RECORD OF SOCIETY OF ACTUARIES
1991 VOL. 17 NO. 3B

POSTRETIREMENT MEDICAL (ADVANCED)

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- SFAS 106 – The Accounting Standard
- Plan design alternatives for controlling cost
- Funding the liability
- Retiree cost-sharing arrangements
- Trend considerations
- Controlling pre-Medicare cost
- Recent changes to Medicare which affect postretirement liability

MR. JONATHAN M. NEMETH: Since I have come to Colorado, I have learned that 37 million Americans are without health insurance, that health care costs are increasing at a double-digit rate, and that due to the aging of our society and other reasons, things are probably going to get worse before better. Hopefully, our panelists will present to you some more optimistic information than I heard in some of the other panel discussions.

Our first speaker is William Reimert of Milliman & Robertson. Bill is a consulting actuary and has worked extensively on postretirement health problems. Bill will be discussing the new FASB standard, SFAS 106, issues such as funding the liability, the pros and cons, and also some of the considerations one should use such as trends in developing a FASB liability.

MR. WILLIAM A. REIMERT: A recent session on SFAS 106 discussed the new standard, and there was also another session on funding. I will take a slightly different perspective, that of a client. What are the implementation decisions to be addressed with a client? Consider four different categories: timing, substantive plan, measurement assumptions, and transition obligation.

Timing – When would the client want to adopt this standard? It has to be effective for most employers by calendar year 1993, technically the fiscal year starting after December 15, 1992, but FASB is encouraging earlier adoption. So, when does the company want to adopt it?

Substantive Plan – What is really the substantive plan that should be accounted for under the statement? This issue is somewhat new, although it is a bit of a carryover from SFAS 87.

Measurement Assumptions – Trend, and assumptions underlying trend.

Transition Obligation – When will it be recognized? I think this is one of the more critical issues.

From a timing perspective there are key issues.

Administrative Feasibility -- What is administratively feasible? I know from my experience in consulting with clients I have found that there are some clients who really have a good handle on these costs or their insurance company or third-party administrator (TPA) has some fairly good statistics. However, many companies do not have a handle on what these costs are. They may not even know who is covered. The actual claim costs may not be tracked separately for retirees from actives. While there has been more awareness over the last few years, there are going to be major problems, especially in a large company with many subsidiaries and locations with, possibly, many different benefit plans. For practical purposes, it may be impossible for them to attempt to adopt it before 1993.

Plan Changes -- Another major and second key issue on timing is, "Does the plan sponsor have any intention of making any significant changes, particularly in plan design?" Typically, it is going to be advantageous to sort through what plan design or plan changes might be made, and if they are going to be adopted soon, it is probably best to adopt them before the statement is adopted, especially if the goal is to try to minimize some of the accounting cost. With the plan sponsors that I have worked with, by and large, that certainly is a major consideration.

The second area I mentioned is the substance of the plan. What is the substance of the commitment from the employer? SFAS 87 is the statement comparable to 106 that set up accounting standards for pension plans, and one of the paragraphs in that said that, if in the operation of the plan, there is an ongoing pattern and a commitment of the employer that has been communicated to periodically improve the pension benefit, then that commitment is really what ought to be expensed rather than just what is written in the plan documents or the summary plan description. The intent of this paragraph is to cover situations where the employer was frequently or at least periodically liberalizing plan benefits.

Costs are to be the full level that ought to be recognized. On retiree health in particular, this is really a double-edged sword. For some plans, it can work the same way that it did under a pension plan if there are dollar-denominated benefits. Companies have started adopting dollar-denominated health plans, some as early as 1986-87. If there is a typical pattern of increasing these dollar-denominated benefits that are being given to retirees to provide health insurance, then again that ought to be recognized as the substance of the commitment, the substance of what should be accounted for and what costs ought to be recognized. But the other edge of the sword comes into play here for the first time. Criticism that FASB received on its initial exposure draft was that a lot of companies contended that they either had a pattern or they had a commitment or they fully intended at least to adjust the benefits provided by the plan as costs continued to escalate. They might increase cost sharing from retirees or increase deductibles or do something to somehow hold down the cost of the plan to something that was affordable, and FASB said that there are really two tests that an employer sponsor can look at. These are either/or tests.

1. Is there a clear, historical pattern of cost sharing? Periodically, every year, every two years, retiree contributions have been increasing. Perhaps it happens at the same time that contributions for active employees are also changed.

2. Alternatively, if there is not a clear, historical pattern, has the sponsor clearly communicated this to the plan participants? Are they in a position where they clearly know that the employer, the plan sponsor, intends to change plan benefits periodically? And they know that the commitment is there. It has been communicated. Perhaps the employer has already told them exactly what kinds of events would trigger such a change. In either of those situations then the FASB is also saying, okay, go ahead, account for the substance of the plan, otherwise we are going to take a look at what is out there, what is written, and that is what has to be accounted for. So, it is important in dealing with these issues with your clients to get a handle on what the patterns have been and what has been communicated. There is certainly time before adoption for clients to communicate clearly their intentions.

MEASUREMENT ASSUMPTIONS (IMPLEMENTATION)

Demographic – A recent session discussed the importance of turnover assumptions in retiree health, as well as retirement age assumptions, and the contrast was made to a pension plan. In a pension plan typically people are vested in five years or ten years, and after that point turnover becomes much less of a significant discount factor in holding down costs. Retirement age assumptions may be less critical if the plan provides either actuarially reduced or at least substantial reductions in benefits if people retire early. Under retiree health quite frequently nobody is vested until they actually retire from the company. The value of the benefits payable to somebody at 55 might have twice the value or potentially more than twice the value of what the benefits might be payable to somebody if they waited until 65, and that is primarily due to the fact that after age 65, Medicare comes into play and somehow plans coordinate with that. Prior to 65, the plan stands on its own, and it has to cover the full freight. It is really important to look at turnover. A lot of pension actuaries may understate turnover. If you are going to do an evaluation and focus on turnover, take a really careful look at what turnover is among long-service employees. Use select and ultimate assumptions. Do not just focus in on an age-related turnover scale or what you may find is that high levels of turnover in the first few years of employment in your actuarial methodology are going to be applied every year through a 20- or 30-year or maybe even a 40-year career or potential career of an employee.

Discount Rate – On the discount rate area, basically 106 is substantially the same as Statement 87. Look at yields on high quality, fixed income obligations, or settlement rates. Outside of one company who actually is offering fully paid, single premium retiree health insurance, settlement rates are really not widely available. Most people are going to be looking at either government bond yields or high quality, triple, double A corporate or utility rates.

Health Cost Trend – In the health cost trend assumption, try to be reasonable. Try to think through what it is that you are really projecting out. Some work on health insurance focuses on health trends over a 6-month or a 12-month period, and sometimes going out 24 months. In contrast, a pension actuary makes assumptions that go out 24 years or 50 years or 75 years, whatever it takes before the final benefit payments are going to be made. Make sure you set some assumptions that somehow provide for the high levels of inflation without just projecting them out indefinitely.

Plans continue to experience high levels of inflation in health care costs. Start scaling down that trend over time because, over the long haul, health costs cannot grow faster than the U.S. economy grows in total. They can for a long temporary period of time. I do not want to say when it is going to end, but at some point it will grow at the rate of the U.S. economy. Check your final trend assumption against its implication about the long-term growth in the health care component of GNP. Right now it stands at about 12%. If you look at growth rates in the U.S. economy, do not just look at inflation. Also factor in per capita or productivity growth because both of those have to be taken into account, and then whatever you think long-term inflation might be and whatever you think long-term productivity growth might be, take a look 20, 30, 40 years out with what your trend assumption would have built in as excess growth in health costs. Some number for health care component of GNP between 15% and 30% is consistent with projections that I have seen. If you get outside of that range, you may be right. I certainly do not know what the future will really hold, but at least be aware of the fact that you are then getting outside of the range. So, be a little careful.

TRANSITION OBLIGATION

The most obvious implementation decisions is what to do with the transition obligation that is going to exist initially, and there are two options set forth in the accounting rule. Under the actuarial methodology that has been adopted by the FASB, this is how to attribute the liability for retiree health (I keep talking about health, but this statement also covers life and other benefits). Take the total liability and carve it out between what is attributable to past employment and past service, what is attributable to the current year's employment, and then what will be attributed or accrued in future financial statements.

Since this standard has not been in effect in the past, and the vast majority of companies have just been pay-as-you-go expensing and also funding for these benefits, what do you do with the past liability, all this amount that should have been accrued in the past, the accrued liability, the past service liability? The FASB gave companies two options:

1. Immediate recognition
2. Funded over (amortization) the longer period of
   a) average future service period of employees or
   b) 20 years

Immediate Recognition – Surprisingly, many companies are very seriously considering immediate recognition. One client contacted us in early January, as soon as the statement was released, and wanted us to quickly update the last set of numbers we had done for them because they were closing their books in a week or two, and they wanted to book it immediately. Two kinds of companies who are interested in considering this are companies who are either in really great shape or who are in really bad shape. The ones who are in really great shape might be in a cyclical business. They might have just had a fantastic year. For example, health insurance carriers are familiar with underwriting cycles in health insurance. Perhaps this is a good period of time for underwriting profits. Maybe this is a good time for people who provide health insurance to recognize these liabilities because a couple years out the underwriting cycle may have turned south again, and then it might not be a good time to deal with this problem. Or, alternatively, the last few years have been tough; to just

clear the decks, get everything recognized and start building for the future, convince not only management but also the board and investors that there is a turnaround coming on. Book it now and get it out of the way to hold down on future expenses. These considerations are involved in the thought process that has been going on with these companies.

To illustrate the magnitude of the numbers, the first four lines are service cost, the portion of the cost that should be attributed to the current year and the interest cost on the cumulative liabilities (Table 1). A return on assets for them under SFAS 106 would be zero because typically they have never prefunded it. From the fourth line, the amortization line, under the very first column the amount is $344 million if they wanted to book it all in the first year as opposed to a little over $17 million if they wanted to spread it out over a 20-year period. To state these numbers in current dollars, the options are between booking a Year 1 cost for them of $377 million versus $50 million, but the good news is, going out over time, they would be looking at about a $33 million accrual each year thereafter as opposed to $50 million. That is the trade-off.

TABLE 1
Transition Illustration
(Amounts in Millions)

	Immediate	Amortization	Difference
Service cost	$ 4.6	$ 4.6	
Interest cost	28.4	28.4	
Return on assets	0.0	0.0	
Amortization	344.0	17.2	
Total cost:			
Year 1	$377.0	$50.2	+ $326.8
Years 2-20	33.0	50.2	− 17.2

Note: Pay-as-you-go cost was $14.3.

For other accounting issues that have to be dealt with, some are outside of the FASB. The SEC Standard Accounting Bulletin #74, sets up rules for companies, requiring them to disclose the fact that there may be an accounting standard that they are not currently complying with. This does not mean that you are somehow violating the rule in SFAS 106. You have to make some disclosure in your financial statement so that readers of the financial statement will know that the new standard exists.

What methods of adoption might be available for the plan sponsor? What will be the expected impact? If the company knows or has an idea what it will be, it is to disclose it, as well as the effect on other matters regarding the company. Will this affect debt covenants? Will this require some changes in business practice? All of these things are supposed to be disclosed. Depending on where the plan sponsor is, there might be some industry-specific standards that an employer should consider.

Insurance Companies – The National Association of Insurance Commissioners (NAIC) does not appear to have any rules on how to deal with this on the annual statement for insurance companies.

Utilities – Utilities or, in general, people whose rates are regulated, must consider the effect on the rate regulatory process and what can be approved.

Defense Contractors – Recently the Cost Accounting Standards Board announced that it will allow government agencies to reimburse companies for SFAS 106 costs even if they are not funded. So defense contractors should investigate with the agency they are dealing with. There are some other FASB statements. SFAS 96 deals with the treatment of deferred income tax effects. The FASB is issuing an exposure draft changing SFAS 96 to deal with problems under SFAS 106, and where there is a lot of deferral time for an expensition before you see the income tax benefit. The FASB is expected to produce an exposure draft very soon. Also, SFAS 81 is to remain in effect for disclosure until companies adopt Statement 106. Finally, the technical bulletin has now been superseded. It has been rescinded because companies cannot now change, other than to the new Statement 106.

On advanced funding, several opinions suggest funding these SFAS 106 costs; that that is a way to keep them under control. I think that is an illusion. It does not end up controlling the costs. The importance of funding is the benefit security to people. Funds outside of the corporation, in a separate trust, are available just as for a pension plan to pay benefits after retirement. Under the SFAS 106 methodology, if you fund the plan, you produces a credit against your cost, the expected return on plan assets. On the surface that reduces the cost accrual, but there was cost to take that money outside of the company. There is an interest cost if the money was borrowed. You just have an interest cost somewhere else. More likely funds that would be generating better future operating income inside the company are in an outside trust. So the result is a loss, unless the after-tax return on the retiree health fund is actually higher than for internal operations.

Some key issues are the following:

1. What is an employer's cash flow if he is going to consider advanced funding?

2. What is his cost of capital?

3. Will this affect his borrowing and what he has to pay on borrowed funds?

4. What is his tax status, both currently and what he sees moving out over time?

5. What is the legal environment?

6. How will this affect employee morale?

The real plus can come from the effect of advanced funding on employee morale. Advanced funding just to get the cost savings does not make a lot of sense unless, for example, it is a regulated company who, for some reason, cannot get these costs reflected in its rates unless it funds the money outside.

MR. NEMETH: Our next speaker is Carter Warfield of Health Care Financing Administration. Besides being an actuary, Carter has an MA in math from Indiana University. Carter, for the last six years, has been the director of the Division of Supplementary Medical Insurance, better known as Medicare Part B. Most employers' medical plans coordinate in some fashion with Medicare; therefore, it is very important to understand what Medicare is paying. Carter will review recent changes in the Medicare program, how the Medicare program works in some detail, and how to develop your postretirement health liability with respect to Medicare.

MR. CARTER S. WARFIELD: The recent changes in Medicare have been overwhelming. I will concentrate on the 50 changes that are primarily in OBRA 89 and OBRA 90, primarily in the Part B side of the program. The physician payment reform has been discussed along with the resource-based relative value system (RBRVS). How does the system work and what impact is there on individual programs? There are two parts of physician payment reform. One of them is the fee schedule, and the other deals with the Medicare Volume Performance Standard.

The general rule states that the fee schedule is the product of three factors:
1. Relative value units
2. Geographic adjustment factor
3. Conversion factor

The relative value units (RVUs) are done for each service. The geographic adjustment factor is for the service in the area. The conversion factor is a uniform conversion factor.

The geographic adjustment factor is the sum or the weighted average of the geographic practice cost indices of three components:
1. Work of the physician
2. Practice expenses
3. Malpractice insurance

This general rule appears in the Notice of Proposed Rule Making (NPRM). The NPRM contains all the relative value units for all the components, for all the services, and also contains all the geographic adjustment factors for all the services. The NPRM was just issued and is now available to the public through the *Federal Register*. The final rule will be coming out in September.

A more detailed rule is that the fee schedule constitutes the sum of the following three terms times the conversion factor:

1. The RVUs for the work times the geographic practice cost index for work.

2. The RVUs for practice expenses times the geographic practice cost index for practice expenses.

3. The RVUs for malpractice times the geographic practice cost index for malpractice.

The conversion factor is to be set up so that in 1991, the program would be budget neutral. Actually, when it is first implemented in January 1992, the fee schedule will be budget neutral. Because of the RVUs, some specialties will receive higher payments than under the old system, and others will receive less. Even with the geographic adjustment factors, there are going to be sections of the country that are going to be winners, and there are going to be sections of the country that are going to be losers. Medicare is trying to adjust for inflation, but the inflation adjustments may not parallel the old system. Consequently, we anticipate behavioral changes on the part of physicians to make up for the losses that they may be incurring. Our assumptions are based on the fact that if a practice is going to be losing money, the practice is somehow going to alter its behavior to try to recapture some of its lost business. Assume conservatively that it will try to recapture half of what it is losing. For those that are gaining, there will be very few behavioral adjustments. Much debate and discussion dealt with resultant behavioral patterns on the part of physicians. Since there are going to be rather dramatic increases and rather dramatic decreases in the process of setting up the fee schedule, there is going to be a transitional period 1992-95 for phasing in the fee schedule. The fee schedule will become fully implemented in 1996.

With Chart 1, the criteria is discussed for the adjusted fee schedule or you actually use the set-up fee schedule and the resultant impact on the system. In 1991 we established an historical payment basis for every service. It is the national weighted average of what the program is currently reimbursing or we anticipate to reimburse in 1991. An update factor will be set for 1992. The criteria for determining whether the service will be affected by the transitional rules is this: If the product of the historical payment basis and the update factor is greater than 85% of the fee schedule for 1992 or less than 115% of the fee schedule for 1992, in other words, if it is within 15% above or 15% below it, then you will get the fee schedule beginning in 1992. Otherwise you will be affected by the transitional rules, which gradually phase in the fee schedule until 1996, when everybody will be under the fee schedule. The process of implementing the transitional rules might conflict with doing the budget neutral conversion factor. Set up the budget neutral conversion factor supposedly based on the data for 1991 before doing the transitional rules. The problem with the transitional rules is that the people who are going to be getting the increases are going to get larger increases than the people who are going to be getting decreases. Consequently, once into 1992, because of the people who are affected by the transitional rules, the fee schedule will not be budget neutral. The

CHART 1
Fee Schedule for 1992 if:

$$0.85 \times FS_{92} < HPB_{91} \times UP_{92} < 1.15\ FS_{92},$$

Fee Schedule is Unadjusted
Otherwise, Fee Schedule is Adjusted by Transition

Note: FS = Fee Schedule
HPB = Historical Payment Basis
UP = Update Factor

conversion factor in 1992 tries to set up a fee schedule with the transitional rules that will be budget neutral. The altered conversion factor to take into account what the impact is going to be on doing the transitions. Also, the conversion factor is reflecting the assumptions for physician behavioral changes. As a net result, by 1996, when the fee schedule is fully implemented, the fee schedule will probably be about 6% lower than what the old system would normally have been. This adjustment done for the transitional rules becomes a permanent factor of the fee schedule. Right now, in the NPRM, the conversion factor is 26.873. That factor will be looked at again. It is based on data from 1989, looking at frequencies of services. Between now and when the final notice comes out, preliminary data for 1991 will be reviewed, and therefore, that factor could change somewhat.

FEE SCHEDULE UPDATE

After the fee schedule has been set up, Medicare must update from one year to the next. The process is set up for Congress to make the determination of the update from one year to the next. The Secretary of Health and Human Services first recommends to Congress as to the update. The recommendation will consider the Medicare economic index (MEI) as it now exists (that will continue to exist, by the way), which is a measurement of inflation and the cost of running a physician practice. The Secretary is supposed to also consider the following:

1. The performance adjustment
2. Access to services
3. Changes in the volume and intensity of services

Then the Physician Payment Review Commission will make its own recommendation as to what the update should be. Congress will use all of this information. Congress may go along with either one of the recommendations, implement its own adjustment, or not do anything at all. There is a default mechanism for doing the updates if Congress does not do anything. The formula for doing the default update would be the MEI less this performance adjustment to be defined. It gets into the volume performance standard. The performance adjustment, though, is limited. If it is going to be a downward performance adjustment, in other words, if this value is positive, then it can be no higher than 2% for 1992 and 1993, 2.5% for 1994 and 1995, and 3% thereafter. If Congress does not act, the default mechanism would go into place. It is impossible to predict what Congress is going to legislate.

Now on to the Medicare volume performance standard (MVPS), to see how this is linked particularly to this performance adjustment. The volume performance standard is an attempt to control the increase in the volume and intensity of physician services. It allows for a standard for the percentage growth in physician services. It is set on a fiscal year basis, and the government fiscal year is the 12-month period that ends in September, whereas the fee schedule is set up on a calendar year basis. Therefore, they are not in the same time frames. After the fiscal year terminates, the performance adjustment factor is calculated. It measures the actual increase in expenditures less what the MVPS update was. Consequently, this performance adjustment is used in the default update for the fee schedule.

VOLUME PERFORMANCE STANDARD UPDATE

Now, the process of doing the volume performance standard works exactly the same way in terms of setting it up. Essentially it is set up so that Congress can legislate what this volume performance standard should be, but in the process, the secretary of Health and Human Services will go through and make a recommendation of what the update should be. Certain factors to be considered are as follows: inflation; changes in the number of enrollees in the program, other than those individuals who are enrolled in risk-based HMOs; changes in the age composition of the enrollees; changes in technology; and evidence of inappropriate utilization of services and other factors that the secretary considers appropriate.

So the secretary can utilize a lot of different criteria before making a recommendation. The Physician Payment Review Commission at that time will go through and make its own recommendation for what the update should be. It usually reviews the one that the Health Care Finance Administration (HCFA) has established, and then Congress can take either one of the recommendations, come up with its own recommendation, or else not legislate or not act at all in terms of determining the volume performance standard. If Congress does not act, then the volume performance standard is set at the default level. The default level consists of the following percentages: Average increase in physician fees; change in the average number of enrollees other than those that are enrolled in risk-based HMOs; particularly for the volume and intensity portion of it, it is looking at the five-year historical average that is displayed from data that are in the most recent trustees' report; increase in expenditures for physician services resulting from changes in the law that have been previously enacted; and, performance standard factor.

There are some other adjustments. Assume that the default standard is the one to go into place when we are doing our particular projections. For example, if the default update were going to be used for 1992 for updating the fee schedule, the system would work as follows.

Take the MEI that would go into effect for 1992. There is another factor in here not preciously covered. It is –0.4%. That comes about because in OBRA 1990, Congress changed the way the update would be done just for 1992. In doing the default update, take the normal process and reduce it by 0.4%, and then subtract off the performance adjustment. Based on the data now, the performance adjustment that is going to be used here is based on fiscal year 1990. So, this is going to be in effect for the update of the fee schedule for calendar year 1992. Use the fiscal year 1990 comparison of actual increases in expenditures with the volume performance standard. Based on the data, actual expenditures increase 10.6% in fiscal year 1990. The volume performance standard was set at 9.1% for fiscal year 1990. Therefore, the difference is 1.5%, and that falls within that range. Remember, this is going to be a downward adjustment, and it has to fall within certain ranges, and it can be no more than 2%; therefore, this difference of 1.5% meets that requirement.

What is the impact on your plans? The fee schedule is going to bring about major shifts in the reimbursement of physician services. Certain physician specialties are going to gain, particularly those people who are dealing in primary care, general practitioners, family physicians in particular, and the people who have been doing some of the more high-tech procedures are going to be the people who are going to

be cut back. For instance, consider cataract surgery. Discussing cataract surgery, Harvey Sobel was afraid that physicians are going to be run out of practice due to drastic cuts in the reimbursement level. Cataract surgery turns out to be the most frequently performed Medicare procedure, and it is probably the one considered to be the most overvalued, and it has been cut repeatedly in past legislation. It was cut in OBRA 1989 and OBRA 1990 and had been cut in prior OBRA bills as well. Sobel shows a geographic location, Manhattan, which is probably one of the more expensive ones which is probably subject to reductions anyway. There are going to be physician specialties that will lose. There are going to be geographic areas of the country that are going to gain, and some areas will lose. In evaluating plans, analyze the geographic concentration of plan participants. Consider behavioral changes on the part of the physicians due to this fee schedule. It is not just going to affect Medicare. Physicians could shift cost into their non-Medicare business, and that could affect not only the postretirement plans but some of the other employer plans as well. And, furthermore, it is probably going to carry over. Maybe the fee schedule will be used outside of the Medicare arena, in some other plans.

Let's discuss the limiting charge. Prior to 1991, Medicare had what they called a maximum allowable actual charge (MAAC) limit. They are using the same concept except they are calling it a limiting charge. The law will specify certain limits. it will affect nonparticipating physicians and what they could actually submit to the program. The upper limit for 1991 is 25% for most services except for evaluation and management services, where the upper limit is 40%. Looking at the MAAC limit for 1990, the increase over the prevailing charge, if they retained that same percentage for 1991, that percentage cannot exceed 25% in general and then 40% for those services that are evaluation and management. For 1992 that limit reduces to 20%, and then for 1993 and thereafter the limit will be 115%. So, plans that are dealing with balanced billing will definitely be affected. One of the plans had about 50% of the physicians participating. Nationally, the participation rate is continuing to increase, and right now, based on charged distribution, it is about 60%. The assignment rate overall nationally is about 80%. This 80% includes all cases from participating physicians who are required to take an assignment and those cases from nonparticipating physicians who elect to take it.

A lot of other legislation changes will affect some reimbursement levels. The first thing is dealing with Medicare as secondary payor. OBRA 1990 extended the match of Medicare data with Internal Revenue Service (IRS) and Social Security data to identify individuals with primary health care coverage in tax years 1990-94. Medicare is attempting to identify those people who are in employer plans so that the employer will become the primary payor. It also extended the Medicare secondary payor provision for disabled beneficiaries through 1995. For people with end-stage renal disease, it increased the period of time that Medicare is the secondary payor from 12-18 months and also prohibited employers from offering financial or other incentives for individuals not to enroll into group health plans that would pay primary to Medicare, unless the same incentive was given to all the individuals under the plan.

Another change that was enacted in OBRA 1990 concerns the Part B premium, which was legislated for five years. This is the first time they have actually legislated a rate for the premium. In the past, Congress has legislated the process of determining the premium rate based on a function of the actuarial rate. It has been 25% from

1984-90, but beginning with 1991, they have actually legislated the rate. Based on the projections that were done when Congress was considering this, the rates turn out to be about the 25% provision, except for 1991. The rate they legislated was actually going to be the cost of living adjustment (COLA) adjusted premium. Also, beginning in 1991, there is an increase in the Part B deductible. That has been raised to $100, the first time that has been changed since 1982.

There have been some program expansions in Medicare as well, particularly in OBRA 1989. In the mental health area, the big change that occurred in benefits concerns the social worker. Clinical social workers are now covered effective July 1, 1990. Before, they were covered in limited settings only. This does not have a particular large financial impact, but the coverage of clinical social workers was a rather large expansion, the first time we have had one of that size for a long time. The outpatient psychiatric mental health limit that Medicare had on services has been eliminated. Pap smears are now covered by Medicare, and that was effective July 1, 1990. The individual can receive a Pap smear once every three years. In OBRA 1990, Congress went back and added the mammography screening benefit. This was a benefit that existed when they had the Catastrophic provision in the legislation which got repealed before it actually went into effect. It is subject to limits on frequency depending on age, and the maximum allowed charge for that is $55 which will be indexed from year to year, and that went into effect January 1, 1991. Hopefully, my talk has provided a better understanding of the fee schedule and physician payment reform.

MR. NEMETH: Our last speaker is Ms. Neela Ranade of Actuarial Science Associates (ASA). Neela is assistant vice president in charge of ASA's health and welfare consulting practice. Neela will be discussing plan design alternatives for controlling FASB expense, including retiree cost-sharing arrangements and also mechanisms for reducing an employer's cash flow with respect to retiree health care.

MS. NEELA RANADE: I wrote an article last year on defined dollar plans, when defined dollar plans were a relatively new concept.

Some of the more interesting developments in plan design are actually due to the interaction of Medicare with plan design, and I'll be taking forward some of the OBRA 1989 and OBRA 1990 concepts presented by Carter.

The May 19 edition of *The New York Times* stated: "Many believe that the American health care system is a system in crisis, a crisis marked by sharp contrasts drawn mostly along class lines but permeating every segment of society. Now, after decades of fruitless debate, it has inspired a sense of urgency." We see that sense of urgency in the actions that employers are taking with respect to plan design, particularly retiree plan design, due to the impetus SFAS 106 has given to this area. This sense of urgency is supported by the results from a survey done by the Financial Executive Institute (FEI). It was a survey of the 20 employers constituting the Committee on Employee Benefits of the FEI, and even though it covers a small group (the employers covered are medium- to large-sized employers), the results are representative of what is generally happening in this area. For instance, the survey found that of the 20 employers, 12 had already modified their retiree benefit plan design significantly, usually for future retirees, and seven expected to make significant changes before adopting SFAS 106. Most of the benefits changes focus on reducing

the employer's burden for the retiree cash flow, but design changes are tied inextricably to the impact the design has on the FASB expense and liability. Look at benefit design for both pre-65 and post-65 retirees, and how some recent laws impact over-65 design. Some plan changes can be implemented to reduce cost. I will focus on newer developments in this area.

Lifetime Maximum – If it's a fairly low maximum, like $100,000, or even lower, you can have a significant reduction in liability. A $100,000 lifetime maximum could reduce liability by 20-30%. Spectrum Funding issued a single premium group health contract with a $25,000 lifetime maximum. It's not recommended as an optimum design because it impacts those retirees most in need of the benefits, namely those retirees who have catastrophic illness.

Restricting the Surviving Spouse Benefit – Some of the older industries have this benefit where if a retiree dies, the surviving spouse gets free lifetime coverage. These industries tend to be male-dominated industries, and that is where the cost is maximum. If you have a largely male retiree population, your liabilities could increase by up to 40% on account of offering this benefit. We have employers who are looking at the surviving spouse benefit and trying to restrict it for a limited duration or a limited level of coverage.

Retiree Contributions – On the question of retiree contributions, Bill referred to the issue of substantive commitment. Under SFAS 106, it has to be very clearly communicated that the retiree contributions will increase as the retiree health care costs increase. Otherwise you are required to assume that the contributions will remain flat.

Flexible Benefit Plans – Several clients have flexible plans for active employees who are now looking at extending the flexible design to retired employees. The primary advantage of flexible, which is that you can make pretax contributions to purchase benefits, is not available for retirees. The Internal Revenue Code makes that very clear. However, an employer may offer options for the medical plan, dental plan, life insurance plan and, possibly, long-term care plan. An employee may opt-down in, say, life insurance and use the credits available to purchase extra medical insurance. So, retiree flexible benefit plans can achieve cost savings and serve the employees' needs. There is a client who had another health consultant, eminent in the flexible area. The pricing they used initially for retirees was the same pricing as for actives. They did not realize the problems posed in terms of FASB calculations. They were combining the active and retiree claims and coming up with the charges and credits. The FASB liability must be calculated based on the expected employer's claims costs for retirees. With equal contribution levels for actives and retirees, since the retiree costs are higher, the retiree contribution as a proportion of the total retiree claims costs decreases over time. This leads to increased trend for the employer's claims costs for retirees. In terms of flexible plan design, we recommend having charges and credits based on expected retiree claims costs. In addition, to keep it clean, under- and over-65 retirees should be treated separately.

If the client wants to use subsidized charges and credits, one has to be careful to avoid an adverse impact on the FASB liability.

An employer may set up a reimbursement account which operates differently than an active employee's flexible spending account. Pretax money from a retiree's pension may not be put into the reimbursement account because the tax law does not allow it. Suppose the employer is providing, say, $3,000 for the retiree's medical costs, and the retiree chooses a lower option because he has coverage under his spouse's plan. Then the excess amount could be put in this reimbursement account, and the reimbursement account can be used by the retiree to pay medical claims such as deductibles or coinsurances or other unreimbursed medical expenses. The alternative to the reimbursement account is to return the amount to the retiree as a taxable amount. However, under the Internal Revenue Code, the retiree cannot get a deduction for medical claims costs unless they exceed 7.5% of adjusted gross income. Therefore, under the reimbursement account mechanism, there is a tax advantage to the retiree but there are increased costs to the employer in running this account. The retiree would have to submit expenses, and there would have to be a carrier writing the checks.

Coordination with Medicare -- Different integration methods achieve greater cost savings than others. Managed care plans are of great interest for good reasons. Of the 20 companies that were surveyed in the FEI study regarding the type of changes they had made or were contemplating, the change in the retirees' share of premiums was the prominent change, but that was followed by instituting managed care provisions, installing retiree benefits based on service or age, and defined dollar plans.

In examining managed care for retirees, look at the employer costs for under-65 and over-65 retirees separately. Under-65 costs for retirees are much larger than over-65 costs. Typical numbers are $4,400 for an under-65 retiree, including dependent costs. For an over-65 retiree, on account of Medicare, the corresponding amount might be $1,200. So managed care for retirees is primarily focused on under-65 retirees. Another reason for relegating managed care to under-65 retirees is the adverse interaction of recent legislation with managed care design for over-65 retirees.

The balanced billing limits have some beneficial effects on over-65 costs. Table 2A displays the limits and the corresponding effects on trends. The effect on trend of the balanced billing limits was estimated for a national employer, the geographic effect was not a big factor. Since the employer plan was rich, utilization of Medicare participating physicians was expected to be at a lower level than national norms. We assumed that 50% of claims were from nonparticipating physicians. The effects on trend that you see in Table 2B also take into account the cutbacks in the Medicare Part A portion due to cuts in hospital spending because of OBRA 1990. We found very dramatic effects. After considerable analysis, we found that in 1992, there would be a reduction in trend of 630 basis points. If our expectation of trend otherwise was 10%, the trend was expected to be lower than 4% under our estimates for the over-65 carve-out plan. In 1993, the reduction is 320 basis points.

We assumed that physicians and hospitals would compensate for the reduced Medicare payments by increasing costs for under-65 retirees and active employees. The result was cost shifting under which in 1991, under-65 trend goes up 130 basis points, in 1992, 130 basis points, and in 1993, 90 basis points.

TABLE 2A
Balance Billing Limits
under OBRA 89 and OBRA 90

1991 Limits	
Evaluation and management services	140%
Radiology, anesthesia & pathology	115
Other physician services	125
1992 Limits	
Evaluation and management services	120
Radiology, anesthesia & pathology	115
Other physician services	120
1993 Limits	
All physician services	115

TABLE 2B
Estimated Effect of OBRA 89 and OBRA 90
on Trend Rate for Employer Medical Plans

Year	Under Age 65	Age 65 & Over
1991	+1.3%	
1992	+1.3	−6.3%
1993	+0.9	−3.2
Assumptions: Employer plan is a Medicare carveout plan with 50% of physicians not accepting assignment		

In this particular plan the hospital carrier was Blue Cross/Blue Shield; therefore, we made the assumption that because of their favorable contracts with hospitals they could avoid some of the cost shifting. In doing this analysis, take into account whether there is a managed care type or a Blue Cross/Blue Shield type of favorable contract under which some of the cost shifting can be avoided.

Interestingly, we have seen very large employers, dealing with large carriers who have put in managed care plans for over-65 retirees, not realizing some of the unexpected effects that can occur on account of the balanced billing limits. An example is shown in Table 3A and 3B. Assume that the in-network plan has a $10 copay and no deductible and the out-of-network plan has a 80-20% coinsurance provision and a $200 deductible. The in-network plan has an incentive for use of in-network physicians. Generally, with a managed care contract, when an employee goes to the in-network physician, the physician discounts will offset the higher level of benefits so that everyone comes out ahead.

Table 3 demonstrates how this works for under-65 retirees but falls apart for over-65 retirees. For under-65 retirees the in-network physician charges $95. Out-of-network

reasonable & customary (R&C) is $112. Therefore, after the plan design coinsurance or co-payment is applied, the plan payment in-network is $85 and out-of-network it is $89.60. The employee liability in-network is $10, and out-of-network it is $22.40. Therefore, in-network, both the employer and employee come out ahead because of the discounted fee schedule. However, for over-65 retirees, it does not work that well. Two factors are the balanced billing limit and Medicare's allowance being typically well below the R&C. In this case the Medicare allowance for a participating

TABLE 3A
Effect of Balance Billing Limits on
Network Cost – 1993

Physicians Comprehensive Office Visit, Code 90080		
Network fee schedule		95.00
Reasonable & customary		112.00
Medicare allowance		80.00
Medicare payment nonparticipating		60.80
	Under Age 65	
	In Network	Out of Network
Billed charge	95.00	112.00
Coinsurance	100.00%	80.00%
Copayment	10.00	0.00
Plan payment	85.00	89.60
Employee liability	10.00	22.40

TABLE 3B
Effect of Balance Billing Limits on
Network Cost – 1993

Physicians Comprehensive Office Visit, Code 90080		
Network fee schedule		95.00
Reasonable & customary		112.00
Medicare allowance		80.00
Medicare payment nonparticipating		60.80
	Over Age 65	
	In Network	Out of Network
Billed charge	87.40	87.40
Coinsurance	100.00%	80.00%
Copayment	10.00	0.00
Normal plan payment	77.40	69.92
Medical payment	60.80	60.80
Plan liability	16.60	9.12
Retiree liability	10.00	17.48

physician is $60.80. The Medicare allowance for a nonparticipating physician is 95% of the allowance for a participating physician. Therefore, under the 1993 limits, the maximum that the physician can bill is $60.80 times 0.95 times 1.15, which equals $87.40, the billed charge. This is lower than the network fee schedule of $95, and the plan actually ends up paying more in-network than out-ofnetwork, paying $16.60 instead of $9.12. This came as a surprise to many of our clients, and they are now examining the over-65 retiree managed care design.

The other problem we found with respect to managed care for over-65 retirees was that insurers had contracts with physicians which stated that they would bill at the rate of the fee schedule. But these balanced billing limits or the RBRVS might be lower. Some major insurers are going to try to implement this as per the law. Frankly, they said, there might be some problems with physicians getting into litigation, trying to get the managed care contract to override the law, thereby allowing them to bill more than the balance billing limits would permit.

Another reason managed care for over-65 may not add value is that Medicare has its own utilization review (UR) procedures. The managed care UR procedures may not add value, being redundant or duplicative. The one area an employer needs to look at is prescription drug costs for both under and over 65.

In Table 4 installing a retiree medical plan, look at how much it's costing the employer for retirement at various ages and then see if the employer wants to change that schedule. If you are a pension actuary, this will be very natural. The point of Table 4 is that for an employee retiring early, an employer has to accumulate a lot more money over a shorter period of time for a traditional retiree medical plan, whereas in a pension plan the effect is not so pronounced since it is typically a years-of-service formula with an early retirement reduction.

TABLE 4
Effect of Retirement Age on Employer Cost
Retiree Pension Benefits Versus Medical Benefits

	Pension Plan		Medical Plan	
Age at Retirement	Amount Required at Retirement Age to Pay Future Benefit	Required Annual ER Contribution over EE Active Life	Amount Required at Retirement Age to Pay Future Benefit	Required Annual ER Contribution over EE Active Life
50	$73,485	$919	$52,223	$653
55	120,877	967	39,756	319
60	133,168	690	26,181	135
65	140,679	473	16,375	55
70	142,003	306	13,244	29
Assumed age at entry: 25				

Table 5 shows the effect of different versions of a defined dollar plan on the FASB liability for a typical retiree medical plan.

TABLE 5
Impact of Design on FASB Liability
Percentage Reduction In

	Benefit Obligation	Expense
Defined dollar	37	44
Defined dollar, prorated for years of service less than 25	39	46
Defined dollar, contribution reduced for age and service	42	50
Defined dollar, 25% premium sharing on dependent	44	52
Population mix: 70% actives, 30% retirees Existing retirees assumed to be grandfathered in previous plan		

Chart 2 is based on the chart seen earlier in Table 4 regarding how much retiree medical benefits cost at different retirement ages. The client didn't like it that intricate, so we came up with something that was an approximation called the Rule of 90. If age plus service was 90, the retiree got full accrual. If age plus service was less than 90, then accrual was reduced by 2% for each point that age plus service was less than 90. The Rule of 90 is not based on the principle of actuarial equivalence; however, clients do not always like actuarial equivalence.

Some major companies have redesigned their retiree medical plans: Quaker Oats put in an expense account for retirees which is $360 a year for 30 or more years of service and $120 for 10 years of service, and they have a catastrophic medical plan as well. Employee premium-sharing is required. The employer pays 95% for 30 years of service, grading down to 75% for 10 years of service.

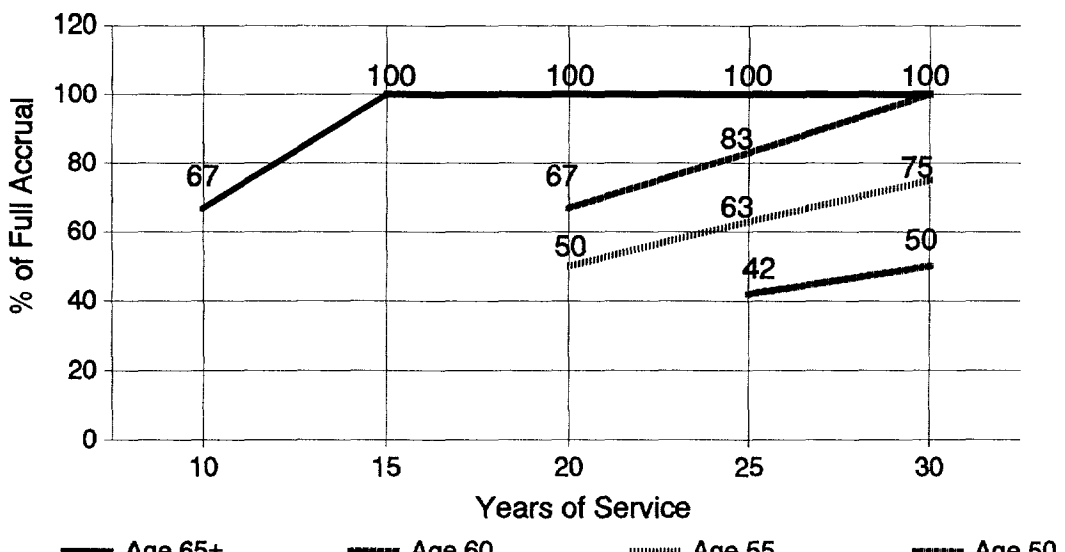
IBM and AT&T – IBM put in a retiree medical cap similar to AT&T. They also put in a health care account. The IBM cap is for future retirees, as is AT&Ts. Several major employers have put in these defined dollar caps. I worked on the AT&T cap which was negotiated in 1989 during the union bargaining with Communication Workers of America (CWA) and International Brotherhood of Electrical Workers (IBEW). Subsequent to that, IBM and some other major companies have installed these defined dollar caps. Caps raise issues of substantive commitment and increases, which Bill touched on. Six of the regional Bell operating companies have caps. Except for Nynex, all the other phone companies followed AT&T's example and bargained caps with their unions.

General Motors (GM) and Ford – The automakers, GM and Ford, are considering putting in caps. They have an understanding with their union where they say that they will be looking at defined dollar caps as a solution to increasing health care costs.

Ralston-Purina – Ralston-Purina made some changes for future retirees that require more retiree contributions. They also put in an employee stock ownership plan (ESOP) with an enhanced company match to the savings plan to let active employees accumulate amounts for retiree health costs.

Defined Dollar Plan

Contribution Reduced for Age and Service at Retirement



American Airlines – American Airlines did something fairly unique. On the theory that people can contribute more ably during active employment than during retirement, they asked active employees to contribute for their postretirement health benefits, and the amounts are put in a voluntary employees' beneficiary association (VEBA). The contributions are based on what age a new employee is when he comes into the plan, and they did it rather innovatively. By making the VEBA cover death and severance benefits, American Airlines got around some of the VEBA restrictions. Employee contributions are returned in the event of death or separation. The employee contributions are estimated to pay one third of the postretirement costs.

Capital Holding Company – Capital Holding Company took the easy way out. They just terminated the retiree plan for future retirees, and the existing retirees were given a cash-out option.