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**FAS 106 – ACCOUNTING FOR OPEBS**

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- What's an OPEB (Other Postretirement Benefits)?
- Selection of assumptions
- Effective date
- Real life experience
- Magnitude of the effect
- Strategies for dealing with the liability

MR. DENNIS M. POLISNER: I'm with KPMG Peat Marwick. I'd like to introduce our speakers. Vince Amoroso, Principal of KPMG Peat Marwick, is from our Washington office. Vince has been heavily involved with many of the technical aspects of implementation of Statement 106. Martha Marcon is an audit partner from the Los Angeles office of KPMG Peat Marwick and specializes in employee benefit plans and also is heavily involved with *FAS 106* implementations. Diana Scott is a consultant with TPF&C and is extremely familiar with this statement. She was the project leader with the FASB on Statement 106.

*FAS 106* has created quite a stir in the financial community and has been a source of concern to many employers sponsoring postretirement benefit plans. The magnitude of the numbers that we've seen associated with these plans have given rise to employers reevaluating the plans and benefits that they are providing to their employees. The enormous economic costs associated with the programs were largely unidentified and many employers were unaware of them. The types of numbers that we see today are staggering with past service liabilities representing very material percentages of companies' entire net worth and, in some cases, even equalling or exceeding companies' net worth.

The size of the expense charges under the accounting methodologies required in *FAS 106* result in charges to earnings that are anywhere from three, four, five or ten times the current cash cost basis expense charges. We have very significant changes that employers must deal with in adopting Statement 106 and our panelists will be discussing various aspects of the statement. First, Martha Marcon will provide us with a background on the statement itself and the main considerations that are in *FAS 106*. Second, Vince Amoroso will discuss the selection of assumptions that are very critical in doing the measurements under the statement. Diana Scott will discuss real life cases and considerations and what companies have been doing, what

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they've been trying to do in meeting the challenges of Statement 106, and how many companies are trying to manage the costs and liabilities that are associated with these programs. Now Martha will talk about the statement.

MS. MARTHA E. MARCON: I find that throughout my travels in dealing with *FAS 106* and talking to various organizations such as yours that are not comprised primarily of accountants, one of the most interesting parts of this process is to understand why *FAS 106* is such a controversial statement and why is it that it has taken us so long to get to this point in the accounting world.

*FAS 106* postretirement statement is very simplistically a method of recognizing obligations that employers have entered into under contracts with their employees. From an accountant's perspective, the concepts that are being adopted in 106 are very simple and we have to sit back and say, "Gee, why didn't we get here a long time ago, because all other accounting models require us to recognize obligations under contracts." This is just one of the things that has been surfacing as far back as the 1960s when companies began to recognize that there is a pension obligation that they have entered into with their employees that also was not properly recognized or consistently recognized from company to company.

The controversy actually started back in the 1960s. The AICPA at that point in time had agreed to discuss the issue and attempt to get some resolution in a relatively short time period. I think that statement came out sometime during the 1980s, so 20 years later we finally got a statement that established some commonality in accounting for obligations under pensions. During that 20-year process, it became quite apparent to us in the late 1970s that not only did we have these obligations to provide benefits to employees under pension contracts, but we also had, in many cases, other types of postretirement benefits that also were not being accounted for or recognized in the financial statements other than on a pay-as-you-go basis.

As long ago as the late 1970s we put the need to address accounting for post-retirement employee benefits on the agenda. It was delayed because it was all embroiled in the pension controversy which we recognized in the 1960s; we had to get that one resolved before we could move on to postretirement employee benefits. Throughout the 1980s we adopted some statements that would allow us to at least disclose our obligations without really quantifying, without necessarily explaining to the reader, exactly what we had agreed to pay to our future retirees.

Finally, the statement was issued in 1990 and is now going to be effective in a couple of years. One clear way of understanding whether or not a statement that is published by the FASB is controversial is by the thickness. *FAS 106* is probably one of the thickest statements I've seen in quite some time. Another way to determine how controversial it is, by how many pages we spend explaining, supporting, or trying to substantiate the statement. In this case, only a small portion of the document really relates to the specifics of accounting and a larger portion is dedicated to explaining why the FASB is doing what they are doing. That is clear evidence that what we have here is a controversial statement.

The controversy is not necessarily because of the underlying principles of basic accounting. We recognize all of our obligations as we enter into those contracts and

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we amortize those expenses over the period for which we're receiving benefits. The controversy lies in the fact that we've been doing it incorrectly for so many years. When we sit down and calculate what the answer is, it's monumental and it will have a significant impact in the market place. Companies are being drastically impacted. Analysts are not really sure what this means to an entity. Loan commitments with banks are totally disrupted because of the statement. However, nothing has changed economically.

The underlying objectives of the statement are basic from an accountant's perspective. We're trying to recognize these benefits as the employees render services. We're trying to acknowledge the fact that we have an obligation in the financial statements that needs to be disclosed and in some cases it really should be recorded. It's kind of like the pension approach where we've come up with some agreement; for us to sit down and recognize the entire obligation in one time period could be extremely detrimental and cause many companies in the country to become insolvent.

Another objective that we need to accomplish is to get some consistency from company to company. Right now we could have two companies' financial statements that show totally different pictures with respect to their employee benefit plans, especially postretirement employee plans, yet the accounting could be so different that you get different answers. We're trying to be more consistent how we account for a particular transaction or a commitment.

It's very important to establish some measure of comparability. We could have two companies, A and B; Company A has a postretirement employee benefit plan and Company B does not. Obviously, Company A's financial statement should reflect that they have a greater future obligation and greater expenses to be incurred than Company B.

The effective dates are rapidly approaching. There is a relatively short time for companies to get the data, collect it, analyze it and consider plan modifications, especially when you're dealing with a very sensitive topic -- benefits that we provide to our employees. The companies are well-advised to get on this immediately, if they haven't already done so, because the communication that will need to take place with respect to their employees is very significant, important, controversial, and very sensitive. The closer we get to coming up with some modifications to plan designs and changes that we might want to consider for accounting purposes, the sooner we really need to think about the impact on the work force.

The good news is that everyone else is in the same boat. You would expect that over time the competitors will all get together. You will find that in one marketplace, plans will begin to look a little more common. In Southern California, where I'm from, there are relatively few companies that provide postretirement employee benefits. It's a relatively young work force, a young market place, and employees don't really anticipate that they're ever going to retire. It's Southern California and the work force is 18 or 20 years old. We find that throughout the country the focus and the interest is more in the Midwest and the northeast corridor as opposed to in Los Angeles. There are a few companies out there that do have these benefits. We are finding that they are all talking to each other, industry to industry, trying to figure out where they go from here.

The transition can be extremely disruptive to a company. If you have regulatory requirements, if you have bank covenants, if you have any restrictions or need to continue a rather smoothing trend in reporting the equity, the appearance of solvency of the financial statements or trends in income, which choice do you make? Which option do you choose for the transition can have great impact in the future. Many companies are looking at their financial stability and concluding that their equity is probably big enough to absorb a one-shot adjustment, which would be very advantageous because it would allow the company to have relatively smooth earnings in the future with a lower expense than a company that can't afford that one-shot recognition on the financial statements and will need to actually take some of that obligation and amortize it over some future time frame. It's very important to recognize in analyzing financial statements from one company to another. It can impact future revenue streams.

We have two choices to recognize the transition asset or obligation. We can either recognize the entire obligation in one year or we can opt to amortize that opening obligation or asset over some time in the future. The FASB statement allows us to select to 20 years if our service life or the attribution period is something shorter than 20 years. The decision that the companies make today will have some long-term ramifications that will affect how you present your financial statements for the next 20 or 40 years. It is a decision that should be well thought out and should not be made solely based on how you are presenting your financial statements in any given year.

You really need to take a look at it 5, 10, and 20 years out, because if we choose immediate recognition of the entire obligation, future net incomes will be favorably impacted. A company that adopts all at once will have a greater net income to report because they'll have a lower expense in the future as compared with a company that elects to amortize the opening obligation over a 20-year time period. Amortization of the initial obligation will cause those future income statements to reflect less income because of the greater expense for postretirement employee benefits. All of that, however, needs to be disclosed in the footnotes to the financial statements, so a reader will be able to factor that in when attempting to look at comparability from one company to the next. Net worth would substantially decrease if they decide to use the one-shot approach of recognizing the entire obligation.

Evaluating what types of disclosures needed to be included in the footnotes to the financial statements was also a very controversial topic. The exposure draft as it was originally issued had substantially more disclosures than what was included in the final statement. The purpose of the disclosures is to cause companies to explain what their obligations are -- a brief description of their plan -- and present information that would help a reader to understand the impact of the financial statements.

We need to disclose all the underlying assumptions that are being used to create the liability. The 1% effect of an increase in health care cost trend rate is intended to explain to the reader the sensitivity that the assumptions have on this calculation. It's real important for our reader to understand that when we're looking at these types of obligations, we can have a range that is as big as the national debt. We need to get that across in the financial statements. Therefore, it was decided that we need to

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disclose a little bit more than you might expect for other types of obligations in which companies have entered.

I think most would agree that probably the one benefit that *FAS 106* brings to companies is the fact that it caused *FAS 96* on accounting for income taxes to be changed rather drastically. As *FAS 109* is printed on accounting for income taxes, major changes to that final statement compared with where it started out under *FAS 96* and the whole thrust behind the change allowing companies more leniency in their ability to recognize deferred tax assets and future expected benefits was really driven by *FAS 106*. When you look at the huge obligations that are being created under *FAS 106* and with the proposed accounting rules under *FAS 96* which almost restrict companies from recognizing any possible future tax benefits, it is like a double whammy.

The FASB, in reconsidering the controversial issues of *FAS 96* on accounting for income taxes, took the obligations under *FAS 106* into consideration. Now the approach we're dealing with in accounting for income taxes is much more lenient and allows companies, in most cases, to recognize at least the deferred tax benefits that would offset this obligation.

MR. VINCENT AMOROSO: I'm going to talk about the calculation process and describe some of the assumptions that are used in calculating these liabilities.

We're going to talk about the calculation procedures. The data collection is perhaps one of the most difficult things. It is unlike the pension model, where the pension plan has been in place for any number of years and the systems to capture the information that is necessary to compute the liabilities already exist and are fairly routinely provided. That process hasn't started at companies that have not yet done *FAS 106* valuations. Even for those that have, it turns out that the data collection is very difficult.

My guess is that in 2, 6, or 8 years we'll look back and say "Oh, now it's a lot easier." But the first few times, just the mere collection of who's covered, what the plans are, what the benefits are, and so on will be very difficult. I've forgotten the number and maybe somebody else on the panel or somebody in the audience knows, but in the field test phase of the study, over two dozen companies actually determined what the effect of the statement would be. This is our reported income and expense doing it the way we currently do it and this is our reported income and expense applying the statement. Several companies or some number of major U.S. corporations had to drop out because they weren't able to provide the necessary data. The data collection part is getting under control, but it will take each company several more tries in order to make it routine.

The basic building block is the expected postretirement benefit obligation (EPBO), and this is the present value of all future benefits. The EPBO is computed with a variation on the pension model. It is typically computed by determining the cash flow from the plan that is expected to be paid. Those cash flow amounts are then discounted back to the present. The discounted cash flows give us the basic building block from which other things will follow.

I think of the calculation of the cash flow as a matrix. There is a spreadsheet that gives us the population. The spreadsheet has a variety of cells that I'm going to describe in just a minute and there is a cost spreadsheet. The product of the appropriate cells gives us the cash flow for that related cell. You then sum up the cells for a particular year and that's the expected cash flow for that year. You continue to do that and to get the expected cash flow for all the years. Now, let's go back and take a look.

FROM THE FLOOR: Population means actual retirees?

MR. AMOROSO: I'm going to talk about that right now. Yes, it does.

We start in the base year and there are basically two inputs – one input into each of these spreadsheets. The base year population is the current beneficiary crowd. To whom do we expect to pay benefits? We would determine this using the relevant cost variable, so that we would show these folks sorted on age, sex, and to the extent that there are any covered children in the retiree group, we would also sort on children.

The base year population is this year's beneficiaries. What we do in order to fill in the rest of the matrix is use traditional pension assumptions in terms of mortality typically for the current crowd. There are inputs. There are not only decrements leaving the group through principally death of the current retiree group, but also attaining a certain age for dependent children, and perhaps getting divorced, to the extent that coverage stops for spouses after divorce. The principle decrement here is mortality.

There are inputs into this crowd. The inputs obviously come from the active work group, so that there is yet another module somewhere else that is feeding into the population. Now, again, the population has shown that we would do this separately for males and for females at different ages. We'd also do it differently for plans because the benefits may very well be different. This will become clearer when we talk about the per capita costs. We might also choose to do it separately for geographical locations. If we have a very big plan sponsor, a company that has people in Burton, Alabama and also people in Century City, Los Angeles, the cost for medical care is different in those two places and so we might very well choose to show them separately for different geographical areas.

The determination of per capita costs is really one of the most involved for anything we do in the *FAS 106* valuation. My own speculation is, again, in 2-10 years, this will become much more routine; but right now, that isn't the case. The goal is to determine what the current per capita cost is for the corresponding population cell. If we have males age 55, then what do we think the current per capita cost is for males age 55 under the given plan, in the given geographical location, etc.? We will probe into what some of the issues are in determining the per capita cost. For those of you who are familiar with experience rating of group medical plans from one year to the next, the process is very similar.

In terms of resources, we ran into a problem when we were doing due diligence. A cell of a very sizeable organization provided their consultants with a list of per capita costs. The consultant then did the calculation, but took no responsibility for the per

capita costs. As we were doing the due diligence to see whether or not the determination of per capita cost was done in a way that bared any scrutiny, we discovered that some of the third-party administrators have spawned little subsidiary firms. These firms will actually take the plan sponsor's claims-paying data and transform it into per capita costs. The question is, did they do a job that bears any scrutiny?

In helping us determine per capita cost, we would like to have claims data, whether it's paid or incurred, and raw claims data. Hopefully the data will be segregated by different plans. We hope that the data are credible. We start with incurred claims data and spread those data over age, sex, and so on. There are a number of resources available to us to help. Typically, if you're with a firm that has folks that have experience in rating medical policies, then it's really that skill that is required in determining what base year costs are. If you don't and you're kind of groping to try to learn some of this stuff, the Health Care Finance Administration (HCFA), which is where this particular data came from, is a good source of information. The Health Care Finance Administration, which is a subset of the Department of Health and Human Services (HHS), is the organization that administers Medicare. They have lots of numbers, and sometimes they'll share some of those numbers and may even put them in graphic form for you.

One of the ways in which they communicate their data and their findings from their studies is through the quarterly publication, *The Health Care Review*, which I recommend to any of you that are either interested in or are going to be doing any of this stuff. It's a green quarterly and it costs \$12 a year. It's really quite a valuable resource.

Chart 1 shows the incidence for hospitalization. The graph shows us the pattern of increase in costs. This is a proxy for the pattern of increasing costs that we would expect to see for an entire plan of benefits, but it merely looks at the hospital days portion and carves out the effect of maternity. We can see that females start out being more expensive than males. Somewhere in the mid-40s or mid-50s the cost for males goes ahead and stays ahead until the end. There are some interesting thoughts about why the curve actually comes down, why the rate of increase decreases as we hit some ages.

This is a piece of information that is actually quite helpful in a couple of ways. We're going to talk about leveraging for trend, and we'll describe what that term means. My dad tells me what's new on the street. He says, "On the street, this is what they say." On the street, word has it that just a few people represent the overwhelming majority of medical claims cost. That was the word that I heard on the street and it turns out that the data that comes from the Health Care Finance Administration, again, tends to put that rumor into numbers.

Chart 2 is trying to tell us that in a group of people that is large enough, we would expect that about 10% of the group would give rise to something on the order of 75% of the claims cost. Let me just give you a numerical example.

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CHART 1  
Hospital Days per 1,000 Persons, by Age Group and Sex

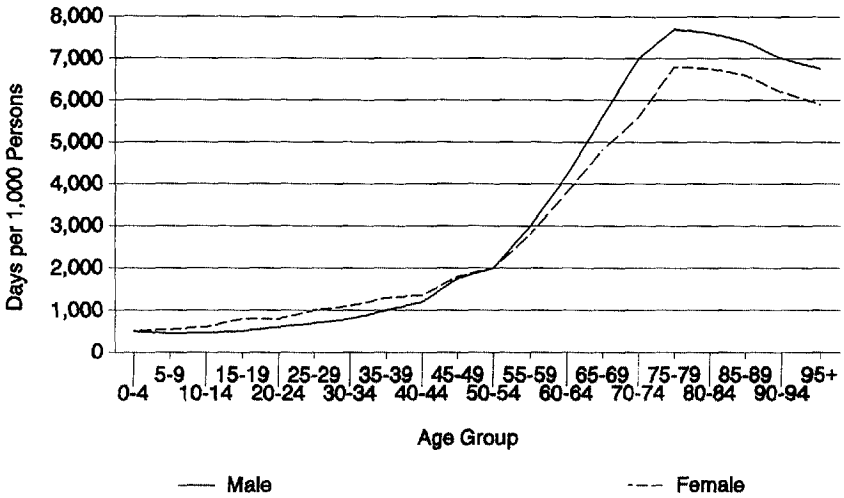
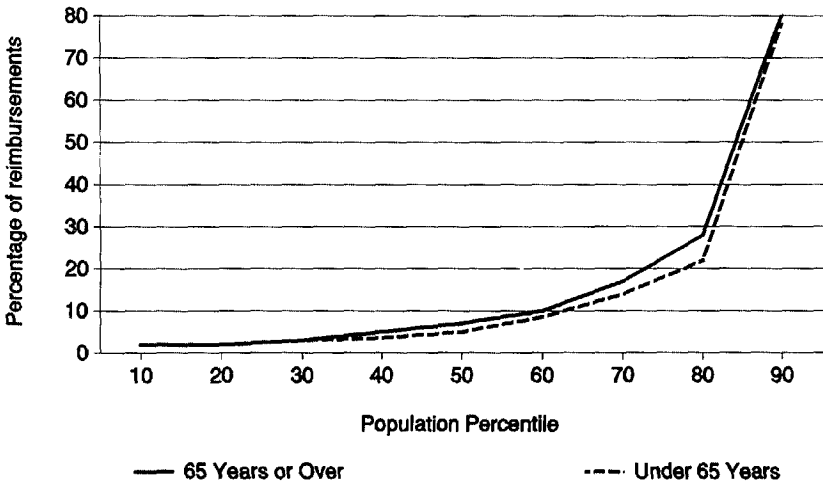


CHART 2  
Cumulative Percentage of Charges Attributable to Various Percentiles of United States Residents, by Age



If we had a group of 1,000 people and we expect that the total claims for that group of 1,000 people is something like \$2 million, then we would expect about 100 of



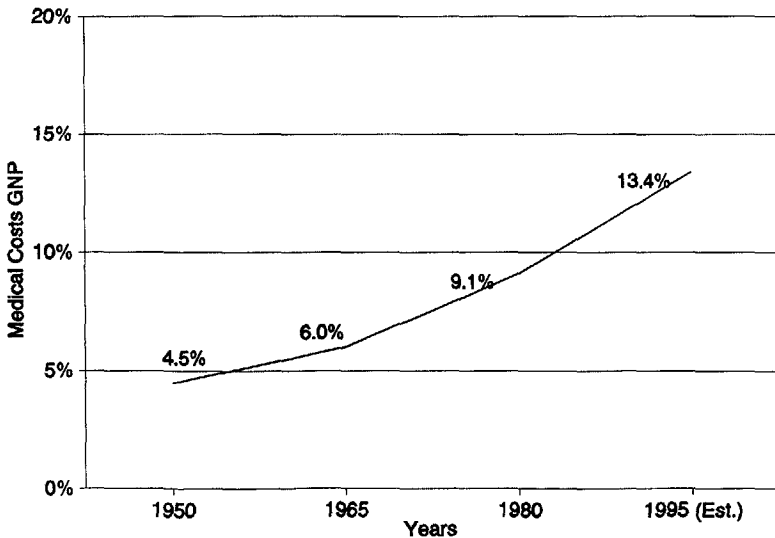
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those people would give rise to something like \$1.5 million. So when we're talking per capita, we're talking averages; but there's really quite a distribution of claims. The distribution of claims puts bearing on how some of the other variables work. Once we have the per capita costs, we then increase those per capita costs using a trend factor.

By the way, this is a closed group valuation. The current existing active work force is a closed cohort and it is from that cohort that new entrants get into the beneficiary group. On the per capita costs, we start with per capita costs and then we increase those costs using a trend factor that we can talk about now.

The information in Chart 3 shows what the trend in health care costs in this country have been. This is emerging as one of the ways in which the trend assumption is selected for valuations under *FAS 106*. Back in the 1950s, the ratio of health expenditures to GNP was about 4.5%. As of this year, and maybe last year, it was about 12% or just over 12%. A few years ago, Ross Arnett – he is the individual at the Health Care Finance Administration who's in charge of projections of medical expenses – thought that by the year 2000 this ratio would reach 15%. As of last year, he revised his prediction to be 15% by the year 1997.

CHART 3  
Trend in Medical Costs



Well, certainly it doesn't take the kind of experience that this audience has to see that this kind of trend cannot go on unabated. In some amount of time, we would be having this dialogue in a hospital room and that wouldn't be very much fun. To paraphrase Joseph Heller, something will happen and we don't really know what it is that's going to happen. The health care trend rate is the most subjective and qualitative element that makes the calculated numbers soft. I'm going to ask you

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where you think the trend is going to peak then I'm going to share with you my kind of eye ball results of this little informal survey, but I'm going to ask you to vote.

I'm going to ask you to vote on where you think that this trend is going to peak, because that is part and parcel to the process of determining what the trend assumption is. These are the following choices you're going to have and then I'm going to share with you the results of this little informal survey. The first choice is, do you think it will peak at 15% or less? The next choices are: 15-18%, 18-21%, 21-24%, and over 24%.

Who thinks it will peak at 15% or less? One person. By the way, there's obviously not a wrong answer here, so I really would like you to vote. Who thinks it will peak between 15-18%? About a quarter of the audience. We better not add up to more than one. This is an actuarial group here. Eighteen to 21%? Maybe half. Twenty-one to 24%? Not quite as many as 15-18%. Maybe half as many as those. Over 25% and over? Five.

It's been my experience that typically two contiguous ranges represent approximately 90-95%. They're not always the same two, but they are two of the following three: 15-18%, 18-21%, and 21-24%. Among this group, the two seemed to be maybe 15-18%, and 18-21%.

My sense of it is that if I had to boil it all down to a single one percent range, I think that the average is about 19% or 20%, but probably not more than 20.5%. That's my sense and this is strictly eye balling it. Anyway, this is a process that can be used in helping us determine the trend rate, and we'll go into the details of how we use this information in just a minute.

Let me just spend a minute to talk about what are some things that actually might happen. It seems to me that in order to get dramatic legislative change we need to have three things. One, we need to have agreement that there is a problem. Two, we need to then agree – and what I mean by "we" is the political types as well as the constituencies – as to how that problem is articulated; i.e., what is the problem? Finally, once we have accomplished step one and two, if we can agree on how to solve that problem, we have legislation. My sense is that we have certainly gone beyond checkpoint one. If there was any doubt whether or not the constituency of this country believed that there was a problem, it seems to me that the election in Pennsylvania of Harris Wofford put it to rest. We still are struggling with what the problem is. There is some disagreement as to exactly what the problem is. The answer to what the problem is probably lies in the union of what the various groups think the problem is – whether it's access to health care, cost of health care, litigation expense, quality of health care and so on.

Once we agree on what the problem is that is, once we have gone through the consensus building and the compromise stage, then we'll get onto what the solution is. I don't know whether this will take one, three, or seven years. My guess is that we'll probably have a series of edicts possibly starting in the states, as we've already seen in some states, or coming in some big dramatic change from Washington. I don't know what's going to happen, but my guess is that in part it will be driven out of Washington.

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For those of you who are interested in one person's opinion, there's a fellow named Daniel Callahan who's written two books. He is a medical ethicist in New York. One of them is *What Kind of Life?* and the other one is *Born to Pay*. He's quite a scholarly sort, a very bright guy who discusses how we are spending our medical dollars.

In any event, Table 1 represents what the *FAS 106* trend has been over the 37-year period from 1950-87. What we see here is that the nonmedical GNP during that period has grown 7.5%. The medical GNP has grown 10.4%, and the net medical trend is something less than the 10.4%. There are two variables that have contributed to the 10.4% that are not properly includable in the *FAS 106* trend. One is the growth in the population. Again, Ross Arnett has published a couple of studies that attempted to quantify what is the effect of an increasing population on the increase in the medical portion of GNP. The other one is the aging of the population. It seems to me that everybody else is getting younger here, but in fact, I think some of us are getting a little older and that has contributed to an increase in the cost. Neither of those variables is properly includable because in the process I described at the outset, there are no new entrants and the aging is taken care of in the way that the per capita costs are shown.

TABLE 1  
Medical Trend 1950 - 1987

	Annual Rate of Growth
NonMedical GNP	7.5%
Medical GNP	10.4%
'Net' Medical Trend*	8.4%

\*Eliminates Effect of Aging and Population Growth

This table shows the net medical trend during the 37-year period. This is the process that we often start with to determine what makes sense in terms of trend. In step one, we decide what is the peak. There were people who thought 15% was the right answer, and 18% was the right answer, and people who thought more than 25% was the right answer. You can see that differences of opinion will have quite a significant effect on the trend assumption. These are legitimate differences of opinion, because we assume that none of us know when we, as a society, will say enough is enough and will be willing to make some of the hard choices that I think face us.

Table 1 shows the level equivalent trend. Now, what are some other things that we need to worry about? Typically, the trend doesn't look like this. We don't see the level of annual trend at, say, 7.5%. Instead, what we see is something that starts closer to what today's trends are, which is something on the order of 10%, 12%, or 13%, although we have seen some higher, and then have that slope down to an ultimate rate that is reached at the peak year. One thing I didn't poll this group on is when do you think the peak will be reached? I also didn't ask, do you think that it will come down after that? There's really a number of things to think about here.

It's my sense that the building consensus is that there is a peak that will be reached and then there will be a steady state thereafter. Although we have seen some that have come gently sloping downwards after that. So, one, we use something like a select-and-ultimate kind of rate that produces the same sort of numbers. Two, we've seen trends that vary on pre-65 versus post-65. We have retirees that retire before 65 and plans oftentimes, but not always, provide coverage for both pre-Medicare years and post-Medicare years.

What we have seen is that there are some folks who use trends that are smaller in the early years, such as starting out at 12% for pre-65 and starting out at maybe 9% for post-65, and then those two points gradually drop to the same ultimate level of maybe 5.5%, 6%, 6.5%, or something else. I think that one of the reasons for using a smaller trend post-65 is, in part, due to the changes in Medicare that have been adopted in the last few years. One is called balance billing.

There is an attempt by the government to constrain doctors' abilities to increase prices or to pass along an increase in prices to all patients, whether Medicare or not, for post-65 coverage. That has given rise to some folks thinking, "Well, what we should do, since there is going to be a constraint on some element of the price, is take cognizance of that in determining the trend." It certainly makes sense to look at it that way. I go one step further and think if we are starting at the macro, the gestalt of this process is that something will happen." I think this is one of the things that's going to happen. If this something has already been taken into account by imposing a peak that the trend doesn't otherwise suggest, then it seems to me like double counting. Anyway, that's my view and certainly, as I say, that's not necessarily a majority view. Maybe we can have some discussion about that.

The other thing is leveraging. Let me describe leveraging to you by means of an example. Pretend the average claim is \$2,000 and our plan provision is a \$300 deductible and 80/20 coinsurance and a maximum out of pocket of \$2,000. If we think that \$2,000 is the average claim in year one and \$2,200 in year two, then when you do the arithmetic it turns out that the net claim goes up by more than 10% because of the effect of the deductible. That is called leveraging.

Let me just spend one quick minute on that. I don't believe it's quite as easy as that because the average claim doesn't tell you what the claims are really like; that is, what is the effect on the paying agent? The paying agent is paying claims that are submitted, and is not paying average claims. Apropos of the chart that showed us what I heard on the street: there is a small group with very, very high claims. These people might show a very tiny effect, if any, of leveraging because the maximum out-of-pocket feature tends to mitigate the effect of that deductible and co-insurance. As you increase those amounts then, it's only those small fixed dollars that have an effect.

The leveraging is a function of the distribution of the claims. We've actually done a little bit of investigation into how that all might work out. It is a process that somehow is quite vexing. I don't know that we necessarily have enough facts at our disposal to make real splendid guesses, but I think we certainly have enough tools to get started on that process.

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Another thing to think about is expenses. Whereas it makes some sense to think that medical claims are going to rise at a rate faster than nonmedical GNP, at least in the short term, that may not be so true for the expense element of the cost. We've seen a number of folks who use different inflation assumptions for the benefit payment portion compared to the expense portion.

Let me quickly describe some terms and then I will discuss the last two charts. These are the terms: EPBO is, again, the expected postretirement benefit obligation. It's the present value of all future benefits. The accumulated postretirement benefit obligation (APBO) is the past service portion of the EPBO. There is a term that I haven't used, which is attribution. Attribution is the concept of over what period of service is the total liability accrued from an income statement standpoint? Basically, it's from the date of plan participation, which for many plans, is from the date of hire until the date when somebody can walk away with the full benefit. The service cost is the normal cost in pension talk. That's the piece of the cost that's attributable to the year. Amortization of the transition obligation is the amortization of the unfunded past service liability at adoption of FAS 106.

Table 2 is taken from Paragraph 394 of the statement. It shows two employees that I have very cleverly named A and B. Employee A is actually Paragraph 394. Here we have the measurement date and the full eligibility date. We use the full eligibility date to determine the attribution period. Here's the discounted medical trend. We're actually going to compute some numbers. Those numbers will be used later on. I'll show you how the numbers hang together. Employee A is 50 and employee B is 62. I think they both retire at 62. The service for B is irrelevant because he's already beyond the full eligibility date. That means all the liability is fully accrued, no more service costs for B. Employee A has 20 years of service; therefore at age 55, he will have 25 years of service. His attribution period is 25 years. We spread the whole liability over 25 years. The life expectancy is 27 years for A and 15 years for B. We really know that we don't do it this way, but it just makes it easier to compute it.

TABLE 2  
Example: Paragraph 394

			Employees	
Measurement Date	12/31/92	12/31/92	A	B
Full eligibility	55/10	• Age	50	62
Discount rate	8%	• Service	20	NA (> 10)
Medical trend	7%	Service at 55	25	NA
		Life Expectancy	27	15
		Retirement	1/1/2005	1/1/93

In Table 3 we have two people retiring. Employee B retires first in 1992 and employee A retires next in 2004. What I've tried to do is to show you the interrelationship between the trend assumption and the discount rate. Claims appears in

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Column A, \$2,796. I think that column appears and even the present value appears in the statement. So the relationship between \$2,796 and \$1,028 is obviously the 8% discount factor.

TABLE 3  
Expected Future Benefits

A				B			
	Year	Claims (EOY)	12/31/92 PV		Year	Claims (EOY)	12/31/92 PV
(63)	2004	\$2,796. <sup>1</sup>	\$1,028. <sup>2</sup>	(63)	1992	\$1,241. <sup>1</sup>	\$1,149. <sup>3</sup>
	2005	3,093	1,052		1993	1,373	1,177
(65)	2006	856	270	(65)	1994	380	302
	•				•		
	•				•		
	•				•		
(77)	2018	3,899	488	(77)	2006	1,731	546
Total (EPBO) \$6,292				Total (EPBO) \$7,035			

<sup>1</sup>  $[(1.07)^{**12}] * \$1,241 = \$2,796$

<sup>2</sup>  $[(1/1.08)^{**13}] * \$2,796 = \$1,028$

<sup>3</sup>  $[(1/1.08)^{**1}] * \$1,241 = \$1,149$

Now, the relationship between \$2,796 and \$1,241 is the trend. What we have is Employees A and B, both age 62, but reaching age 62 twelve years apart. If we know that \$2,796 is the right answer on December 31, 2004, then you see the arithmetic. It's discounted by 1.07 to the 1/12 power. It gets you down to what the claims cost in 1992. This shows you the relationship between how you apply the discount rate and the trend factor.

Table 4 shows how the numbers hang together. The sum of the present values -- \$6,292, \$7,035 -- is the EPBO. The APBO is the past service portion of the EPBO. Remember, Employee B already passed his full eligibility date. In *FAS 106*, that's the magic point at which everything is fully accrued. Therefore, the whole EPBO is fully accrued for Employee B. Employee A still has five years to go, so the APBO is 20/25 of the EPBO.

Finally, Employee A has a service cost because, again, the way the EPBO gets accrued is through the service cost allocation process. Finally, Table 5 shows the 1993 periodic cost. We have a service cost. We have an interest cost which increases the beginning-of-the-year present value to the end of the year. Finally, there's the amortization of the APBO and here we do it over 20 years. We have a choice of either spreading it over 20 years or taking it all at once. That, in a real whirlwind, is the calculation of the numbers. I realize that I did not do justice to many of the assumptions, but to the extent that we have time and someone has special interests, then by all means we can dwell on that at whatever length you want.

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TABLE 4  
12/31/92 Measurement Date  
Results: Example

	A	B	Total
EPBO	\$6,292	\$7,035	\$13,327
APBO	5,034. <sup>1</sup>	7,035	12,069. <sup>3</sup>
Service Cost	252. <sup>2</sup>	NA	252

<sup>1</sup>(20/25) \* \$6,292 = \$5,034

<sup>2</sup>(1/25) \* \$6,292 = \$252

<sup>3</sup>(Transition Obligation)

TABLE 5  
1993 Periodic Cost: Example

Service Cost	\$252
Interest Cost <sup>1</sup>	966
Amortization <sup>2</sup>	603
Expected Return Assets	<u>0</u>
	\$1,821

<sup>1</sup>(0.08) \* \$12,069 = \$966

<sup>2</sup>(1/20) \* \$12,069 (Transition Obligation) = \$603

MS. DIANA J. SCOTT: For the final segment, I'd like to go through the piece that's called implementation exercises. These will be a lot more fun if you participate too. What I did was put together eight different situations that have come up in different areas of implementing FAS 106. I just wanted to get some discussion going and get your reaction. These are areas where there has been some confusion or some disagreement. I thought, at least based on my insights, discussions, and follow-up with the staff at the FASB, that we could clarify any of these potential misunderstandings.

The first case is a situation in which you have actives and retirees participating in the same plan. They pay a blended rate of \$1,500. Now, the company wanted to avoid recognizing a FAS 106 obligation, so it looked at the cost and determined if we were to cover retirees only, they'd pay about \$2,100 each. If we covered actives only, the cost would be about \$900 each. They had set the contribution rate for retirees at \$1,500, so there's a \$600 shortfall. So they said, "All right, what we'll do is pay \$900 for each active. But then the actives, if they want to participate in the plan, have to pay \$600 to participate, to get coverage." Of course, the retirees are paying \$1,500.

How many of you believe that the company has successfully avoided a FAS 106 obligation? I should have you talk to my client. The right answer is no. There has been some dispute about that and what it really comes down to is that when you have a situation where you have actives and retirees participating in the same plan, and there is an employer contribution as well, the amount that the individual participants are putting in is deemed to go first towards covering their coverage. You can't say, "Well, the company is paying for the actives and the actives are paying for the

shortfall for retirees." The \$600 that actives are paying goes first towards covering their costs. Then, if they happen to be paying more than their cost, you would reduce the employer's obligation by that amount.

Now, the way to avoid this is to give the actives a choice, but that has other consequences. You could say to the actives, "We're going to pay \$900 for your coverage. You can either participate in an HMO and you won't put in any of your own cash, or you can decide to join this indemnity plan with the retirees and you'll have to put in another \$600." Essentially you're saying, "We're giving you \$900 to use and then you decide if you want to spend \$900 for coverage or \$1,500 for coverage with retirees. In that case, the employer has avoided a *FAS 106* obligation. The down side is are you going to get enough actives to participate in the plan with retirees to keep those costs down, or will costs continue to rise over time because of the predominance of retirees in the group?"

Case two is an interesting concept. The client said, "Well, we have a collectively bargained agreement that says that we're providing retiree health care benefits only for the duration of the agreement." However, the underlying presumption in *FAS 106* is that, as in evidence to the contrary, an employer that has provided retiree medical benefits in the past or is currently promising to continue the benefits in the future has a *FAS 106* obligation. Do you think by putting language in a contract that says you're specifically limiting your obligation to the three-year term of the contract that you can avoid the *FAS 106* obligation? You guys are crack consultants. No, you can't.

This was, again, a nice try. A lot of people are making nice tries. There is, in *FAS 106*, the presumption for all plans that if you're providing benefits today, you'll continue to do so in the future. Now, if that's true, in the case where an employer is providing benefits to actives or noncollectively bargained groups, where the employer clearly has the ability to terminate the claim at any point in time, it certainly follows that where the employer doesn't have the unilateral ability to make that change that the employer has to continue the plan and that the plan will be an ongoing plan.

The next one is another nice try. A company redesigned its plan to accrual based on a matrix. They were trying to give individuals who have 25 years of service 100% coverage. They thought, "Gee, we've heard about this neat trick where you start accruing benefits at age 45 and then you drop off everybody who's not yet age 45 from the measurement process. We think that's pretty slick and so what we're going to do is say that none of your service counts or you don't start accruing the benefit until you're age 45. When you're age 45, then the benefit that you accrue is based on your age at the date that you were hired. So if you were hired at age 20, then you have 25 years of service at age 45. We'll credit you with 100% of your benefit that year. Now, if you were hired at 25, you've only rendered 20 years of service, so the year you turn 45 we'll credit you with 80% and then you'll accrue another 4% each year over the next five years and so forth. In order to be eligible for benefits under the plan, however, you have to attain age 55 and have rendered at least 10 years of service under the plan."

The first question that arises is, what is the beginning of the credited service period for attribution purposes? Let's look at the fellow who was hired at age 20. How



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many people would say that we start accruing benefits for him from age 20? About a third. How many would say we accrue benefits starting at age 45? One. Actually, I have faced this situation on more than one occasion. The companies in both cases were told by their auditors that you don't have to start accruing anything until age 45. That's not the right answer. We certainly didn't want to have a lot of inconsistency out in the community. So we talked to all of the accounting firms and the FASB and everybody is in agreement that even though you say you weren't accruing a benefit under the plan until age 45, there's no substance to that because the benefit that you're accruing looks right back to your age at date of hire. That negates any notion of no accrual of benefits prior to age 45. So the beginning of the attribution period, in this case, would always be date of hire.

In fact, in any situation where you're trying to structure a plan to start accruing benefits at age 45, any time you differentiate between individuals based on their date of hire or their years of service up to that point, you have to go right back to the beginning of their service period to start the accrual process. Now, the other interesting question that has been viewed differently is, what's the end of the attribution period? Let's look again at the fellow who was age 20, who we say accrues 100% of his benefit when he's age 45. Remember that you're only eligible for benefits if you retire on or after age 55 with at least 10 years of credited service.

How many of you would say that, for an individual expected to receive benefits under the plan, you would accrue 100% when he's age 45? About two. How many would say that you attribute benefits for this individual from date of hire to age 55? That's the right answer. The reason is that even though you're saying that you're accruing 100% of benefits at age 45, again, there is not a lot of substance to that because there is one more step that has to be completed – you have to work until you're age 55 or you have to at least work for the company when you're 55. In this situation, although what they were trying to do was interesting, it didn't work. It gets them right back to the typical 55 and 10 plan, accrue from date of hire to the full eligibility date, which in this case is 55 for the individual hired at age 20.

Another interesting situation I've seen is one where a plan provides 85% coverage to employees who render 10 years of service, 90% coverage to employees who render 15 years of service, and 95% coverage to employees who render 25 or more years of service. In order to receive any benefits under the plan, you have to attain age 55 and have rendered at least 10 years of service. The first question is, is this a front-loaded plan? How many of you on the surface would say that this is a front-loaded plan? Only two people. That's kind of interesting, because the initial reaction with this case is that this is clearly front-loaded.

Now, for those of you who think it's not front-loaded, what would be your rationale for saying it's not front-loaded?

FROM THE FLOOR: Is that a meaningful curve in this context? What are the ramifications if it's front-loaded?

MS. SCOTT: If it's front-loaded, you would have to follow the benefit formula. You would have to accrue 85% coverage over the first 10 years – 8.5% for each year for

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the first 10 years -- and then 1% for each of the next five years and then 0.5% for the next 10 years. So you're following the benefit formula exactly.

MR. AMOROSO: The service cost is different. The 8.5% of the benefit is accrued in year one as opposed to total service -- instead of dividing total service into the 85% or the 100%.

MS. SCOTT: Does anybody have any rationales for why you think this plan would not be front-loaded? This is one the auditors are going to ask you about.

FROM THE FLOOR: The argument is the same as the previous one. The guy who is age 45 is meaningless; he has 100% accrual. The guy starts at age 25 or age 35 and has 85% accrual. He still has to work another 20 years.

MS. SCOTT: Right. You're exactly right. The real key here is looking at when somebody is 55 and would be entitled to receive a benefit under the plan, how many years on average have they worked. When you do this, you're not looking at any individual, but you're looking at the group as a whole and you're saying in a typical situation individuals who attain age 55 have, let's say, 17 years of service. Now, do I think that getting 85% coverage for 17 years of service is necessarily front-loaded? Well, I'm not sure that it is. When we took this issue to the staff at the FASB, they agreed that that's the reason for attribution of benefits in this plan.

Now, if most of the people are hired at age 45 and, on average, would have 10 years of service at age 55, it is a front-loaded plan. So the key is how much service is there at age 55. I have to tell you. I was surprised that this issue even came up but, again, it's come up more than once. I would never have guessed anybody would structure a plan to front load benefits. If anything, you would think they would back load.

Now, you must decide whether you should have everything accrued at age 55 or, if the person hasn't yet rendered 15 or 25 years of service, is the incremental benefit trivial? If the benefit is viewed as trivial, you'd have to fully accrue by 55. If you view the benefit earned for each additional year of service as nontrivial, then you would just ratably accrue the expected benefit over that service period to the "full eligibility date." How many of you think that earning 1% for years of service from 10-15 is trivial? There's no right or wrong answer here. It's really judgment. We had about 10. How many of you think that 0.5% for each of the next 10 years is trivial? An auditor would definitely view 0.5% as trivial.

Martha, what would you say if you had a claim that provided 8.5% for the first 10 years and 1% for the next five? Would you say that 1% is trivial?

MS. MARCON: My mind is so trained to not work in a vacuum; it would depend upon the client. That's an honest answer and that's something that you need to consider when you're talking to the auditors. If I have a client that always does everything on the edge, I'm going to start out with a more conservative answer than if I have a client that is very, very conservative. I'm more likely to be lenient in giving the conservative client an answer. Whenever you're dealing with a judgmental area, there are too many other factors that enter into the decision-making process.

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Oftentimes, you would think that consultants don't really see that process going on inside the auditor's mind. That's an honest answer.

MS. SCOTT: In the two situations that I've encountered with this type of plan, the auditors have viewed the 1% benefit for each of the five years and the 0.5% for each of the next 10 as being trivial. So they agreed that this wasn't necessarily a front-loaded plan, because they agreed with the argument that if you had 17 or 20 years of service at age 55, it wasn't front-loaded. They did not agree with accruing beyond age 55 or 10 years of service, whichever came second.

A real typical situation. Everybody thinks this is so neat. We're going to change our plan from your basic 55 and 10 and to get coverage you have to work the 10 years after age 45. What are the down sides to that approach? Did I hear service costs somewhere?

FROM THE FLOOR: Service costs that are perceived.

MS. SCOTT: Service cost is certainly higher. You have more volatility if your work force isn't static. Companies hate volatility, which is why we all have to live with the corridor approach for gains and losses. There is one other reason that can be compelling as well. What if the company were to amend its plan in the future? You've dropped out everybody who's not yet age 45, so to the extent that the amendment affects anybody who's age 45 or older, including fully eligibles and retirees, the effect has to be amortized over average remaining service to full eligibility date which, when you have only a 10-year credited service period, is going to be somewhere around four to five years. That may give a much more rapid amortization of prior service costs than companies would like, so that's a third reason you might want to consider this before leaping in. I'd strongly recommend running the numbers for about a 10-year period before you take that approach.

In the interest of time, let's move on to Case 8, primarily because this one is not readily apparent to everyone. In Case 8, a company has decided that it wants to immediately recognize the transition obligation on a consolidated basis for its U.S. plans. The first question is, must all of the subsidiaries follow immediate recognition? The answer to that question is, for consolidated purposes, all of the units have to be on the same method of accounting, that is, immediate recognition. They also have to adopt at the same time. If the parent decides in 1992 that they want to adopt the statement and take the hit immediately, for consolidated purposes that has to include all U.S. operations.

Now, if you have separate company financial statements for any of the subsidiaries, for those separate company reporting purposes the subsidiary is not required to adopt until 1993. The thing to remember here is that even if the subsidiary has fewer than 500 participants, it is still locked into 1993. By virtue of the parent being a publicly held company, it's also viewed as being publicly held. Second, in those separate company financial statements, the subsidiary may, for those statements, use delayed recognition of its transition amount. There may be reasons why they want to delay recognition. It does require maintaining a second set of records for the subsidiary company.

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Now, setting that aside, are we locked in for all of the non-U.S. plans to immediate recognition? How many of you think yes? One? Well, you're right. If you adopt immediate recognition for the U.S. plans, you're locked into it for the non-U.S. plans. Once a company makes the election to immediately recognize the transition amount, there is no going back. You apply it to all operations for consolidated purposes. Similarly, if a company decides to delay recognition of its transition amount, there's no going back. You can't say five years down the road that I only have three-quarters of this left, it's been a good year and I want to get it behind me. Once you make the decision, it has a 20-year life.