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POSTRETIREMENT MEDICAL

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- *SFAS 106*
- Plan design alternatives for controlling cost
- Funding the liability
- Retiree cost-sharing arrangements
- Trend considerations
- Controlling Medicare cost
- Effect of recent changes in Medicare

MR. DARYL J. VEACH: Our first speaker is Adam Meyers, an ASA and an Enrolled Actuary. He's a Vice President with Hay Huggins. The next speaker is Michael Cotter. He is an FSA, an Enrolled Actuary, and a Senior Vice President with Hay Huggins. I'm an FSA with Ernst & Young.

MR. ADAM E. MEYERS: I would like to provide an introduction to *SFAS 106* and discuss the philosophy behind the new postretirement rules, the methodology for the *SFAS 106* expense calculation, the effect of *SFAS 106* on company financials, and the impact of funding on the expense. In addition, I will provide a very brief introduction to some of the most common funding vehicles.

Why are retiree health and welfare benefits now a problem for employers? Basically, the problem has been around for many years, but it has come into focus only recently. We've seen skyrocketing medical costs for nearly a decade, which is really the primary reason for employer financial concerns. At the same time, we're seeing an aging work force, which means more retirees per active employee, and that trend is ever-increasing. We also see a shrinking Medicare offset, medical costs increasing faster than the Medicare reimbursement. This is somewhat mitigated by the balance-billing rules of Omnibus Budget Reconciliation Act (OBRA) of 1989 and 1990, which limit the physician charges to Medicare eligible charges. But, with the trend toward early retirement, we're seeing increased liabilities with no offset to which the balance-billing limits apply.

These benefits have little or no funding associated with them. They are primarily pay-as-you-go, where benefits or premiums are paid as they arise. The Financial Accounting Standards Board (FASB) expense requirement in 1993 is the reason for the current focus, but it's not the cause of the focus. These problems have been around for a long time. In particular, postretirement medical (PRM) benefits were not recognized as retirement benefits and were considered a minimal feature of the active medical plan. Employers have been surprised by the level of their PRM liabilities once they've done the calculations.

How big is the problem? We're seeing mind-boggling numbers. Seventy to eighty percent of the large- and medium-sized firms continue life and health benefits for former employees. We've seen escalating pay-as-you-go costs. For large plan

sponsors with a mature work force, pay-as-you-go costs can be expected to quadruple in the next 15 years, and these costs are just the tip of the iceberg. We are seeing enormous accrued obligations reflecting future liabilities with respect to service today. As you probably know, GE declared liabilities in the neighborhood of \$4.2 billion. IBM declared \$2.3 billion. GM will be declaring liabilities on their books in the neighborhood of \$16-24 billion. There might be as much as a trillion dollars in liabilities if we were to include future accruals.

Now what is the FASB view of postretirement benefits? Really, the postretirement medical view is very similar to the way FASB views any postretirement benefit, including retirement income benefits. Basically, the Financial Accounting Standards Board sees these benefits as a deferred compensation arrangement, where future benefits serve as compensation for current service and therefore, they should have an associated current cost. Like retirement benefits on *SFAS 87*, they should be accrued in the years earned, over the working lifetime of employees. In fact, nonrecognition on the balance sheet distorts the financial statements. The employer's assumed obligation to pay deferred compensation is a liability. It should be recorded on the balance sheet, according to the FASB. Now the situation with respect to retirement benefits is even worse than it was with *SFAS 87* because retirement benefits, for the most part, were funded where postretirement medical benefits were not.

The objective is to improve the financial reporting for retiree health and welfare benefits. How is this objective attained? Accrual accounting versus pay-as-you-go will include a portion of the cost on the balance sheet, which will impact on profit and loss (P&L) and the bottom line. The FASB is asking employers to disclose certain plan information, in footnotes, that was never disclosed before to shareholders. The hope is to achieve a uniform method of recognition, which may take some time, but will ultimately facilitate company-to-company comparisons. It is similar to *SFAS 87*.

The accounting impact, full accrual costs versus pay-as-you-go, significantly affects the employer's P&L, often reducing profits by 20% or more. In cases where profits are small, they can be totally wiped out. We've seen average annual increases in the neighborhood of 1% of payroll, on a pay-as-you-go basis, to 10% or more of payroll under *SFAS 106*. The impact will vary by individual employer. Plan features are different, the demographics are different; and the assumptions will be different. Many assumptions are still being developed. There are still many unknowns, and Daryl Veach will discuss the impact of the assumptions on the cost.

To which benefits does *SFAS 106* apply? The benefits covered include health and life insurance, tuition reimbursement, and any other welfare benefit. The focus is on single-employer retiree welfare benefit plans. Pension and disability benefits are not covered. *SFAS 87* basically took care of the pension benefits, and FASB is now working on disclosure requirements for disability benefits.

Welfare benefits provided to disabled employees who meet the eligibility requirements, and are considered part of the retiree medical plan, would be counted. But, if such individuals are part of the active plan, they're not included in the liability.

The effective date is, generally speaking, fiscal years beginning after December 15, 1992. There is, however, a two-year deferral for non-U.S. plans and small nonpublic

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plans with less than 500 participants. Participants would mean anyone who is expected to receive an employer-provided benefit, so you can really have more than 500 employees and still meet the requirements for this two-year deferral. When I say "non-U.S.," Puerto Rico is considered part of the United States.

After December 1990, the Securities and Exchange Commission requires an early indication of the impact of *SFAS 106* to the extent known or reasonably estimable. Lately there has been increased pressure from the Commission to disclose as soon as possible. In an addendum to minutes of a FASB meeting, they made it very clear that employers will not be able to wait until 1993 to disclose these liabilities. Companies that did not disclose in 1991 will probably be forced to disclose in 1992 and in annual statements before the January 1, 1993 effective date. I don't think that the SEC will buy a 1993 disclosure. Multiemployer plans have it a little bit easier. For these, you only need to disclose the description of the plan and the amount contributed on a pay-as-you-go basis.

The final *SFAS 106* introduced the new concept of a substantive plan, which wasn't in the initial exposure draft. It basically explains what plan of benefits is actually being valued. It forms the basis of the accounting and it represents the current and the future terms of the plan and the understanding of the terms between the employer and the plan participants. Note the term "understanding." It's important. It includes the written plan which reflects plan documents, insurance contracts, and summary-plan descriptions (SPDs). In addition, a consistent past practice of cost-sharing between plan participants and the employer is considered. For example, if retiree contributions have been increasing 5% a year for each of the past 10 years, when you do the valuation, that assumption can be assumed to continue.

In addition, this really should reflect the intent and the ability to change future cost sharing ("the ability," meaning that the participants will accept the changes without striking or demanding other benefits). The intent here means that the description of the changes must be communicated to participants. These new rules have a tendency to reduce the cost. They allow the employer to reflect increased cost-sharing provisions in the valuation process.

If no written policy for future change in cost-sharing has been formalized, now is a good time to develop and communicate such a policy to employees. An exception exists for collectively bargained plans. Basically, only the written plan should be reflected, because the employer doesn't really have the unilateral ability to make changes in the future.

The aggregation of plan rules applies to employers with multiple retiree welfare plans. Why aggregate? Basically, to simplify the accounting process and to lower administrative fees. There are two sets of rules for aggregation. One is for measurement purposes, and one is for disclosure purposes. The one for measurement purposes is more stringent. Funded plan costs must be calculated separately. In addition, health and nonhealth plans have to be calculated separately; i.e., life insurance or tuition reimbursement would have to be measured separately from medical.

Unfunded plans may be aggregated if (1) they provide different benefits to the same group of employees, (2) you have a separate dental, medical, and vision plan provided

to everyone or, (3) they provide substantially the same benefit to different groups of employees. If you have a comprehensive medical plan, one for unions and one for nonunions, and there is a \$100 deductible for the union plan and a \$200 deductible for the nonunion plan, you'd be able to aggregate; these benefits are substantially the same.

For disclosure purposes, there is broader latitude. Generally, plans will be aggregated, even health and nonhealth plans. Separate disclosures are required if retiree health and other welfare benefits are each a significant portion of the liabilities. Also, this applies if U.S. and non-U.S. plans are each a significant portion of the liabilities. In addition, total assets and accrued liabilities of overfunded and underfunded plans have to be disclosed separately.

What are the basic reporting requirements? Again, they're comparable to *SFAS 87* for pension plans. There is a net periodic postretirement benefits cost that is analogous to the net periodic pension costs for *SFAS 87*. It represents the cost of providing postretirement benefits attributed to the current accounting period, and it's charged against the company's earnings for the year. In addition, there are many disclosure items that have to be included in the footnotes of the financial statement. Note that the total liability that is equal to the expected postretirement benefit obligation does not need to be disclosed.

The attribution method describes how costs are assigned to each financial accounting period. The first step is to develop the expected postretirement benefit obligation, which is equal to the present value of benefits expected to be paid, based on the substantive plan and the actuarial assumptions. Basically, the expected postretirement benefit obligation (EPBO) consists of three pieces. We allocate the accumulated postretirement benefit obligation to past service. That's the portion of the EPBO attributable to past service. The amount attributed to the current year is equal to the service cost. And the amount attributed to the future service is aptly named the future service cost. The measurement date is usually the end of the year, and we disclose as of the end of the year.

The EPBO is divided into level annual amounts over the attribution period, which runs generally from the date of hire to the first full eligibility date. The full eligibility date is the date at which each employee earns the right to receive full benefits from the plan, and this will often be earlier than the assumed retirement age.

If the plan defines an accrual methodology and the plan is front-loaded, then the attribution won't be level annual accruals over the attribution period. We may assign greater portions of accrual in the earlier years in accordance with the plan document. In addition, the plan can define the beginning of the attribution period to be a particular age, for example age 45, so that anyone under age 45 would have no costs to accrue. You cannot define the beginning of the attribution period so that the entire benefit is earned over a ridiculously short period of time.

The EPBO is equal to the accumulated postretirement benefit obligation (APBO), for eligible actives and current retirees. For actives not eligible, the EPBO is broken into APBO, service cost, and future service costs.

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As an example, you could have a plan that has eligibility requirements of 20 years in addition to receiving a pension benefit. If the early retirement provisions under the pension plan are 55 and 10, then full eligibility will be age at 55 with 20 years of service. This is the first date at which both of the above requirements are met. The full eligibility will vary by hire age; for example, for employees hired prior to age 35, the full eligibility date will be the date at which the employee reaches age 55. For employees hired after age 35, the full eligibility date will be the date of attainment of 20 years of service.

The basis of the projected benefit reflecting the substantive plan equals the health plan costs at time of retirement, plus the cost of health plan increases after retirement. Basically, we split the net present value calculation of the EPBO into two separate components: (1) the present value of total eligible expenses, less (2) the present value of Medicare reimbursed expenses. We apply different medical trend assumptions to each. *SFAS 106* requires the use of the projected unit credit (PUC) like *SFAS 87*, satisfying the attribution of benefits requirements where benefits are allocated from date of hire to full eligibility date, unless a later beginning date is defined.

The following describes the components of the net periodic postretirement benefits cost. The service cost represents the portion of the EPBO attributed to the employee service during the current accounting period. The interest cost represents one year's interest on the APBO and the service cost, and it's based on an interest rate equal to the return on high-quality fixed-income securities. In addition, there's a credit that's equal to the return on plan assets, and this will apply only if benefits are funded in a segregated fund approved under *SFAS 106*. But the return on assets is the only way of offsetting the accumulating interest cost component, which is why I think serious consideration should be given to funding. In addition, there are a few amortization pieces in the first year. There's an initial transition obligation which is equal to the difference between the APBO and the assets at date of transition. We have a choice of either recognizing this initial transition obligation immediately or amortizing it over 20 years, the average future working lifetime of participants expected to receive employer-provided benefits. There's been a lot in the press about whether or not the big companies are choosing to take the hit all at once. As I said earlier, GE, IBM, and GM are taking the hit all at once.

There are a few reasons why companies might want to consider taking the hit all at once. One is the feeling that everyone has got to take some hit in the first year, and maybe in this first year the financial statements won't be scrutinized quite as closely. In addition, if the hit is taken all at once, it represents a one-time line or extraordinary item on the balance sheet. If it's amortized, it becomes a portion of the ongoing operating expenses. The decision to amortize or not to amortize is going to depend on the company P&L situation in the year of adoption, as well as some other company-specific factors.

Let's take an example of a company (Table 1) that had a payroll of \$40 million. The pay-as-you-go costs of \$500,000 represent about 1.25% of payroll. The expense after the implementation of *SFAS 106* represents 10.9% of payroll. So, here, the FASB expense is nearly nine times the pay-as-you-go costs, and I don't think this is

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unusual. The costs would have been much greater if the initial transition obligation was taken all at once; but, in ongoing years, it would have been less.

TABLE 1

Example	
Expected postretirement benefit obligation	\$35,000,000
Accumulated postretirement benefit obligation	17,000,000
Plan assets	0
Transition obligation	17,000,000
Net periodic postretirement benefit cost	
Service cost	2,000,000
Interest cost	1,520,000
Return on plan assets	0
Amortization of transition obligation	<u>850,000</u>
Total	\$4,370,000
Current pay-as-you-go cost	\$500,000

The basic effect on the balance sheet liabilities is that if you take the beginning-of-the-year liability, add the expense, and take out the cash outlay, which includes benefit payments, you get the end-of-the-year balance sheet liability. A liability is an accrued expense and it is created when the amount of expense is more than the cash outlay. An asset or prepaid expense is created when the cash outlay is in excess of the expense.

Now, the list of items required as footnotes to the financial statements are similar to the *SFAS 87* requirements, with one exception: the sensitivity analysis requirement with respect to trend. You need to show the effect of a 1% increase in the health care trend rate on APBO, service costs, and interest costs, holding all other assumptions constant.

What is the first step in resolving postretirement issues? Basically, we want to do a financial analysis – perform an actuarial analysis of the current plan and obligations under the new rules, including various alternative adoption strategies. We want to assume that the current plan won't be modified, just to get a feel for the level of flexibility that the employer has with respect to cost, based on the current plan. The points to consider are: (1) to test an appropriate range of assumptions; (2) consider immediate recognition versus amortization; (3) consider adopting the statement prior to the 1993 effective date, and (4) consider prefunding the costs of the plan to offset the interest cost component of the expense. In addition, we may need to take a look at forecast of cost and disclosure items to completely answer some of the key questions raised by *SFAS 106*.

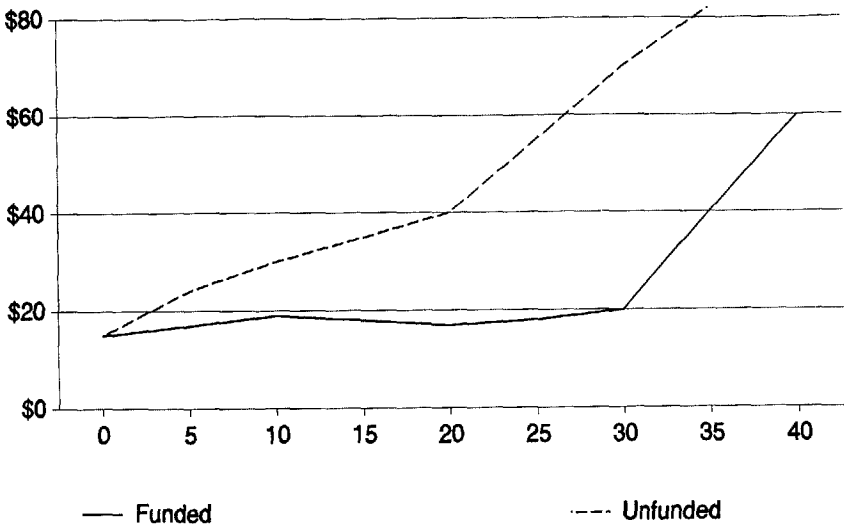
After the analysis is complete, there are basically three possible employer actions. One is to eliminate the plan. This is the most drastic approach. We've not yet seen a significant number of plan terminations. I'm sure that's going to change in the future. Employee stock ownership plan (ESOP) benefits or other retirement benefits can be used to replace the PRM benefits if the employer decides to eliminate the plan. A second and more common approach is to at least consider redesigning the plan to

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alleviate some of the added expense. Mike Cotter will discuss that in detail. Also, because most retiree plans are not funded, a significant portion of the net *SFAS 106* cost is attributable to the interest cost component which is directly related to the APBO. Funding would offset this interest cost by the return on assets.

Chart 1 illustrates this point. Here we have FASB expense comparison -- a funded versus unfunded scenario. It's based on a 40-year open group cost projection with a 2% growth per year. Chart 1 shows that, without funding, the cost is significantly greater over the entire period and widens over the 40-year span. The effect is due primarily to the interest cost component, which is offset by the return on assets in the funded scenario.

CHART 1
FASB Expense Comparison

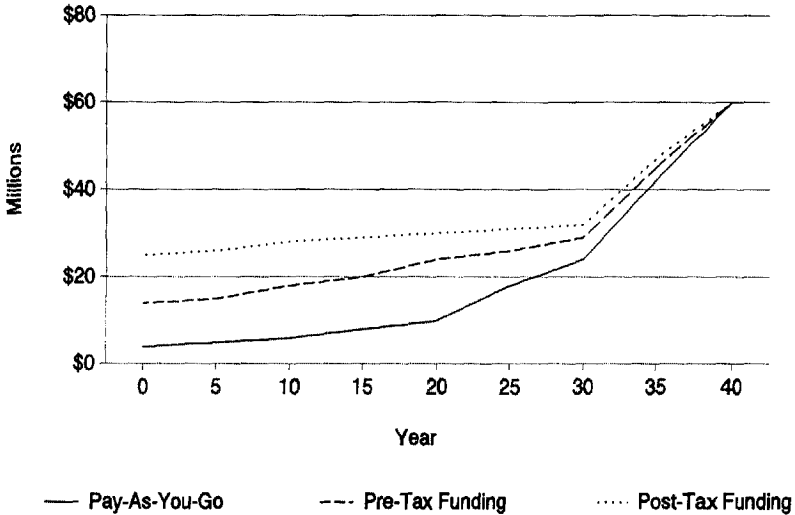


In Chart 2, we have a comparison of contributions under two funding scenarios versus pay-as-you-go. While the expense scenarios begin at a higher level, the three graphs ultimately do converge over time with the achievement of a state where benefit payments are going to equal the contributions necessary to fund the plan because of the investment income buildup, which fully offsets the interest cost. And, of course, the posttax funding levels are going to be higher than the pretax funding in the early years.

On the subject of funding, I'll briefly go through the funding exercise here. What are we looking for in an optimal funding vehicle? Basically, we're going to think of ourselves as getting three cherries if we can meet three requirements. Otherwise, we're going to get lemons on our slot machines. The three requirements are tax deductibility of employer contributions, tax-free asset accumulation, and tax-free

benefits paid to retirees. If we can meet these three provisions, then we've found a suitable funding vehicle.

CHART 2
Contribution/Pay-As-You-Go Comparison



I will digress briefly and talk about the adoption of DEFRA. The way I like to remember the acronym DEFRA is that it Destroyed Every Funding Vehicle for Retirees Available. That's a bit of an exaggeration, but it severely limited the use of voluntary employees' beneficiary association (VEBA) trust funds. Tax deductible contributions were limited; a funding method to be used was specified; and assumptions were restricted. It required funding on a level basis over the future working lifetime of active employees, which isn't so bad, but its projection had to be based on the current cost of the plan. No assumption is permitted for medical trend; therefore, the tax deductible contribution is going to be severely limited.

So much for cherry number 1 for VEBAs. We do get some tax deductible contributions, so it's not quite a lemon. Maybe it's a peach. The application of the unrelated business income tax on investment income knocked out cherry number 2 entirely. Any amount of investment income that's allocated to the retiree health plan is going to be taxed. Cherry number 3 remains intact, at least with the VEBA. Benefit payments are tax-free under DEFRA. An additional "noncherry-related" impact is restricted treatment for key employees requiring the use of separate individual accounts for contributions and disbursements. Now, this also goes toward the 415 limits and, as a result, a lot of key employees typically are excluded from VEBA funding vehicles entirely, and often from other funding vehicles. For example, a 401(h) account requires a separate account for key employees, even though the 415 limits aren't impacted.

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I'd like to do a very cursory review of some of the funding vehicles, particularly with respect to our cherry and lemon analysis. Now, this is by no means an exhaustive list. The need for decent funding vehicles in this area has been a great impetus for a lot of actuarial creativity. The VEBA was popular until DEFRA. It's a Section 501(C)(9) trust that is designed to hold assets for health and welfare plans. Again, we have limited taxable contributions. There is tax on investment income which gives us a lemon. The benefits are not taxable, so we have a cherry.

The Section 401(h) funding in a qualified pension trust was established in 1965, but it suddenly became popular with DEFRA, when DEFRA basically destroyed VEBA as a viable option in many cases. We fund the health and welfare benefit in the same trust as the pension plan. The catch is that the contributions to the 401(h) account are limited to one-third of the pension plan contributions. So, if the pension plan is fully funded, we're out of luck entirely. Here we have a three-cherry potential, assuming that there's room in the pension plan for contributions. We get tax deductible contributions; reinvestment income, and benefit payments are tax free when they come out.

Similar to 401(h) is the defined-contribution approach, where we fund within a money purchase plan, or ESOP. Again, 401(h) contributions are subordinate to the retirement plan, i.e., limited to one-third of the contributions of the retirement plan. The other potential problem is that the benefits may actually be taxable when they come out. The IRS hasn't yet ruled on this. Proctor & Gamble has put a 401(h) within an ESOP. It's called an HSOP and the IRS has given them a private letter ruling. There is currently a moratorium on such private letter rulings. It really doesn't make sense that they should be taxable, but the IRS has refused to rule on that at this point.

In addition, we have the option of qualified retirement trust funds. It's often used in conjunction with the elimination of the retiree health plan, and the intention is that employees will use retirement income for the medical premiums. Of course, there's no guarantee. You can do this within a money purchase plan or 401(k) profit sharing plan. Chrysler has a 401(k) plan where the intention is for employees to fund for this PRM benefit. Here, we get a cherry for tax deductible contributions, a cherry for tax-free reinvestment income, but we get a lemon in terms of benefit payments. As with any qualified retirement plan benefit, benefit payments are taxable when they are taken out.

Another creative alternative is corporate-owned life insurance (COLI). In COLI, the employer purchases life insurance with after-tax dollars. The cash value builds up and the death proceeds are used for medical payment. So here we get a lemon and two cherries. Another idea is the trust-owned life insurance concept (TOLI). That provides the best of both the VEBA and the COLI worlds, but it's a life form all its own. Here, we purchase life insurance policies through a VEBA so that the contributions up to DEFRA limits can be made on a pretax basis. Like a VEBA, we get limited tax deductible contributions, (maybe a peach), and we still get the tax-free investment income and tax-free benefit payments when they come out. On the surface, this appears to be the best vehicle out there, unless the pension plan has some room. The problem is that the life insurance vehicles pose problems with respect to insurable interests and communication, which in many cases causes discomfort for employers.

To sum up, what are the advantages of prefunding? The funds contributed may receive certain tax advantages. We may receive a more equitable allocation of costs over time, which avoids large contributions later and smooths the accrual of obligations. We'll be able to lower the *SFAS 106* expense by offsetting the interest cost component, and we'll also see increased security of benefits to employees. Now this might be a double-edged sword because, if the employer later wishes to terminate or reduce benefits, it may be seen as strengthening the promise to employees.

The disadvantages are: (1) we may achieve a higher after tax return by investing elsewhere or in the employer's own business; (2) we may restrict the sponsor's flexibility in revising future plan benefits; (3) the tax advantages are severely limited; (4) the 401(h) restrictions may be too limited for effective funding for qualified pension plan trusts; (5) the insurable interest and communication problems might be significant with respect to implementing COLI or TOLI; and (6) we have less cash flexibility because the trust contributions have to be used for health benefits.

MR. MICHAEL C. COTTER: I call postretirement medical benefits "the final frontier." Sounds a little tongue-in-cheek, but I think it's really more on the mark than you might think. When you think about the other major benefit categories, active health and welfare benefits or retirement benefits, they're funded either on a term plus basis or they're fully funded each year. Also retirement benefits have been funded on an actuarially sound basis since pre-ERISA days. Where do postretirement medical benefits fit in this area?

Nobody has paid any attention to funding and we're all in a lot of trouble now, as we've seen with *SFAS 87* and *SFAS 106*. Not only are your postretirement medical benefits unfunded, but the liabilities and costs are still generally unknown. Many of you have done valuations so far, but I think you might agree that more companies than not still haven't taken a look at this. The real costs in these plans are typically not even considered in plan design. In fact, the typical postretirement medical plan is generally designed as an add-on feature to the active life health plan. It's not really considered very often as a plan structure on its own with respect to design.

Just to give you a little idea of what's been happening over the last several years, Table 2 shows results of a survey of about 1,000 companies taken in 1989. Two years later, in 1991, it shows what kind of change has occurred in postretirement medical coverage. Now you might imagine that a lot of people are trying to get out of this by eliminating coverage. But, if you look at these results, you'll see that there has been very little movement in that direction, at least so far.

If you look at the first two categories of covered groups, "early and normal" retirees and "normal" retirees only, 65% were covered in 1989 in this survey. In 1991, it was down to 61%. The "early retirees only" coverage remained the same. So, the drop was basically in early and normal retiree coverage, about 4%, and that's the increase you see in the "no retiree" coverage . . . there's not exactly a stampede to get out of these plans.

This suggests two things: (1) there isn't a major trend toward plan elimination, or (2) the majority of employers still haven't started to look at this. They're still waiting for the implementation date and waiting until the last minute to take a look at this.

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TABLE 2
Prevalence of Companies Surveyed

Covered Groups	1989 (916 Companies)	1991 (1,048 Companies)
Early and normal retirees	59%	58%
Normal retirees only	6	3
Early retirees only	7	7
No retiree coverage	28	32

Table 3 compares postretirement medical benefits with active life health care benefits and pension benefits. Health care is a medical benefit. Pensions are income benefits. Postretirement medical tends to look like the health care benefit. But that's one of the few similarities. Why are the benefits being provided? Health care benefits are being provided for current service. You get active health care coverage in the year that you work. Pensions are provided for prior service along with postretirement medical. It's much more like pensions in that area.

TABLE 3
Comparison with Health Care/Pensions

	Health Care	Pensions	PRM
Type	Medical	Income	Medical
Why	Current service	Prior service	Prior service
When	Active	Retirement	Retirement
Basis			
Compensation	No	Yes	No
Length of service	No	Yes	?
Age	No	Yes	?
Social Security/Medicare	No	Sometimes	Sometimes
Inflation	Yes	No	?
Spouse/Dependent			
Coverage	Yes	Yes	Yes
Subsidized	Yes	No	?

When are they provided? Health care is provided during the active lifetime; both pensions and postretirement medical are provided during the retirement period.

What are the bases of determining these benefits? Are they compensation-related? Well, here's one of the areas where it veers away from pensions. Health care and postretirement medical are typically not compensation-related, whereas retirement income is.

Active health care benefits are not based on length of service, whereas pensions are. What about postretirement medical? Well, the traditional design is not particularly service-related. I'm not sure that's the right answer in terms of taking a look (or a new look) at these plans in terms of redesign.

Health care benefits are not age-related, while pensions are. Postretirement medical benefits are age-related to some extent. You need to be eligible to retire in the postretirement medical to plan to get the benefit. But does it depend on your age that you are at retirement? Is the benefit bigger or smaller, depending on what age you retire? This is something that really should be looked at a little more closely.

Active health care is not related to Social Security or Medicare. Pensions are sometimes related to Social Security and postretirement medical benefits are sometimes related to Medicare, depending on if it's pre- or post-65.

Active health care certainly relates to inflation. Pensions typically do not. You have some exceptions here and there, but typically the costs are very well controlled and you don't have automatic cost-of-living increases. Postretirement medical traditional design says that it is related to medical inflation, but is that really the way you want to continue it? Is that really the right approach?

Spouse or dependent coverage is available under all these plans, generally. Are they subsidized for the actives? Yes. Are they subsidized in pensions? Generally, no. There's a reduction in income benefits, for any kind of spouse or dependent coverage. This is one of the areas that we should look at a little more closely.

We want to ask ourselves if postretirement medical benefits are more closely tracking health care benefits or pension benefits? And I think the answer is, pension benefits. I think that's the thing you want to look at when you're talking about redesign. We're going to hit on that area or that concept several times before I'm finished.

As far as redesign goes, I categorized it into two different areas. One is called existing plan modifications. These are the standard approaches to reducing costs. When we look at redesign, we're almost always looking to reduce cost. Short of eliminating the benefits completely, the simplest approaches include reducing benefit levels or coverages such as (1) increase deductibles or co-insurance, or eliminate coverages like dependent care, (2) increase cost sharing by increasing the proportion of the premium the employee pays or the retiree pays, or (3) increase or make eligibility requirements more strict for retiring into these programs. With the exception of eliminating benefits completely, each of these approaches will cut costs, but they won't change the pattern of rising employer health care costs for retirees. They may ratchet down the costs, but the underlying problems are still there.

Let's look a little more closely at the features of a typical traditional postretirement medical design. Benefits, not dollars, are provided. The benefits are defined by services, not cost or expense of services. All medical inflation increases go directly to the bottom line of the employer cost. And the other hidden cost areas, what I call the areas of sensitivity, are big early retirement subsidies. There generally is no reduction of any kind in the traditional design for early retirement. Dependent coverage is generally a full subsidy. There isn't any reduction in the coverage for the individual, if dependent coverage is desired. And, of course, benefits are independent of service, generally.

I want to take a closer look at each of these areas of sensitivity to see what we're really talking about. In taking a retrospective look at cost, let's take an employee

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hired at age 35 who may either retire at 55 or 65 (see Table 4). If he retires at 65, the annual dollar contribution for the plan that was chosen here was about \$600 a year, if this plan had been funded during the active working lifetime of the employee.

TABLE 4
Retirement-Age Sensitivity

Age at Hire	Age at Retirement	Annual Dollar Contribution (Single)
35	55	\$1,700
	60	1,200
	65	600
45	55	\$2,300
	60	1,400
	65	700

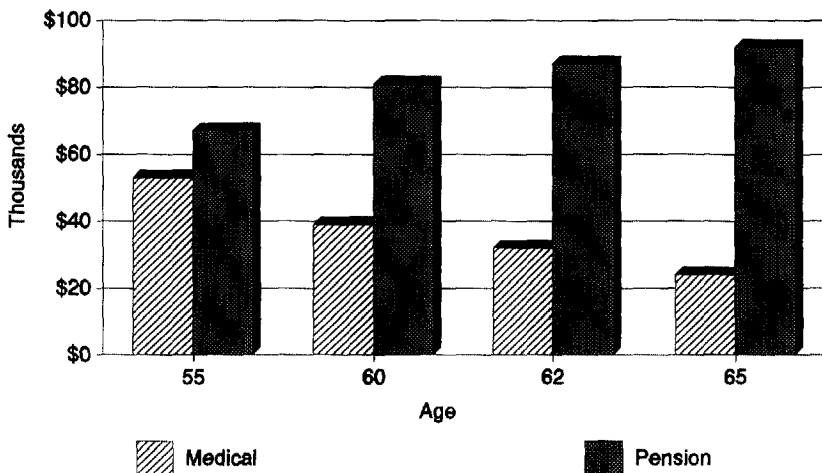
However, if the employee decided to retire at 55 instead, it would require about \$1,700 a year for that shorter period of service. This is a particular problem because the employer doesn't know when the employee is going to retire. How can you plan anything reasonable on any kind of funding basis with this kind of situation? A retiree at age 55 requires a three times faster buildup than the retiree at 65. This level of volatility is totally out of the employer's control in current design.

Looking at this from another angle, we have accumulated liabilities for different retirement ages. For postretirement at 65, of course, the full age-65 benefit is generally payable; plus there is no Medicare offset. What happens to a retiree at 55 in a retirement or standard pension plan? You have lower service benefit because the benefit is a direct function of service. You have early retirement reduction factors. And you don't have any Social Security supplement similar to the Medicare supplement or the Medicare replacement that you have for pre-65 retirees for postretirement medical.

Basically, under a pension approach, such as a defined-benefit pension plan, any normal funding program will have enough assets for each of these key points -- probably more than enough for some of these situations to cover the retirement age contingencies. There will not be any surprises. At 55, there should be enough assets to cover the present value of benefits on the pension side, if the employee choose to retire at that age. In each subsequent age, additional funding will get us to the point where there are enough assets in the trust to cover the expected benefits. But it's the opposite with postretirement medical. (See Chart 3.)

If you were assuming the employee was going to retire at 65, and you were funding toward that present value, when the employee was 55, you'd have much less than that. You'd have only a fraction of what you'd need to actually cover the liabilities that had accumulated for an age-55 retiree. So there is something wrong with this approach. It's totally backward from any kind of logical actuarial approach.

CHART 3
Present Value of Pension Versus Medical Benefits



The next area is hire age sensitivity (Table 5). You have two employees, who are both 45 now but one was just hired and the other one was hired 20 years ago at age 25. The cost per year is twice as much for the late hire because this plan is service-independent. Typically, this is not the kind of situation you ever see with pensions. Here, you're basically benefitting the employee that's hired 20 years later twice as much per year of service as you are for the 25-year-old hire.

TABLE 5
Hire-Age Sensitivity

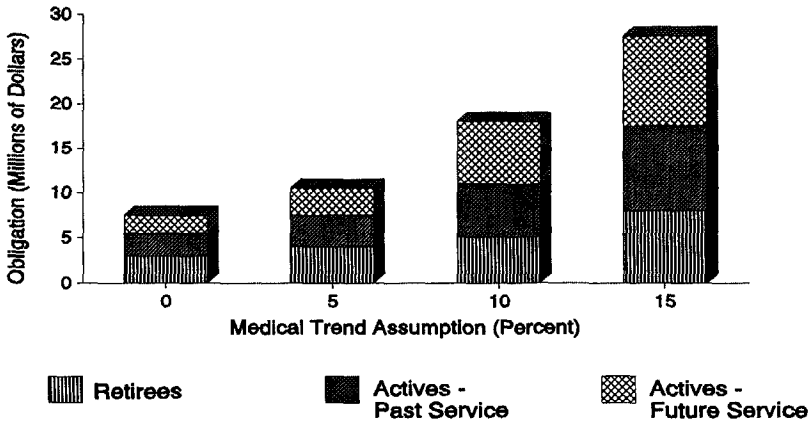
Age at Hire	Age at Retirement	Annual Dollar Contribution
25	65	\$350
45	65	\$700

With respect to areas of sensitivity, the most important is the trend sensitivity. Chart 4 illustrates the liability for three population segments: (1) the active future-service segment, (2) the active past-service segment, and (3) the current retirees. Looking at the actives versus retirees and the trend situation from 5-10%, you see that the obligation doubles for the active segment. It goes from \$6 million at 5% to about \$12 million at 10%. There's a 20% increase in the retiree segment – a much smaller increase because the payout period is much shorter and closer to current time. Overall, it's a 64% increase in total accumulated liabilities. So, trend, obviously, is the biggest factor in this situation, but not the only one. It's been one of the major focuses of problems with postretirement medical design, but the other areas of sensitivity are also quite important in the issue of redesign.

More substantial changes need to be considered than those existing plan modifications that we talked about earlier. A real departure from traditional design is required. This is what I call "new plan structures."

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CHART 4
Trend Sensitivity



The first possibility is linking benefits to years of service. This is the same thing that the pension actuaries have been familiar with all along. Postretirement medical has never typically had this, but it makes a lot of sense. A lot of companies are quite interested in this approach. The second possibility is providing reduced early retirement benefits. This one is a lot harder to implement. Somebody retires prior to 65 and, in fact, your plan typically gives that person a much higher level of employer-paid benefit because Medicare doesn't exist yet. If you actually want to implement early retirement reduction factors here, you'd not only give for a smaller benefit – and have the Medicare benefits that don't exist not covered, but you also would provide a smaller level of benefit pre-65 and a smaller level of benefit at 65, if you were trying to design this like a typical defined-benefit plan.

The defined-dollar approach, of course, is one of the areas that's gotten a lot of attention. This is defining a dollar level of employer-paid benefits each year rather than benefits based on service. The defined-contribution approach, which requires setting up accumulation accounts earmarked specifically for postretirement medical benefits, is another approach.

What are the features of the defined-dollar approach? What does it look like? It's really like a defined-benefit plan. Very often people call this a defined-contribution approach, but that's really the wrong label. It is a defined-benefit approach. It's simply not salary-related. The company pays a level of benefit defined as an annual dollar amount. The retiree pays the balance, whatever that turns out to be. So the amount the company pays ends up being unaffected by medical inflation. The retiree ends up footing the bill for the entire difference. This is certainly a hard-line approach, but it is an approach that really does do something to control the increasing costs. I think it's going to become more and more popular as liabilities become more real to employers across the country.

Often, this type of approach has some kind of index and some kind of controllable annual level of increase – something like 5-6% per year. You actually might not have to reduce the benefit at all for current retirees or for employees retiring in a current year. You might be able to cap the increases prospectively for what the employer pays with a maximum 5-6% increase per year. This approach can also include a service link, or some kind of concept of early retirement reductions.

Chart 5 is a graphic illustration of the defined-dollar approach. The top line, of course, is the traditional approach that represents a pay-as-you-go cost for a 1991 retiree. Now, in this situation, the traditional cost is increasing at medical inflation and that's why it's a fairly steep curve. The defined-dollar approach with no index is represented by the straight line. Of course, you're paying the same dollar amount for this retiree each year for their lifetime. The retiree will pay the difference, so the retiree is going to pay whatever the cost-sharing portion was at day one in 1991, plus the difference between the top line and the bottom line. So 10 years later, they're paying a hefty portion of the retiree medical cost. But it does control the cost for the employer.

The line in between, of course, is a defined-dollar approach with an index, and that line can fall anywhere between the other two lines, depending on what kind of index you choose. In fact, many employers may choose no index and then reconsider it every few years. This will do something to keep their expenses down for awhile until it becomes obvious that they've set up a pattern of increases. This is certainly an approach that is going to have the most substantial impact on postretirement costs. In fact, for some of the companies for which we've looked at this, we've decreased their annual expense by about 40%. It doesn't do anything to current levels of benefits. It only starts hurting a little bit year after year, a little bit more every year, depending on how rapidly medical inflation continues to grow.

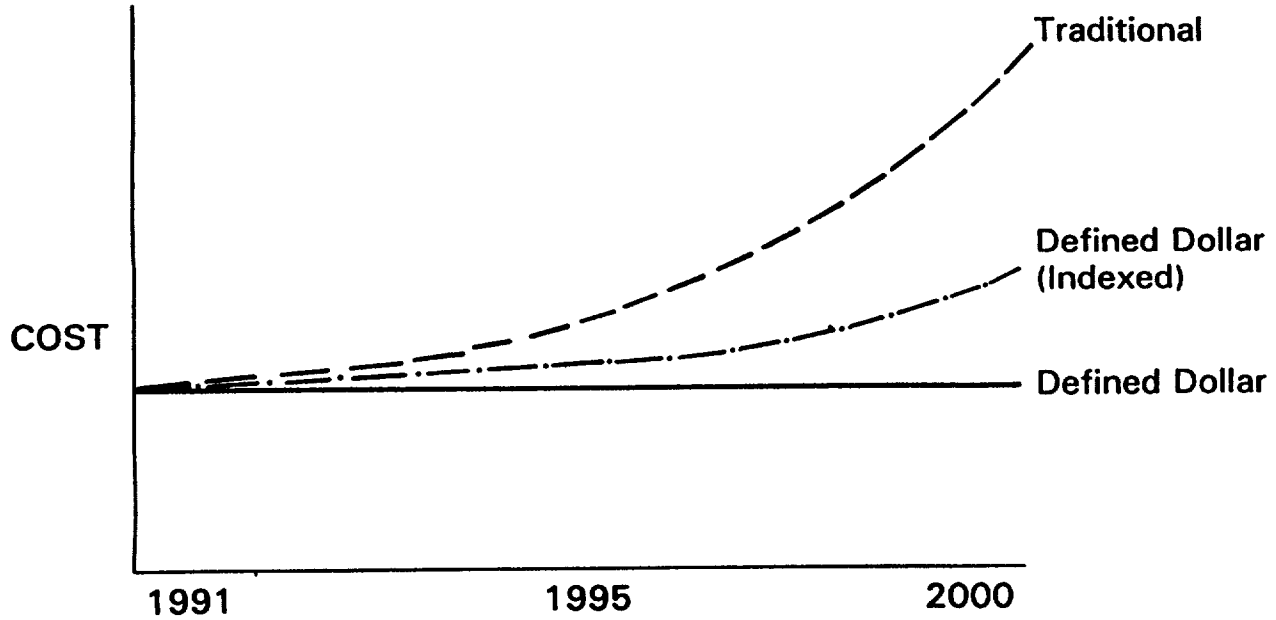
The defined-contribution approach has an annual contribution made to a trust during the active working lifetime of the employee, just like a typical defined-contribution retirement plan. These benefits, by definition, are fully service-based. You don't have to design it this way. It's simply going to work that way. You're going to make a contribution for each year the employee works. There are absolutely no subsidies. You don't have to worry about early retirement subsidies, because whatever is there is the limit. If the employer retires early, there's less there.

It's very, very straightforward. There are no unfunded liabilities issues, and the accounts are earmarked to pay retiree medical premiums.

Chart 6 shows how this works. We've got the same traditional line as in Chart 5. We've got a straight line again for the defined-contribution approach. Now, this straight line works this way only if your defined-contribution postretirement medical benefits are being paid out of this trust via an annuity approach. That is, whatever is there is converted to a lifetime annuity that is available each year to pay retiree medical premiums.

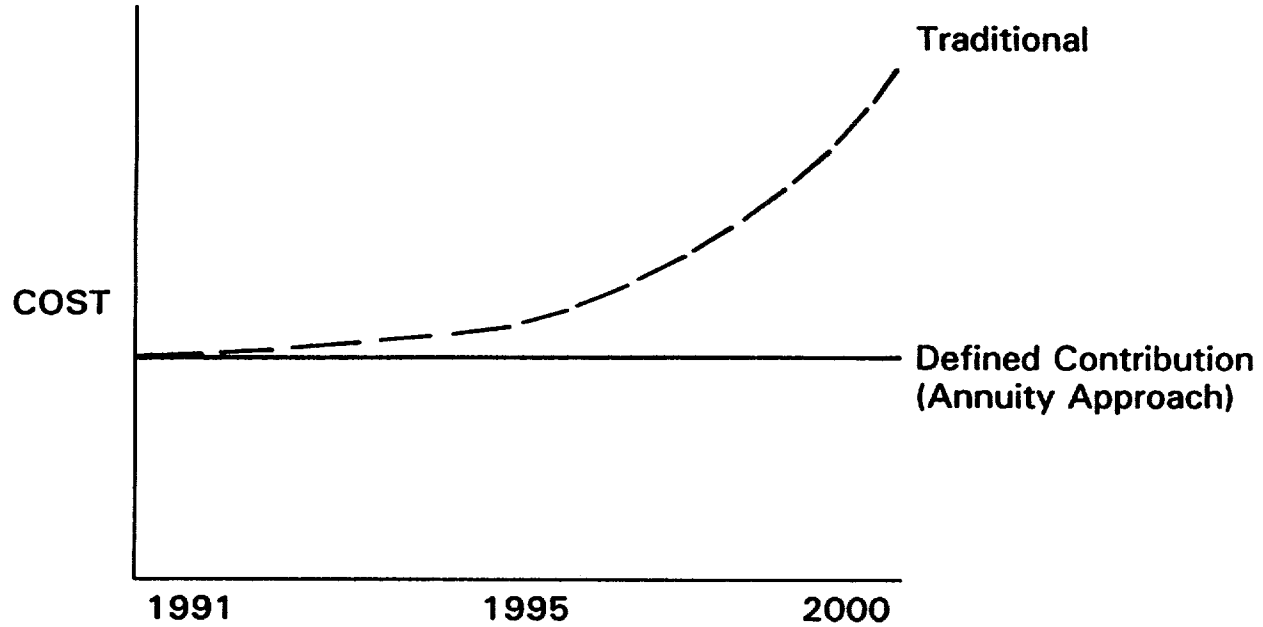
If, in fact, the account is available to fully pay premiums or fully pay the employee and the employer portions of the premium until it's used up, then you'll end up having a line that follows the traditional line up to a point and then drops down to zero. So,

DEFINED DOLLAR APPROACH



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DEFINED CONTRIBUTION APPROACH



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I don't actually recommend that approach at all. I think an annuity approach is the only thing that makes sense here.

When we look at plan redesign, I think, we want to consider reducing these major areas of sensitivity. First is the hire-age sensitivity which links benefits to years of service. That's genuinely straightforward. The retirement-age sensitivity is a tougher one and is a harder sell in most situations. It has some limited applicability. Consider reduced early retirement benefits, but limit reductions in early retirement benefits, after taking into account the fact that Medicare doesn't exist prior to 65. I think that reducing the post-65 benefit for pre-65 without taking into account Medicare's absence becomes so severe that the pre-65 plan becomes relatively meaningless. On the other hand, almost anything is possible here. Many plans have pre-65, fully-employee-paid availability. We're talking about something that may be almost as severe as that, but, since fully-employee-paid pre-65 benefits are available (and they do work in some situations), any level of employer-paid benefits certainly should work as well.

The third and final area is trend sensitivity. Defined-dollar benefits are a very good way of cutting out the trend sensitivity entirely. And, finally, the defined-contribution approach does all three of these things. Just by definition, it gets rid of the hire-age sensitivity, the retirement-age sensitivity, and the trend sensitivity. All of these are just wiped out because you have no unfunded liabilities. You're simply paying what you pay each year and letting the retirees fend for themselves with what they've accumulated at that point.

All this is nice, but there are a lot of practical considerations you've got to think about when redesigning benefits. You've got to discuss with your employer, your company, or your client what their issues and their considerations are with respect to each of these areas. Who do they believe should be at risk for future health-care cost increases -- the employer or the employee? And how important is the benefit to each segment of the work force? What about management and union employees? For example, can reductions in the benefits for the union employees even be bargained, or is it just something that's not touchable? You've got a lot less leeway in terms of reducing your costs overall, if you can only work with the management employees.

What's the employer's commitment to continuing the current plan for any particular group? This is both a philosophical and a legal issue.

What does the employer feel it has an obligation to do? One is a moral and one is a legal obligation. Typically, retirees are fully grandfathered, although that's not always the case these days. Defined-dollar approaches are being applied to existing retirees, so the retiree's benefits aren't being cut back today, but they'll be cut back every year after the first year of implementation. Actives over early retirement age might be grandfathered. Actives under 55 or early retirement age are typically not considered in any grandfathering. In some situations, future employees are just cut out, because many employers might not be willing to cut out their postretirement program entirely.

They just don't allow eligibility for new employees. They might consider some trade-offs or replacements elsewhere -- retirement plan increases, for example.

You need to consider other specific subgroups that might be important to the employer. The other thing you've got to look at is, how does retiree medical coordinate with other retirement benefits? Very often you're talking with an employer that is considering cutting out retiree medical benefits or cutting back on them. If you say, "Well, let's see if your employees can afford that; let's look at your retirement program, and if it is on the very modest side, there's really not going to be a lot of room for employees to go anywhere if their retirement benefits are barely covering their income requirements." In addition, they're cutting out postretirement medical.

Is it a paternalistic company or a laissez faire company? Does it believe the employer has some obligation to provide benefits or does it only do what the employees want? For example, one employer I worked with wanted to offer in bargaining, an option to stay in the postretirement medical plan, or to have a 50% match on 6% instead of a 25% match on 6% in their 401(k) plan. Well, I think we all know that an additional 25% match on 6% in the 401(k) plan is not even going to come close to the value of the postretirement medical benefit plan. However, it depends on whether they're short-service or long-service individuals. This is a situation where you know what the employees are likely to choose, especially the young ones. But it may not be in the best interest of the employer.

Adequacy versus cost issues have to be balanced. Significantly higher cost sharing is likely to be a part of any redesign effort. Long versus short service is the same issue of the retirement approach versus the active health care approach. Should service be a part of this kind of plan redesign? I believe it should.

Does the employer have a concern about the retirees or does it care only about the actives because they're the only ones that are currently producing anything for them? Does the employer want to encourage early retirement or are early retirement windows a likely feature in the future company plan? Even if they are, that doesn't have to necessarily be considered strongly in the basic retirement design. But ad hoc window situations could be set up each time. These are questions that you have to ask. You must know where your employer stands before you really know which of these possible solutions is going to work.

If you've got a postretirement plan, the first thing you need to do is determine the FASB annual expense. Then the employer has to determine if that current level of expense is acceptable. If it is, then you're fine and that's all you have to do. You can jump right into considering funding alternatives. If it isn't, you've got to consider redesign, which is what we have been discussing.

I think the idea that these programs should be considered like retirement programs, just like the retirement actuary considers designing a pension plan, is an approach that gets "eyes open" with the employer. You give them these ideas -- early retirement reductions, service linkage, limiting the costs with an index -- and you put them in the context of how you design a retirement program. Employers can see, quite clearly that it makes a lot of sense. I haven't had a single employer with whom I've discussed this who hasn't thought this is the direction they want to consider going, unless they told me before we even started that they're happy with their plan as it is and didn't want to touch it. That's a very rare situation indeed.

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Once you redesign the plan, then you've got to consider funding alternatives. I think what we're saying is that most companies haven't even gotten past the first box. Most people in this room have gotten about halfway down in the flowchart and haven't gone all the way -- many haven't gotten into redesign. Most probably haven't gotten into funding. Has anybody implemented funding approaches with their employers or clients in the last couple of years? A few. Just a handful.

MR. VEACH: I'm going to discuss assumptions. I think this is an emerging actuarial field. I see a lot of valuations from within our firm and from other firms, and there is a wide variance on the degree of sophistication in those assumptions. I think there's a tendency here to rely on the fact that this number is a highly variable number anyway, especially with respect to the medical trend. Therefore, the argument is, why get overly sophisticated in all the assumptions when you can change the trend by 0.5% and make a 10-15% difference in the number. On the other hand, you should be more careful than that. If you do get into redesign later and take out that medical trend, then your other assumptions become more important.

I'm going to talk first about the trend, since it is the most important assumption for the clients that do leave medical trend in as a component of their plan design. We're going to approach this from the viewpoint, if we knew exactly what was going on, what kind of trend assumptions would we use? We'll discuss the relative merits of all the levels of sophistication later.

Most actuaries are now beyond using flat trends. To set the initial levels of trends, you need to look at the employer's recent history. In order to consider that recent history, you need to analyze the data yourself. Don't ask the employer how costs have been increasing. They really don't understand trend. You need to get the data and analyze it, and take out the impact of any plan design or demographic changes. This is the same process you should go through if you are trying to project an employer's cost for the next year. You want to look at the history of the trends, but, in addition, you have to look at the current market trends. I see a lot of valuations that are using 10%, 11%, 12% for initial trend, and I know very few actuaries that would be using trends at those levels if asked to project next year's costs.

Once you've initially established where the trend should be, you want to decide what that trend is going to do in the distant future and choose an ultimate trend level. I've noticed that there's a trend towards lower ultimate rates, as we get closer to the effective date of SFAS 106. I'm not sure if everyone is becoming more optimistic or if that's due to client pressures. Keep in mind, too, that these are the client's assumptions, not necessarily the actuary's assumptions. You, the actuary, might be asked by the auditor if the valuation was done in accordance with SFAS 106 and, if you feel the assumptions are unreasonable, you should say it wasn't. There is definitely a trend downward. I always relate the ultimate trend to the discount rate since this is what drives the liability. Two years ago, I could see anywhere from maybe 2% below the discount rate to 2% over for an ultimate trend. The most recent surveys I've seen now show very few are actually over the discount rate and I've seen some as low as 4% below the discount rate. I think this is very optimistic.

The next question, once you've got your initial trend and your ultimate trend is, how soon are we going to reach that ultimate trend? I've seen this vary from 5-20 years

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and, once again, as we get closer and closer to the adoption date, I see that select period getting shorter and shorter. Obviously, this holds down the liabilities. I'd say the average now is probably under 10 years, and a couple of years ago, it would have been anywhere from 10-15 years.

Hopefully, very few people are using flat trends now as we better understand the impact of using a flat trend and what that's going to do in terms of actuarial losses. The question is, are those flat trends close enough? In other words, we don't really know what the medical trend is going to do the next 40 years, anyway. The other question is, do flat trends meet the explicit assumption requirement? If we know that trend is not going to be a flat 8% or 9% next year, is that an explicit assumption?

One subject getting a lot of press lately is the use of GNP models. How many people know what a GNP model is? Most of you. It's simply taking the health care expenditure component of the GNP and projecting that at your medical trend rates and then projecting the rest of the GNP under a GNP increase assumption. What percent of the GNP will health expenditures be? I think it's a useful exercise for education and for making sure trends are not completely unreasonable. I contend that it's not very useful for setting absolute rates. For one thing, there is a lot of debate about what percent of GNP is the limit. What else are we going to spend money on? What are our other products? We're cutting back on defense, so what is the GNP going to consist of? Is 20% or 25% a realistic limit?

You can argue all day on that and not reach a consensus. What is the GNP growth rate? Now you've added another assumption. Do we develop another model that tests our assumptions for our GNP model that's testing our medical trend assumptions? I think it's useful in terms of making sure you're not doing something that's completely unreasonable, and it's useful for supporting the fact that the trends have to come down, but it's not very helpful for setting your absolute medical trends.

I would say that the minority of valuations that I look at are currently using separate over 65 versus under-65 trends. There is a growing tendency toward using separate over- and under-65 trends. Once again, we run into the question of, is it sophistication to the point where you're just introducing precision without additional accuracy? There are some very strong arguments that over-65 trends should be lower. We have the Resource Based Relative Value Schedule (RBRVS) and balance-billing limits and Medicare deductibles on the Part A that are indexed. On the other hand, drug charges are experiencing higher inflation than other charges. So before you answer the question of whether to separate those trends, you need to look at your plan design and the method of Medicare coordination, whether you use a carve-out versus 100% coordination of benefits (COB).

Another controversial area is separate Medicare trends. *SFAS 106* clearly states you can't assume any changes in Medicare law. The question then is, does the current law include cost shifting to employers? There are some strong arguments that, even within the current law, there will be some additional shifting and that Medicare reimbursements will increase at a slower rate than employer reimbursements.

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The leveraging effect is another thing I see either ignored or glossed over with the vague assumption that, ultimately, deductibles and co-insurance levels will increase at the same rate.

As we get closer to the adoption date of *SFAS 106*, we're going to have to be more precise about what the substantive plan is. Have those future increases been communicated to employees or is there a history of increasing those deductibles and co-insurance? The ideal way to take leveraging into account is to project gross costs and then separately project the value of the deductibles and co-insurance. I see very few valuations that actually use this method. I think it's acceptable to use net costs instead. But if you use net costs, you need to adjust your trend levels to reflect the impact of that leveraging.

Another technique I see is separating the components of trend, one for general inflation, the additional medical inflation, utilization increases, new technology, cost shifting, and leveraging. You can build your initial trend through these components and then take into account where those components are ultimately going to be. Once again, I think this is very valuable in terms of getting in your mind why you're expecting medical cost increases to go down over time. As far as how much it helps in setting your absolute medical trend values, once again, I think each component has probably as much uncertainty as the whole.

A great number of employers are getting medical trend out of their calculations through plan design. When they do that, these other assumptions become much more important. One interesting thing I've noticed is participant group. Who needs to be included in the valuation? I've seen cases where only employees in the current medical plan are included. In reality, unless your retiree medical plan requires participation in the active plan throughout the career, then you, in fact, need to include all employees that can possibly be eligible once they retire, which is usually all full-time employees.

There might be an exception. If you have a service formula that figures benefits based on a dollar amount per year of service, and the first year of service is not included, then you should exclude people with less than one year of service. There's an advantage to this design for people who are doing the pension valuation and want to use the same database. Often, the pension database excludes people with less than one year of service.

I see a lot of 100% participation assumptions used when there are employee contributions. Even with fairly low contributions, somebody will have access to a government plan with free medical care and will refuse the coverage. So you don't want to use 100%, even if it's only 98% or 97%. It will at least show that it's an explicit assumption and that it was thought about. You should look at the history, if it's available. You want to be careful too, with this assumption, if you're implementing cost-sharing changes, a defined-dollar benefit (DDB) plan, or any plan that's going to shift more cost to retirees. Your participation is likely to drop over time, and so, in theory, you should use a participation rate that would be select and ultimate.

OTHER KEY ASSUMPTIONS

Retirement Rates

You shouldn't use pension retirement rate assumptions, necessarily. The pension assumptions may be simplified because the effect on the calculation is not as great. If a person retires earlier than expected, then their pension actuarial present value is lower than expected. On the medical plan, as you saw in some of the graphs that Michael used, the opposite can happen. So you want to make sure those retirement rates are as explicit as possible and they should be age-related probabilities, not flat assumptions. The retirement rates can have a very large impact on most clients' *SFAS 106* liability.

Termination Rates

You need to be careful here. The tendency is to use the pension assumptions. You need to be careful if you have a different employee group eligible for the retiree medical than is eligible for the pension. That's especially important if the pension plan excludes employees with less than one year of service. If you're including those employees with less than one year of service in your valuation, then obviously, that's a high turnover group, so you need to either have separate turnover rates or first-year turnover and then tie into the pension assumption.

Discount Rate

It's usually the same as the pension assumptions. You could argue that it could be different if the duration of the liabilities for some reason is significantly different. They usually are slightly different. The medical usually has a longer duration. But the duration of the liabilities ends up being so long that you can't find a fixed-income investment that goes out that far, so you end up using 30-year, high-quality fixed-income investments to set your rate anyway.

Mortality

Most people use the same mortality as is used in the pension plan. There's a weak argument for using higher mortality rates. Mortality in a pension plan is actually income-related -- the higher the income, the higher the liability. It has been shown in a study, that higher-income people have very slightly lower mortality than the lower income people. So you can use that argument if you want to get to a level of detail to actually use a slightly different mortality table.

Administrative Charges

The last thing I want to discuss is administrative charges. I've seen a number of different methods for reflecting this. The most popular, I guess, is to use a flat loading, 4-5% of expenses. Some questions arise. How should that be allocated to the retiree? What is the expense for administering those retirees versus the expense for administering actives? Should they be separate for over-65 versus under-65? There's an argument that administrative costs can be higher for the over-65 group because of the Medicare coordination and the more frequent phone calls from retirees that have the time to call. The insurance companies will not usually separate this out, but the issue is the same if you have an insured plan that has an insurance rate that is the same for everybody. There is still an additional liability for the retirees even though you're getting a flat administrative charge for the retirees. If the retirees actually cost more to administer, you need to reflect that because, if you took those retirees away, the insurance company might be able to lower its expense charge.

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The future increases are often combined and, if you use just a percentage loading, you're assuming that those administrative costs are going to increase with medical trends. That's probably not right because administrative charges are going to increase with the wages of the people doing the administrating; plus utilization increases, if they're getting a higher volume of claims, minus any efficiency improvements and systems improvements, and so on. I'll let you guess what that is, but it's certainly different than medical trend.

MR. ADAM J. REESE: Adam, I think inadvertently in your speech, you said that GM adopted its \$24 billion liability. GE and IBM have, but GM announced that they haven't adopted it yet.

MR. MEYERS: Okay, that's true.

MR. REESE: Second, on the key employee issue for Section 419(A) plans, it really isn't that much of a problem. Key employees are essentially employees and retirees for up to five years. And then they drop off out of the key employee group. So it's likely that there is only going to be a few key employees who are not able to obtain coverage out of the plan. One point on Michael's presentation. There was a recommendation to annuitize a defined-contribution account balance to provide a level stream. I'd ask you to look at that again. I think the retiree can use up their account balance fully by trickle down and using distributions, paying tax on the distribution using the net proceeds to purchase each year's health care premium, and using up the full amount of the account balance. The only way that they're going to use up the full amount of the annuity is if they beat the table. So I would argue that it's better to use up all of the account balance.

MR. COTTER: Well, there's a point, but my concern is that retirees aren't going to use this wisely, and if they use it up, they're out of health care benefits entirely, after a certain point. Then we have a different kind of problem -- in retirees without healthcare benefits.

MR. REESE: Last, I didn't hear any mention of other methods for lowering the obligation without changing the plan -- accounting gimmicks -- and I was thinking that some focus could be made on paragraph 409 which doesn't look at accounting for employees in their early years of employment but only attributing from, say, 10 years after hire.

MR. MEYERS: I mentioned that you can define the beginning of the attribution period at a later age. Like age 45 or something.

MR. VEACH: In talking with employers, I found very few that are interested in the accounting games. I think their view is that it's either going to get them now or get them later. So unless they're financially distressed companies, of which there are enough out there, that have reasons to hold it down, most are more interested in actually lowering the liability, not playing the accounting games.

MS. JEAN M. WODARCZYK: A couple of questions and a couple of comments. First of all, there was presumption throughout the discussion that the costs are the costs are the costs. Do you see any movement for employers trying to squeeze

some efficiencies out of these programs? I work with a good number of employers that have large numbers of retirees and most of the plan design changes won't address their issues -- specifically, managed-care opportunities or movement towards Medicare risk contract opportunities.

MR. VEACH: Regarding managed-care opportunities, I have seen a lot of employers looking at that, primarily for their under-age-65 group. In other words, it does very little to help the over-65 group. You end up spending more on administration to help save the government in-patient costs. I have seen some clients doing some efficiency studies on the administration of their over-65 group, and a lot of clients have found that there is some waste in terms of not properly coordinating with Medicare, not administering the carve-out in accordance with the plan and so on. You're right, the first thing employers should ask is, "How can we get the actual cost lower?" Then they say, "Okay, if we can't get those total costs down, then we have to shift more of it to employees."

MS. WODARCZYK: I would suggest that even if you are shifting more to your retirees, or your future retirees, you still need to keep your eye on the ball of the total costs or it becomes prohibitive in total.

MR. VEACH: I'd agree with that. I might even argue that it's going to become prohibitive no matter how well you keep your eye on it. That's a different social issue. The other comment on the Medicare risk contracting is, I've actually seen a trend away from that. And I think that the few people who have gotten into that, have either gotten burned or found out they've not been able to make it work, and I think until the government addresses the reimbursement levels, I don't think you're going to see a lot of that.

MS. WODARCZYK: My second comment has to do with the defined-dollar approach that Michael was talking about. I'd just like to say that while the defined-dollar approach appears to be nice and neat and tidy, the costs are the costs are the costs; and if the company isn't paying for them, the retiree is, and most of these programs end up with intergenerational inequities, with younger employees, essentially, not having any retiree medical programs if the company really believes that they're going to be in this program for the long haul. However, my experience is that most employers that move into this really do not believe that the defined-dollar approach is anything other than an accounting gimmick and fully intend to change their defined-dollar approach over time. My question to you is, I know of one company out of about 30 that I can think of off-hand, that really believes that they will stick with their defined dollar. Do you know of others that are?

MR. COTTER: The companies I've talked with who are interested in the defined-dollar approach are doing it with the belief that this is really what they want to do. It's not just an accounting gimmick to keep the current costs down. In terms of the level of retiree coverage, yes, the retiree is going to end up paying a larger share. Unless you believe medical trend is going to continue indefinitely to outstrip general inflation, (which if you put an index approach here, you should consider trying to track) eventually you're going to get to a higher level of cost sharing, but some kind of steady state. If you don't believe that medical trend is ever going to get to a general level of inflation, then we have a totally different problem. What we have is a

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situation where medical costs are going to eat up the entire GNP which, frankly, I have a hard time buying.

MS. WODARCZYK: I agree with that. Finally, on assumptions. One assumption that I find is more powerful than even medical trend is the spousal assumption. It's often overlooked, particularly with employers that have different demographic mixes. Banks and insurance companies, for example, that have high female employees, oftentimes find they only have 30-40% spouses in the medical program, while the pension may have very different rates. And mortality -- often people are using the mortality assumption from the pension while, because of spouses, you're covering an entirely different group. If there is one thing actuaries should be able to measure in these measurements is mortality and mortality of sex-distinct, not unisex. I wish that we would look at this a little more carefully. Given the high spousal participation, recognizing sex-distinct mortality patterns is important.

MR. VEACH: I think most actuaries, including myself, do use sex-distinct assumptions. And so to that point, you apply the mortality separately to spouses and retirees and it should be taken care of. I agree with your point about the spouse participation percentage though. Once again, the tendency is to look at our current actives' spouse percentage. You can't do that and it's not always best to even look at the current retiree group. You really have to use your judgment in saying, "Are we making design changes that are going to shift more cost to the dependent? What is the level of spouse participation going to be at the time of retirement in this program? Is it going to change over time?" So that's a very good point.

MS. WODARCZYK: Very big assumption.

MR. JUAN N. KELLY: I'm a consultant working with a number of multiemployer plans. I understand that the AICPA has an initiative requiring multiemployer plans to comply fully with *SFAS 106*, even though *SFAS 106* doesn't say that. Does anyone on the panel know the status of that and what's driving it?

MR. VEACH: I work for Ernst & Young and I recently saw that something had been released. I think it was an exposure draft, wasn't it?

MR. KELLY: I believe so. I know there's some Society of Actuaries members on a task force working with the AICPA. I would think someone would know something about it.

MR. VEACH: Yes, and it's obviously going to be a big issue because I think a lot of multiemployer funds, at least the ones I'm familiar with, have tended to use pay-as-you-go accounting and they can get to the point where they have a lot of retirees and it becomes a big problem. I'm not familiar with where that stands.

