, I think, believe that there should be some good evidence that this is going to happen in the future. Again, we may see some rules in the final pronouncement in this area.

The next area that the FASB is going to address is this issue of attribution, which, as I mentioned, has been pretty controversial; that is, having all these expenses accrued by the time a person is first eligible to retire. Let me just finish up by saying that the final area that they're going to get involved in is the transition issue; specifically, in the area of over how long you can amortize these liabilities. And that is, supposedly, going to be the last step and then they're going to come out in the Fall or late 1990, I should say, with what will presumably be the final pronouncement.

Now going back to these issues; namely, the attribution issue and the transition issue. Harvey pointed out that if you change the trend factor by 1% or if you change the discount rate 1%, you will get about a 20% change in your liabilities. In other words, if you change your discount rate up 1%, you'll get a 20% decrease in your liabilities. If you change your trend up 1%, you'll get a 20% increase. They go in opposite directions. So, obviously, picking the right trend number and picking the right discount number will affect your costs. But, also, what will affect your cost is the attribution period; and, if the attribution period is stretched out to age 65 rather than age 55, the APO and service cost can go down. It may not go down, but it can go down, depending on your group, and it can go down dramatically 15-20%. You can see, if you reduce those two components, you're going to get a fairly good size reduction in your expense number, and that is a bottom line issue, at least with a lot of these heavier smokestack types of industries.

Looking at the amortization period, if you take that 15 year period and stretch it out to 30 years, you're going to change your expense. It will go down, but it isn't going to be that dramatic. I mean, it's going to go down a little bit, but it isn't going to be a difference between a good bottom line and a bad bottom line. So, while the overall goal is to try and get these numbers, I think, to be more reasonable, I think that what we'll see is probably more of a push to change the attribution method. I think we're going to see a push to change everything, but I think the real push will be to try and change the attribution method, and there does seem to be some hope for that. While the FASB is not going to back off on accrual accounting, they may be receptive to longer attribution periods and they may be more receptive to using a longer amortization period.

Just summarizing what their conclusions to date have been: accounting will have to be on an accrual basis; most of the major rules are already out, they're in the exposure

draft; and then there may be some fine-tuning in the area of discount rates, trends, and some of the other assumptions that you can use.

MR. VICTOR J. MORAN, III: I'd like to address the question of the health claim cost trend assumptions. There seems to be an inconsistency in one respect. There's been some discussion that assumptions should be separate and explicit, but there also seems to be a pattern of lumping the projection of the increased utilization of health care services with the projection of the sequence of rates of increase in prices of health care services into a single trend factor. Now which way does the FASB intend that this be addressed? Are they arbitrarily assuming that these two are part of the same item? And, second, what are the authoritative sources that actuaries are turning to and coming up with such extremely optimistic projections, as to the rapid tapering off of trend rates?

MR. ROCCAS: Harvey or Richard, I'm going to put that back on to you, since both of you are health insurance actuaries.

MR. SOBEL: Let me see if I understand the first part of your question, or let me paraphrase it. Are you saying that shouldn't we be explicitly having utilization versus cost increases, is that the first part of your question?

MR. MORAN: Yes.

MR. SOBEL: One could do that, although it becomes very difficult, especially when you don't have very good base line data to begin with. And then many times, if you're studying costs versus utilization for a specific employer, it's very difficult to get good information. Sometimes one can observe very funny patterns that overall per capita costs are moving in the direction one thinks, but you may have changes in coding patterns. For example, instead of having an OBGYN claim code as one claim, with the full global fee, you may have intermediate visits unbundled that will yield very funny utilization increases, with the cost per service decreasing. So, unless you're in a situation where you can really get good information, I think it's very hard to be very explicit. It doesn't stop you from doing it.

MR. MORAN: But that sounds like you're letting mechanics out with your sisters.

MR. SOBEL: Also, FASB -- my reading of FASB -- does not require a separate breakout of the two, and I don't really think the FASB has considered it. I think they've looked at the trend rate as an all-inclusive trend rate.

MR. MORAN: Which makes it easier to trim it downward.

MR. ULLMAN: Yes. I don't think they've gotten to this.

MR. SOBEL: The only comment I'd make on the optimism in the trends is that actuaries have different approaches to doing the trends. I've shown you an example where we trended net claims, and if you have a fixed deductible and out-of-pocket, you will get some leveraging. The leveraging will wear off, so you will have that causing a moderation in trend, and I share Dr. Enthoven's belief that, even though technology can

be costly in the short run, there are long-run savings to be gathered through technology, but that's a separate discussion.

MR. ROBERT E. CIRKIEL: I have a question I'm going to direct to both George and Harvey. It has to do with the effect of aging on cost. Is aging a significant feature of putting together a cost? I just wanted a comment on that, as curiosity a year later. Do they still feel that way? And throwing it up to the panel, do you feel that way?

MR. ROCCAS: I can only comment on the field study and some work that we had done. That, apparently, is the phenomenon. Costs don't rise significantly after age 65, except in the year of death or the year close to the year of death, which, I think, is probably going to be somewhere in the late 70s or the early 80s.

MR. CIRKIEL: If I could, they also mentioned at the same presentation that in the year of death they didn't feel that there was a significant increase in cost either. Both comments surprised me at the time, that's why I'm mentioning them to you.

MR. ULLMAN: Can I jump in and give some thoughts on that. The Gresch and Leong Study on Medicare, which was done about ten years ago, showed an increase in cost from age 65-85 and then tapered off. I think it's about 2% per year. I jointly authored a paper, on costs of New York City Blue Cross, showing increasing costs after filling in the deductible and copay. Increase in costs were between 65-85. I find it very hard to swallow that costs wouldn't increase with age, and, everything I've heard about Medicare is that in the year of death costs explode.

MR. SOBEL: I would second Dick's observation. I used Gresch and Leong data. I took quinquennial aging and I took the fifth root of it, and I got some of my aging factors by grading into some commercial carrier experience. And where I've been able to get data I've seen the effect of aging. It's not clear to me what the commentators that you paraphrased were saying. What's possible is that some people have speculated, although data are very sketchy, that there may be different morbidity between an active versus a retiree. Because, if somebody's retiring, they may be less healthy, and so a 55-year-old retiree may exhibit different morbidity than a 55-year-old active; and, depending on how you're studying the data, you may get some funny results.

MR. ELLIOTT I. COBIN: I'd like to add that the field test data did show increases between 65 and 75, but then they sharply tapered off after 75. I've also seen that in some other studies.

MR. CIRKIEL: One other quick comment then, if I could, on a different subject. For those of you who don't have any practiction at all in pensions, the technique that Dick presented, in terms of enhancing or giving better pension benefits to a group of people in lieu of taking away medical benefits, can't always be done. There are potential discrimination issues that are called separate benefit structures and you need to test for them.

MR. HARPER L. GARRETT, JR.: The question is for Dick. I just caught the last part of that, but on your illustration B, I was intrigued with the, if I understood correctly,

current retiree with a $30,000 liability. You were recommending to the company that they buy him out by giving him $10,000 cash, maintaining $10,000 instead of $30,000 of liability, and pocketing the other $10,000.

MR. ULLMAN: Yes.

MR. GARRETT: Did your attorneys feel that was something with current retirees that would stand up? I mean, I could see a retiree spending the $10,000, running through the other $10,000 liability and being back on your doorstep, and I would think a jury would find in his favor. It just seems that's the kind of story that you would likely see.

MR. ULLMAN: Well, the idea was to give the retiree -- offer the retiree $10,000 in cash as an inducement for getting off the present plan. Once having done that legally, I don't think he or she would have a claim against the company for benefits, which he or she had voluntarily given up. To most people, $10,000 is a lot of money and it's very nice to get it in the form of a lump sum.

MR. GARRETT: I guess I would just suggest that, when you're dealing with people who might be in their 80s, a jury might find that you took advantage of them, but I may be wrong. It just seemed to me like something that might come back to bite you. I'd be very cautious about deals with people older than 65 that takes away a benefit that they have. Just a comment, just a thought.

MR. ULLMAN: Your point is well taken.

MR. GARRETT: I just want to follow up on Joe's question to Harvey earlier, if I understood correctly. I think I agree with Harvey that you don't have to separate the utilization, except, I think that the FASB does want you to have different trend factors for things like doctor's cost, hospital cost -- that sort of thing. They expect you to apply maybe five different trend factors, if you can.

MR. SOBEL: I've seen that done and would certainly recommend that, where we have a separate program. For example, if I'm doing base hospital, base medical/surgical, supplemental major medical and prescription drugs, it's wholly appropriate. I think it becomes a little more difficult when it's a comprehensive major medical or even in the example I gave you -- a wrap. I only showed one number just for simplicity, but, in reality, I could have presented to you separate trends, yes.

MR. GARRETT: George, you were talking about the types of things that the FASB has been considering and I just wondered if anybody in the room was at the meeting, because I understand they did make some decisions, and I got that second or third hand from someone.

MR. ROCCAS: Obviously, when I prepared this, I could not prepare it as of the current date. I have not heard, by the way; what did happen?

MR. GARRETT: Let me just pass along what I heard, for what it's worth, which is second or third hand. But I understand that the FASB did decide to permit anticipation

of plan amendments. In the area of cost shifting, such as coinsurance contributions -- things like that -- that if you could show you had a history of changes, you could anticipate the same. I guess the way you would implement that would be to just subtract the value off the trend factor that you were otherwise going to apply. It was one of the things that employers uniformly ask at the hearings. Frankly, I never thought that the FASB would reach this conclusion, but I understand that they did reach a tentative decision on that.

I understand that they also received a tentative decision, in a very short time, that they were going to maintain the attribution period at date of early retirement even though, again, it was uniformly believed that it should go to date of actual retirement.

MR. ROCCAS: I'm glad you passed that along because I . . .

MR. GARRETT: Well, for what it's worth, okay.

MR. ROCCAS: As far as the attribution period is concerned, I was under the impression that they were not going to make a decision on that until later, but maybe something changed.

MS. CAROLINE S. CARLIN: I have a question for Dick again about the illustration -- group B. You had stated that all plans in that flex situation will have strong utilization management features, cost sharing, cost containment features, and disincentives. Because in the Medicare eligible population so many HMOs are pulling out of the market and you've lost so much leveraging once Medicare takes over and pays the lion's share of the cost, traditional things like pre-certification lose a lot of their oomph. Have you thought that through? What sort of cost containment features have you thought about implementing?

MR. ULLMAN: Actually, we did not pursue that aspect of it to it's logical conclusion in making the presentation to this company. So, if another situation were to surface, we would have to think that through to a further extent.

MS. CARLIN: Do any other panel members have suggestions on cost containment in the Medicare eligible population?

MR. SOBEL: Well, I would just say, I agree with you it's tough. Medicare has its own protocols, and the fact that the hospitals are on DRGs limits the ability to gain any savings from reduced length of stay, so the employer is probably trapped. The only observation I could make is that, if the conditions are right, perhaps a Medicare HMO might help save dollars.

MR. COBIN: I would add, utilization review on prescription drugs would probably be very important and could help a lot. Drug costs, I'm understanding, are increasing at a trend rate of more than 20% at this time.

MS. CARLIN: It's also 30-50% of your Medicare eligible cost. That's the only area where I found you can really have a significant impact.

MR. MARTIN E. STAEHLIN: I just want to say real quickly that -- I'm not going to answer for my other Chicago coworkers -- I was at that meeting, but I didn't go to the presentations, so I just want to say something about the cost. I think it was true, as Elliott did comment, that the charges went up into the early 80s. They did go up from 65-85, but I'm not sure if it was tongue and cheek about shattering the myth of the age curve. The cost did taper off in the late 80s and 90s. There was another thing, though, said about the last year of life. I think, again, that may have been a tongue and cheek comment, in that, we didn't have data by, you know, how much was in your last year of life. So, I'm not sure they could have said that -- somebody may have seen that as a sidelight.

The other thing that I want to say is, that it was true that, if you either had Medicare carve-out or exclusion, the claims were leveled from 65 for the entire rest of your life. So, although the charge level continued to go up, as did Medicare's payments, the claims that the employer would see and pay were level. So that post-Medicare, the cost to each retired life was relatively flat, if you had exclusion or carve out. That also may have been the nature of the comments that, after you're older than 65, costs don't change to the employer.

MR. ROCCAS: I think that was the context because I don't think anybody really cares. I shouldn't say that, but I don't think an employer cares whether the Medicare piece goes up or not. I think he's only going to be concerned about his piece, so, I think that was the context of the idea.

MR. SOBEL: I can't comment on the flatness beyond age 65, but in my example, I've shown that once a person turns 65, there's a 5% drop off in what's being reported as gross charges. These charges are the items I talked about, which are the hospital DRGs being less than charges, the participating providers being reimbursed at the Medicare allowance, and nonparticipating doctors being capped off at the MAAC. When we go to the ban on balance billing next year, it will even intensify. So I think that there's a spike, at least a one-time spike when they cross over the 65-year-old threshold.

MS. JUDITH A. DISCENZA: We've looked at this aging phenomenon just recently and found that, if you split it into three pieces, it becomes pretty explainable, at least in our eyes. Part A claims continue to climb indefinitely. We didn't split out the last year of life, but part A claims continued to climb indefinitely. Part B claims, the inpatient services, especially surgery, parallelled part A and continue increasing. But part B benefits, for office visits, actually go down for ages older than 80, and we found that quite reasonable in that the aged would have a more difficult time getting to a physician's office.

MR. SOBEL: Did you look at utilization versus cost per service?

MS. DISCENZA: I wish I could remember.

MR. SOBEL: Or is it just per capita?

MR. DISCENZA: I know it was at least per capita; I didn't actually look at the other.

MR. ROCCAS: Could I ask you a question on that? Concerning what you said about that in the 80s the office visits went down. I'm not sure where I've seen this, but I've seen some comment that was that, by the time most people -- a lot of people get to their 80s -- they're either in a nursing home or they're the people who are so healthy that they are on their own or they're living without medical problems. And that the nursing home people are probably the ones where the cost may be just going out of sight; but, again, that's not being cost shifted back to the employer, as I understand it. Do you find that phenomenon or did you see any of that in your statistics?

MS. DISCENZA: It's so early and we didn't look at that. We were just trying to figure out what it was that made part B seem to flatten out entirely and found that, if you split it into those two components, at least it seemed reasonable.