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THE BEAST THAT ATE THE BOTTOM LINE: FAS 106 VALUATIONS

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Recorder: WILLIAM J. KLUNK

- Issues and assumptions
- Data
- Per capita claim cost before versus after age 65
- Transition strategies

MR. THOMAS TOHER: Our panelists are Andrea Feshbach from Foster Higgins and Mac McCarthy from William Mercer, and our recorder is Bill Klunk from William Mercer.

I thought I'd first take a look at a few bottom lines in 1992 annual reports that businesses put out for their shareholders. They all have stories to tell and things to say. I have two examples, one modified a little bit for presentation and the second, completely adulterated for my purposes; I'll point out the adulteration.

The first example demonstrates a loss of \$0.08 a share in 1992 against a gain of \$1.69 a share in 1991. The management people had a very good report to the company's shareholders, and the management people said they had a fine year, continuing in their growth and income in value to shareholders. You might ask, "How could they do that with a straight face?" This is a little explanation of what happened. If we looked at the net income or loss before we made any accounting changes, the value to shareholders of \$1.44 in 1992 versus the \$1.69 in 1991 looks a little better. The accounting change, of course, was the implementation of FAS 106 or postretirement medical benefits. The difference between these two numbers and the previous ones is what is known in the trade as "the cumulative effect adjustment." Basically, management took the accumulated postretirement benefit obligation (APBO) and expanded it.

The next example demonstrates another adjustment in management's story to its stockholders. We should look at the earnings in terms of net income or loss before any unusual charges. Between the two years there were some asset sales, plant close downs and so on. Now, 1992 at \$1.66 is starting to shape up as at least a better year than 1991. This is management's version of the bottom line. When you take out accounting changes, the unusual items and the amount of increased retiree benefit expense (this is the service cost plus the interest cost that went through ordinary operations), 1992, on a comparable basis with 1991, showed earnings per share of \$1.77, compared to \$1.62 for the prior year, a growth of 9% and something that management could be very proud of.

So, if we look at the numbers on an apples to apples basis (Table 1), management has shown to its shareholders that it has really given them value. One of management's comments in the report was that the effect of the accounting changes, while a significant number, didn't hurt the company's cash position one bit, and the bond

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rating stayed up; life will go on. These are just accounting changes and will be footnoted in future annual reports.

TABLE 1
Net Income (Loss)

Earnings/Losses	1992	1991
Net Income	\$ 1.77	\$ 1.62
FAS 106 -- Current Net of Tax Benefits	(0.11)	--
Net Income	\$ 1.66	\$ 1.62
Unusual Items	(0.22)	0.07
FAS #106 -- Cumulative	(1.52)	--
NET INCOME	\$(0.08)	\$ 1.69

Let us go back through a recapitulation of the two years. For net income, if we factor out all the unusual items and variances between 1992-91, we see \$1.77 versus \$1.62. The current charges for FAS 106 were \$0.11 a share, service cost and interest cost. But, that's also net of taxes giving us the \$1.66 against \$1.62. The unusual items are detailed. The company had a loss in 1992 of \$0.22 a share for selling off assets, a gain the previous year. The cumulative effect adjustment, as management calls it, is \$1.52 a share and we get back to the \$0.08 and \$1.69. But, from presentation to stockholders, the number management wants you to focus in on is \$1.77 and \$1.62. The \$0.11 is going to be there, and if we factor that into share prices as opposed to getting rid of the unusual items, for a company that's selling at 20 times earnings, that's a few bucks a share.

The last idea I'd like to talk about is the impact of taxes on the bottom line. FAS 106 may be "The Beast That Ate The Bottom Line," and we can see how it did it in that example, but there is a way back: APB 11 and FAS 96, two operative standards for accounting for income taxes. For 1993 and earlier years there's FAS 109. There are primary differences, which you'll see in the example. APB 11 is an income statement treatment of taxes, so each year a company looks at income and expenses on a tax basis and on a GAAP basis, figures out the differences and makes a provision for income tax, either a credit or a debit. The management people just sort of throw these things into accounts without any "reality tracking." They could have taxes from 1972 with 1972 rates buried some place.

FAS 96 tried to go to the balance sheet as the basic idea of making a provision for taxes, looking at all the items on the balance sheet, assets and liabilities, book values versus tax values, and the basic allowance for income taxes was to look at the company at a point in time. The company was allowed to put up a tax benefit if you had taxable income that would be generated or reversed from differences between book and tax values. FAS 96 was a rather stringent statement and few companies adopted it.

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FAS 109 is a little bit different, but it's gone back to the balance sheet concept. So, the tax people go down the balance sheet, compute deferred tax credits and deferred tax liabilities. They do a nice footnote on it, and then they set up what's known as "evaluation allowance." If you have a deferred tax asset, and this would be the case if we booked retiree medical expense, that's a liability. Presumably, in future years, there will be tax deductions for that. You'd set up an asset equal to your tax rate times the liability, and that number will get remarked every year, depending on the liability. If, in the assessment of management, it's more likely than not that these tax credits will occur, then you're allowed to put up the full assets. Otherwise, there's a reserve for doubtful accounts.

Table 2 is a real example modified by me. This company adopted FAS 106 in 1991 and happened to be operating under FAS 96 for tax purposes in 1991. Before anything happened it lost \$1.05 a share. Under FAS 106, the company decided to take the cumulative effect adjustment, which was \$3.96, and show a nice loss for the year, \$5.01. In 1992, the company came out real good. There wasn't a bottom line for the beast to eat. The company lost \$12.03 just on operations; however, to help everybody out, management switched over to FAS 109 for accounting, and FAS 109 gave the company a tax benefit of \$3.33. If you compared that to the 1991 results, had the company put together FAS 106 and FAS 109, perhaps 1991 would have looked a little bit better. Apparently the management people decided that 1992 wasn't going to be that great, so they held off adopting FAS 109 and picked up \$3.30 a share to take a terrible year to awful.

TABLE 2
Net Income (Loss)

Earnings/Losses	1992	1991
Before	\$(12.03)	\$(1.05)
FAS 106	-	(3.96)
FAS 109	\$3.33	--
FAS 106 (Loss)	(1.92)	-
FAS 109 - Benefit	0.79	--
	\$(9.83)	\$(5.01)

There is a little story here, though. The last two items are things that I gratuitously added to the company's profit and loss statement for the year. I looked at the statement's footnote, and the footnote discloses an actuarial type loss in FAS 106 that's been deferred to future years. This is really two years of operations, the start of 1991 to the end of 1992, most of it happened in 1992. The company has a deferred loss of \$1.92 a share, \$2 a share from the operations of its actuarial assumptions and other things in its retiree medical plan. FAS 106 would give the company a \$0.79 benefit, if I computed it correctly. But, the company's net loss, when we put all these together for the year, would have been \$9.83.

For thoughts of losses and actuarial assumptions, I'm going to turn the program over to Andrea Feshbach for a little discussion. Andrea is a managing consultant with A.

Foster Higgins in the Minneapolis office. She's experienced in both pension and group actuarial consulting, and she's going to present the assumptions and computational issues in performing FAS 106 valuation. She'll discuss demographic assumptions, plan related assumptions, economic assumptions, sensitivity of assumptions, attribution issues, cash flow and expense projections.

MS. ANDREA FESHBACH: Actually, I'm not really going to discuss all these things. I'm going to hit the high points of some of the things I've experienced in dealing with FAS 106 valuations and then hope that during the question session some of you who have had other interesting experiences will share them so that we can all learn from them.

Challenges with respect to demographic assumptions come when there has been no defined-benefit plan or when the defined-benefit plan's withdrawal and retirement assumptions have been sloppy. You can certainly do that when you're doing a pension plan valuation, but you can't when you're doing a retiree medical valuation. It's been an eye-opening experience to some employers that do not have a defined-benefit plan to ask them for enough information to do a select and ultimate turnover study so that you can have realistic turnover assumptions. It's also interesting to predict retirement ages when you have a small or nonexistent retiree population.

Based on experience, I can give you a few suggestions on how to do a retiree study that will make sense. First, make sure that the group of retirees in your pension plan, if that's the data you have to work with, is the same as the group of retirees in your retiree medical plan. We had one situation where the defined-benefit plan was contributory. Only about half of the group participated in it, and the retirement experience of the people who had a retirement plan was considerably different from the retirement experience of the people who didn't. Another thing that mucked up a retirement study for us was the fact that many former terminated vested employees entered the retiree group at age 65 but were not eligible for the retiree medical plan. So we had to pull them out of the study. Another situation had to do with early retirement windows in the past. If you're trying to predict the future experience of your active population, you probably should not recognize all the early retirements that came with the windows.

Another thing: take special note if the retiree medical plan now is not the same one that was in place when your current group of retirees retired. The same would be true if you had substantial retirement plan changes because that can obviously affect the age at which actives retire.

Regarding disability, you need to decide how significant this is for your group. On mortality assumptions, I had an insurance company client that started out wanting to use a CSO table. We had to convince the client that a CSO table is loaded in favor of early death because it's a life insurance table and that it might not be appropriate for a retiree medical plan.

Let's discuss plan-related assumptions. As far as retiree participation, you're going to have challenges if you don't have that many retirees, and you're not sure what the actives are going to do when they get to that status. Obviously, how much the retirees have to pay to be in the retiree medical plan is going to affect things. There

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are preexisting conditions. Sometimes even the spouse plan that's available may determine how many retirees will stay with your plan versus how many go to a spouse plan. On the spouse and dependent coverage issue, how many spouses are going to be covered at retirement may be very different from how many spouses are covered among your actives.

An advertising agency told us, "Everybody is single and nobody covers spouses. Don't worry about it." Well, that was true of most of the agency's people who were in their 20s and 30s and turned over about every two years. In the core group of people who were in their 40s through 60s, a lot were married, and it was highly likely that they were going to continue their coverage into retirement.

Remember, alternative plan elections. The plans that your actives are in may not be the ones that they choose when they retire. If you have a big snowbird population of retirees, then, even if they're in the HMO as actives, they may choose the indemnity plan when they retire. Similarly, if their health deteriorates, they may decide that they want the indemnity plan at retirement.

Regarding administrative costs, it's hard to convince some employers that, even though they don't have much administrative cost for retirees now (because they don't have retirees), we still need to load something in. First-year claim cost is what Mac is going to be talking about in just a little while, so I'll skip over that one.

Changes in deductibles, out-of-pocket limits, retiree premiums, life insurance limits all get into the issue of what is your substantive plan. Can you assume that the deductibles and out-of-pocket limits are going to increase at medical trend, at general CPI trend, or not increase at all? Obviously, this is crucial. In the past, have these amounts actually increased every single year, or do they only increase every two, three or four years? When you project your trend, this will matter. Life insurance limits might come into play if you have life insurance benefits that are half of active pay but limited to \$30,000 or something like that. Is that \$30,000 limit ever going to increase?

Let's move on to economic assumptions. This is the fun part. If your client has been dealing with FAS 87, they are very familiar with discount rate and long-term rate of return on assets. If not, you'd go through the same sort of reasoning. Actually, I'm waiting for a plan where I can have a long-term rate of return on assets assumption. None of the plans I deal with are funded.

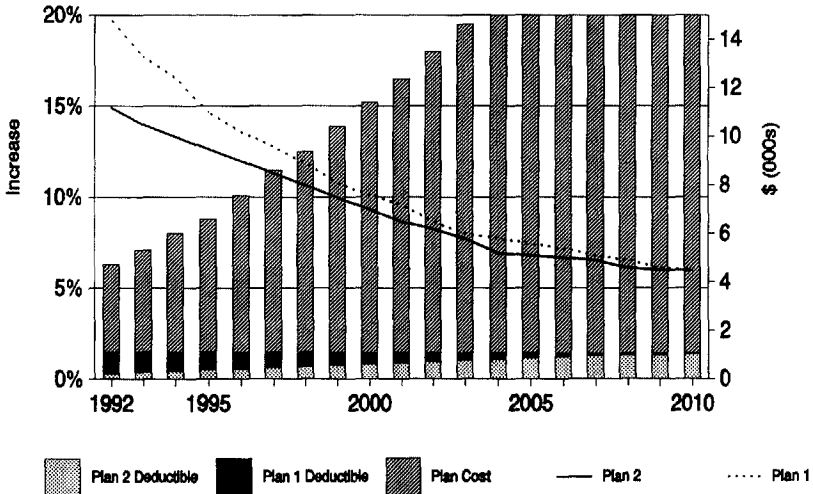
On the health-care-cost trend rate, the first thing is the gross-eligible-charge trend. This trend is on everything that the plan covers, whether it's paid for by the employer, by Medicare, by the retiree, or other. Health-care inflation, utilization, and technological advances are going to have a big effect on this.

Changes in health status might be an antiselection situation where your population is going to get sicker over time, perhaps because the costs to the retirees are fairly high, so lifetime limits might come into play. Sometimes you have a plan where the lifetime limit is as low as \$25,000. Typically, you're not going to have a lot of data on who is reaching this limit already. You're just going to have to do a forward projection. Obviously this will affect your trend quite a bit.

Then, let's talk about the net incurred claims trend, on what the employer actually pays for, net of Medicare reimbursement and retiree cost sharing. In some situations this trend may be exactly the same as the gross-eligible-charge trend, and in other cases it could be substantially different. I'll give you one example of this. I had a client with a generally standard medical plan, \$200 deductible. The client acquired another company that had a \$1,000 deductible plan and decided to keep the \$1,000 constant until the \$200 deductible caught up with it. This was important for the client's active plan because it was transferring employees between the companies and the client did want to eventually reach uniformity. Once the lower deductible reached the \$1,000 the client would increase both with medical trend.

Chart 1 shows you what happens. If you start with the very bottom, that dark line is the \$1,000 deductible, and then the light grey line under it shows the \$200 deductible increasing every year until about 2009 when it reaches \$1,000. The dark line starting at 15% and coming down to 6% is the gross-eligible-charge trend for the lower deductible plan, which was also the net-incurred-claim trend. The dotted line is the net-incurred-claim trend for the \$1,000 deductible plan. The \$1,000 deductible has a leveraging effect so that the trend starts out at 19%, decreases gradually and meets the lower trend just at the time when the difference in the deductible is wiped out.

CHART 1
Net Incurred Claims Trend

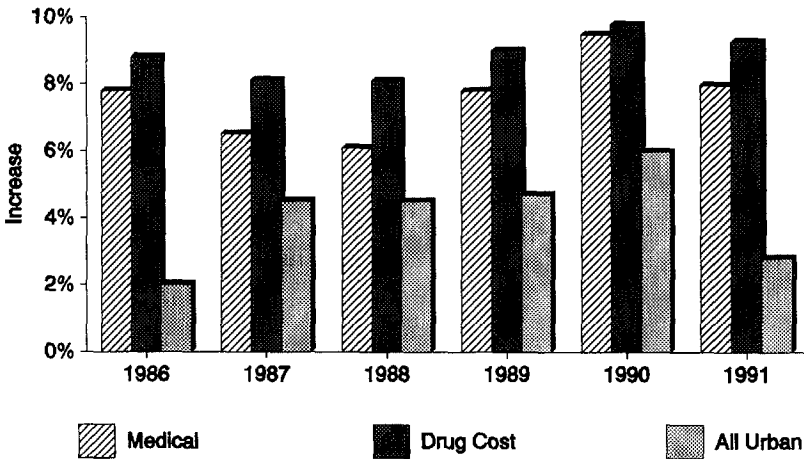


You know you must disclose the effects of a 1% increase in gross-eligible-charge trend. The net-incurred-claim trend is probably the one that you're actually programming and valuing. So, remember that when you're doing a 1% change in the gross trend, that does not necessarily mean exactly a 1% change in the net trend. In the \$1,000 deductible situation, we would have to go back and look at a gross trend that decreased from 16% down to 7% and see what effect that would have on the net trend for the plan with the higher deductible.

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The type of service may affect your trend assumptions. Chart 2 shows some figures that I imagine you're fairly familiar with: yearly increase from 1986-91 the medical CPI, drug CPI, and an all-urban CPI. Medical trend averages about 8%, the drug trend about 1% more than that and the all urban considerably less, maybe 4% or 5% average over that five-year period. For post-65 retirees, the drug cost can be 40% of the employer cost, and it might be worthwhile having a separate valuation for the drug costs. Similarly, if your retiree plan covers dental expenses, the trend for that is considerably lower than the medical trend, and it might be worth isolating that piece.

CHART 2
Yearly Increase in CPI



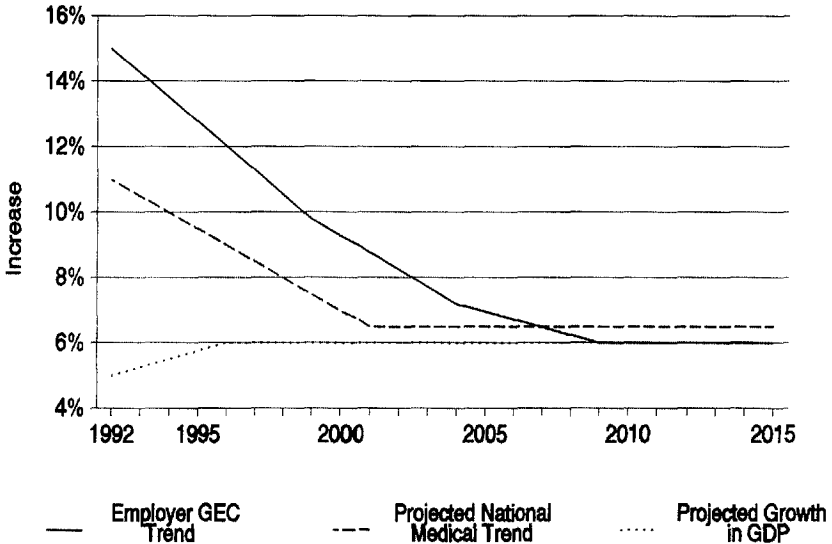
Source: U.S. Department of Labor, Bureau of Labor Statistics

Consider managed care. Depending on how many of your retirees are likely to participate in a managed versus a not managed program, you may want to use a separate trend there. There is some debate over whether managed care permanently decreases your trend or whether there is just a couple-of-year effect. That's something you might want to consider.

Next, let's discuss gross domestic product (GDP) constraint – whether medical care is the beast that will eat the GDP. You want to make sure that whatever trend you assume for your particular employer, if you compare that with what you're expecting to be the increase nationally in medical costs versus the increase in the GNP or GDP, you're coming up with a reasonable result. Chart 3 assumes that the growth in GDP, 5% at the moment, will eventually become 6%. The national medical trend, currently 11%, will decrease, ending at about 6.5%. This particular employer's gross-eligible-charge (GEC) trend, which is 15% at the moment, will eventually decrease and match the GDP growth of 6%. You'll notice at the end that the national medical trend is coming out a little bit higher than this employer's trend. An explanation for this might be that, for the population as a whole, the aging of the population will

show up in the national medical trend, but for the employer, the aging is supposed to be in the claims curve.

CHART 3
Sample Trend Rates
Case 1



Take a look at this Chart 3 for a minute. We have a 15% employer trend, 11% national trend, and 5% GDP trends to start out with in 1992, and they all converge by about 2010 at 6-6.5%. Now, what if we changed those assumptions somewhat? What if we said: the national trend isn't going to decrease quite this steeply; the GDP isn't going to increase quite as fast; the gross-eligible-charge trend for this employer starts out at 15% but generally stays about the national medical trend until the ultimate point.

That would look like case two in Chart 4. We have the same starting points and the same ending points, but we're taking a lot longer to converge. Now, what is the effect of this on our assumption as to how much of the GDP is going to be absorbed by medical costs? In Chart 5 we can see what the difference is. We're starting out at 14% of GDP, as being the U.S. medical costs basis.

The dashed lines are case one, the optimistic case where, by the year 2015, we'd end up at about 19% being absorbed by medical costs. The solid line, which is case two, shows that in the same 23-year period we are now up to absorbing 27% of the GDP as medical costs. Now, either of those could be right. We don't have a crystal ball, but you need to think about where your assumptions are leading you so that you come out with a reasonable result.

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CHART 4
Sample Trend Rates
Case 2

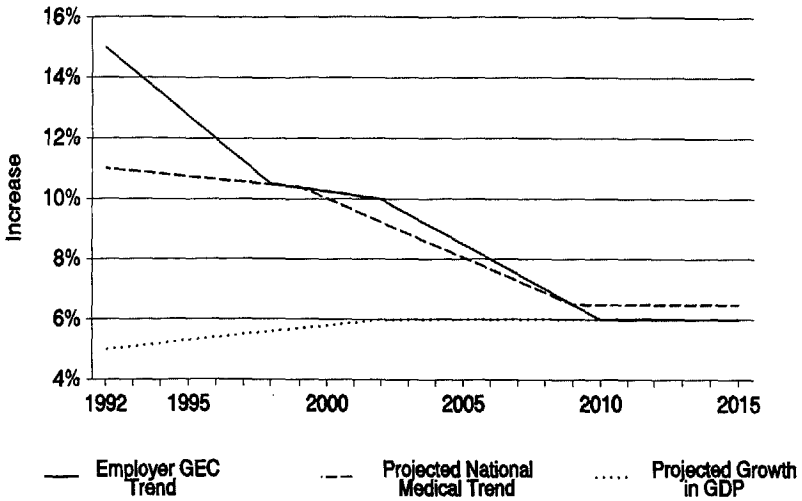
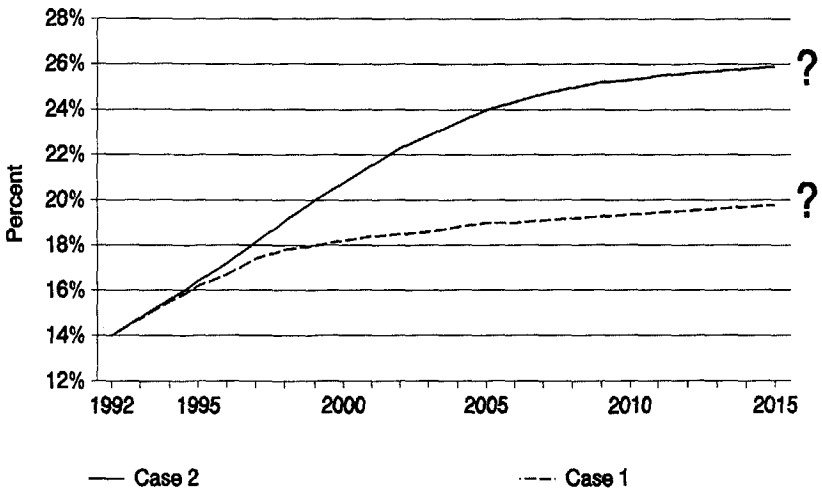


CHART 5
US Medical Costs as
Percentage of GDP



Just an aside here -- somebody expressed to me what they call the epidemiological model of health-care costs. In any population the number of new cases of an epidemic is based on the number of both infected people and noninfected people at the moment. The people who have the disease are the ones who are contagious and can spread it. The people who don't have it are the ones who can get it and produce an increase in the infected population, so an epidemic will always have the number of people who are sick increasing very quickly at first, almost an exponential increase, and then it will level out. The fastest rate of growth is right about when half the population is sick and the other half isn't yet. It was suggested to me that health-care costs are similarly going to have to level off when the percentage of the population that isn't paying prohibitively expensive medical costs is so low that medical costs can no longer grow. It's an interesting thought.

Select and ultimate versus a weighted average trend -- I think several years ago some of us tried to use one medical trend number for all future calendar years, perhaps because our valuation systems weren't up to handling the calendar-year differences. I don't know if I'd risk that right now. Every time I've done one of these it's been quite sensitive to those calendar-year-trend assumptions, but I'd be interested in hearing other people's experience on that.

There should be testing of sensitivity to assumptions. We talked about an increase in the gross-eligible-charge trend. I've found it useful to, at least, vary the retirement age assumptions a little bit to see what effect that has on the results; it can be eye opening. Plan changes have an effect on experience. Obviously if you change the plan, you have to look at every assumption and figure out if it still makes sense -- plan participation, retirement ages, antiselection, the whole bit.

Tom's example showed a case where the second-year results can look bad if you didn't guess right on your first-year assumptions. This can be especially significant if you have an employer that recognizes the entire liability all at once. You want to know what's going to happen if you guess wrong for that first year.

I've not had a chance to do a second-year FAS 106 valuation, although I've done second-year studies before employers adopted it. Often, we found that whatever assumption we initially used for medical trend for the second year, the experience in the first year was so bad that in the second valuation we couldn't use that second-year trend. So, if you wanted to be right, you'd have that medical trend decreasing very gradually, at first.

I'll just mention one example to show how interesting attribution issues can be. An employer, in 1986, read the handwriting on the wall and decided that it did not want unlimited infinite retiree medical liability, so it announced to its employees that the number of years of medical coverage that the employees would have once they retired was going to be equal to the number of years of service that they had at the end of 1986. It didn't matter when they retired. They could retire in the year 2000, and if they had 20 years of service in 1986, then starting in the year 2000 they'd have a maximum of 20 years of retiree medical coverage. All employees had to have 15 years of service at retirement in order to have the retiree medical benefits.

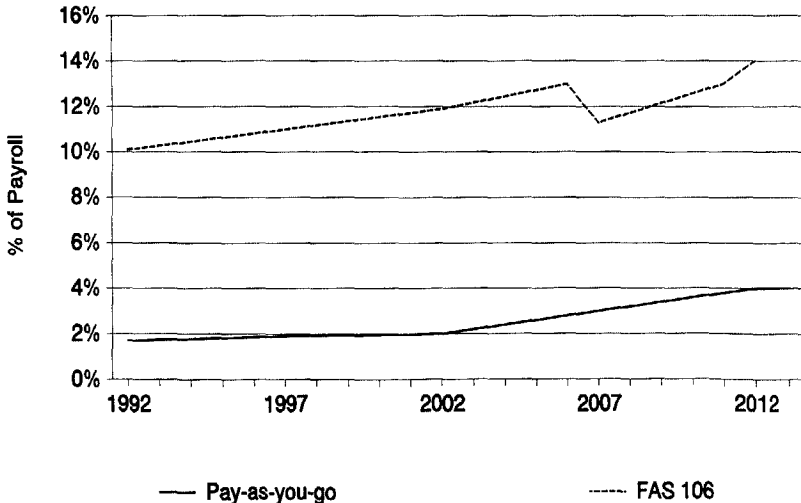
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The question arose, what is the APBO under these circumstances? We discussed it, the client discussed it, and the auditor discussed it. Finally, we took it to the FASB and FASB kicked it around for a week. We all came to the same conclusion, which was that the service after 1986 only affected vesting. It only affected whether you had the 15 years of service on the date of retirement and did not increase the benefits. The only service that affected the level of benefits was the pre-1986 service, so the entire expected postretirement benefit obligation (EPBO) for all the actives was APBO, and it could all be recognized the first year as a transition obligation. Well, our client was thrilled because it had a really strong balance sheet. The company wanted to take it all in one gulp, and that's what it did.

On cash-flow and expense projections, when you do your ten-year projection of benefits or claim payments, you want to make sure that the first year on the projection looks a lot like the actual claims that you had in your last year of experience.

Regarding expense relative to cash flow, in an unfunded plan, the question always arises, although expense starts out higher than pay-as-you-go, don't they cross at some point? Well, Chart 6 shows a forecast valuation we did for one client. The pay-as-you-go cost, slightly less than 2% of payroll in 1992, increases to about 4% in the year 2012. FAS 106 expense, on a 20-year amortization, starts at 10% and increases to 14% by 2021. It doesn't look like they're ever going to meet.

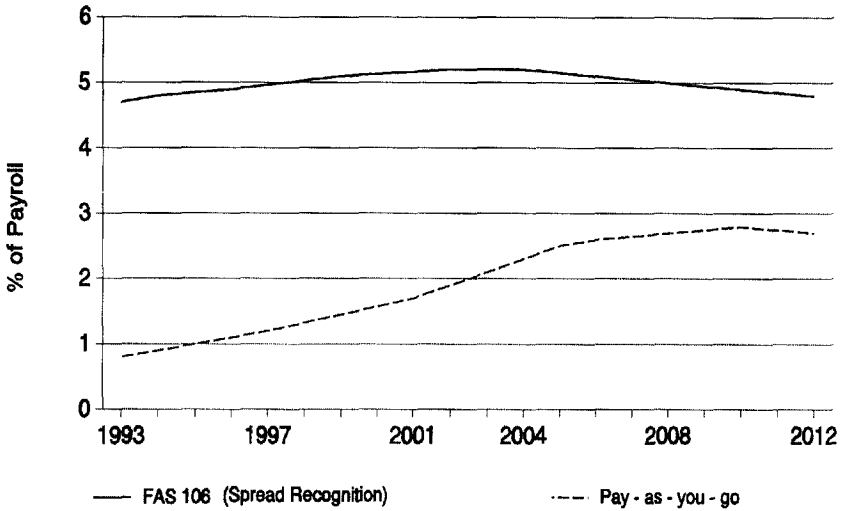
CHART 6
Expense Charges



Another client said, we're going to cut off this obligation. Anybody who is hired after 1988 will not get retiree medical benefits; won't this help? The answer is, yes, it does help, but not as soon as you might think. Chart 7 shows a forecast we did for this situation.

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CHART 7
FAS 106 Cost Effect*
Financial Services Company



* Hires After 1988 Pay 100% For Coverage

FROM THE FLOOR: These are open group forecasts?

MS. FESHBACH: The first one was an open group forecast. The second one isn't because the post-1988 hires are not covered, so this is a closed group.

FROM THE FLOOR: Is this a relatively immature group, and I assume no funding?

MS. FESHBACH: No funding, and it's not particularly immature.

FROM THE FLOOR: That is because the existence of funding will cause them to cross a fair amount.

MS. FESHBACH: Absolutely.

FROM THE FLOOR: You'll notice a trend toward the cross in Chart 6 if you have funding.

MS. FESHBACH: Yes, that was an unfunded plan. So is this one. As you can see, the pay-as-you-go cost, which is less than 1% right now, is going to get to about 2¼% in the next 20 years. The FAS 106 expense, slightly below 5% now, will increase to slightly above 5% over 10 years and then start gradually decreasing. You can see that these lines are coming together, but I think I'll be retired by the time it actually happens. On that happy note, I'll turn it back over to Tom.

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MR. TOHER: Our next presentation comes from Mac McCarthy. He's a group actuary with Mercer in the Richmond office, and he'll be presenting a little different perspective on the valuation, somebody that actually knows what's going on in these claim costs. Mac generally provides group actuarial consulting services to a variety of clients on the pricing and valuation of health and welfare benefits. He's going to discuss claim data, the determination of cost by age, some survey data and some plan design alternatives.

MR. LAWRENCE J. MCCARTHY: No, I don't really know what's going on as far as retiree claim cost. I have some opinions, and I probably won't share any of those. We have a lot of other people in Mercer who have opinions, and I will share a little bit in terms of what the consolidated opinion may be in some of those areas.

With regard to claim data availability, FAS 106 indicates that, when doing a valuation for a plan, you should use the plan's own historical claim cost data, split by age, to determine your claim cost by age assumption going forward. Now, unfortunately, that's generally not available at all, or if it's available it's probably not totally credible for most of your groups. When you start breaking it down by age brackets, either 5- or 10-year brackets, or even pre-65 and post-65, you deteriorate the credibility on that population.

There is a growing effort to capture claim data for retirees partly because FAS 106 gives you a strong incentive to collect that information separately, so you don't double count it on your profit and loss statement. Also, a number of larger employers are getting into detailed health-care claim data analysis through systems that they're purchasing from insurance companies or consulting firms. The availability of data on large employers in that format certainly helps going forward, trying to understand what's going on with the situation.

Luckily, FAS 106 also indicates that if you don't have reliable data for that particular plan you can use data collected from other employer plans, make appropriate adjustments, etc., and that's mainly what we're all about right now. We have a few clients where we feel they're large enough that we can actually get some sense of what's going on, and we can then generalize that to the particular plan that we're doing a valuation on at that point in time.

Some of what I'm going to share with you today is data out of what we call at Mercer *postretirement evaluation clearinghouse*, which is an attempt within Mercer to gather information on valuations, compile it and publish it internally to give us a sense of our assumptions' reasonableness. Are we in the right ballpark? What's going on? It does not relieve any group actuary of the need to do a decent analysis and set the assumptions based on the client's information and situation, but it does at least tell you if you are in the ballpark or down the street somewhere.

The first bit of information is what we are seeing Mercer actuaries use for claim cost assumptions. Typically, in this clearinghouse, we adjust everything to age 65. These are age 65 claim costs before Medicare. Of course, you'd have to understand a little bit more about the underlying plan designs and that sort of thing, but for 1992 valuations, typically we saw people using somewhere around \$3,900 as a median assumption (Table 3). After Medicare, we see it's dropped down to about \$803

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(Table 4). One thing that you might notice between the two tables is that there is significantly more variance in the after Medicare numbers than there is in the before Medicare numbers, and that's likely due to the strong leveraging effect that different Medicare integration methods have on the cost.

TABLE 3
Postretirement Medical Valuations Clearinghouse
Age 65 Claim Costs Assumptions -- Before Medicare

Percentile	1991 Valuations	1992 Valuations
20th	\$2,617	\$3,065
Median	\$3,295	\$3,934
80th	\$3,961	\$4,972

Claim cost assumptions determined from credible retiree experience

TABLE 4
Postretirement Medical Valuations Clearinghouse
Age 65 Claim Costs Assumptions -- After Medicare

Percentile	1991 Valuations	1992 Valuations
20th	\$530	\$572
Median	\$753	\$803
80th	\$983	\$1,238

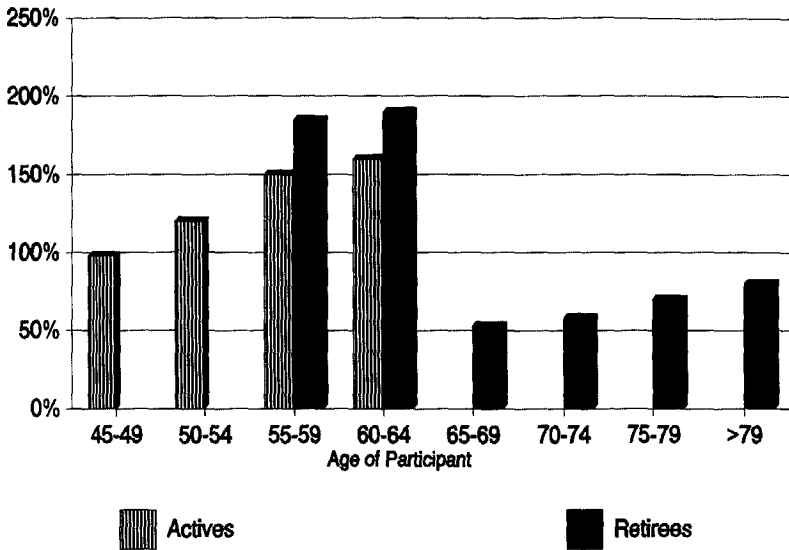
Claim cost assumptions determined from credible retiree experience

One thing I should point out, on both these tables, these are assumptions that were set for groups where the actuary felt the retiree experience was credible in and of itself, so the company can do a standard projection using actuarial and underwriting techniques from one year to the next. I don't have the exact detail on the number side, but the average was about 1,000 retirees in each of the groups that these numbers were pulled from.

Given some idea where that figure should fall, you need to assess the relative claim cost. It gives you one age, that sort of thing, but how is that varied by age as required for FAS 106? Chart 8 is something directly out of a client for the Richmond office of Mercer. It's a very large employer in the southeast, something on the order of 250,000 active employees, about 55,000 or 60,000 retirees in its population. It is a fairly rich benefit plan in the nature of 90% coinsurance with about \$150 deductible. I believe it's \$750 out-of-pocket maximum. The Medicare integration technique is an exclusion-type plan, for those who are familiar. That's where you subtract what Medicare pays from the covered charges, then apply deductibles and coinsurance.

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Chart 8
Medical Per Capita Claim Costs
As a Percentage of Average Employee



We were particularly interested in how retiree claim costs differed from active claim costs, given the same age. That is illustrated in the 55-59 brackets and the 60-64 brackets. There seems to be, from this chart and this particular employer, about a 20% differential between those costs. The other thing of significance is that the differential grows the younger the retiree. We did have data down at younger ages, but then you start getting into disability retirements and having to weed that out. Now, this all kind of makes sense to us because retirees under age 65, often retire because of poor health, and there's also a conjecture that maybe retirees have more time to go to the doctor than active employees. That may be a factor; it is important to take into account when you're looking at active claim costs and trying to generalize them to the retirees. There will be some extra morbidity load for those retirees. Associated with that, if you look at the rate of increases by age, there seems to be a much lower aging factor for retirees than there is for actives in those older ages. I believe that, if the active employee is between 50-65, we would see in this group about a 4-5% per year increase in the employee's cost through aging. For retirees from 55-75, we're seeing an average of 2.5% per year for aging. This is significantly different than you might get if you looked at Medicare claim costs, for example, by age.

Generally, when trying to assess the claim costs by age for a particular group, you need to deal with whatever information is available. Sometimes you'll have what you consider to be very credible data, such as the client that we just had up there. Here there is such a large number, and you understand so thoroughly what the plan has been doing and what the changes are, that you use that information directly. Of course, that's a real rarity. Often, you won't even have the claims for retirees split

out separately. If you do, it may not be split between over and under age 65, and you may have to come up with some sort of method to use the information you have but then supplement that with information from other employers or general modeling techniques.

Of course, there are plenty of situations around, and more will emerge as smaller employers start evaluating liabilities for FAS 106 purposes, where you have no credible client-specific data, and you have to use general employer information. Certainly if you have credible data, you can apply standard techniques and produce a claim cost that, in aggregate, you feel comfortable with. You probably still will have to go to some outside source to get an aging factor, so you can adjust that by age. If you have less than credible data, there are a variety of different techniques. This is one example. As I said, often you're going to have data that you're comfortable with but not everything you want. In particular, we find situations fairly commonly where we're comfortable with the active experience. We have a credible pool there that we think we can generalize to retirees, but the retirees are just so small or excluded in some way that you're not comfortable with the retiree experience. The AAA guidelines for doing FAS 106 valuations mention one possibility: take the active experience, age it and use that for retiree claim costs. One approach that we've taken in that situation certainly projects the active experience according to whatever trend you're using for the actives. Apply an active aging table according to whatever trend you're using for the actives. Apply an active aging table to get an age-65 claim cost. Then, take that age-65 claim cost and adjust it for retiree age, because the two are different. So, you have to go to a benchmark and then deviate off that. Certainly for the post-65 you need to take into account some sort of Medicare offset, depending on the integration method and the richness of the underlying plan.

The difference between a coordination of benefits (COB) and a carve-out Medicare will be relatively larger if you have a low plan, something like a \$500 deductible, 80% with no out-of-pocket limit, than if you have a plan that's incredibly rich. There won't be as much difference between a COB and a carve out if you have a rich underlying plan and you're paying close to 100% anyway, so what's the real difference?

Another general example would be a situation that we run into with smaller groups. We have a client in our office for whom we have actually done a third FAS 106 valuation. The client adopted for 1990 as soon as the standard came out, and unfortunately, the client has only about a few hundred employees and ten retirees. So, there's no credible experience anywhere that I would rely on to do the retiree claim rate. Basically, we used information on other employers in the same location. We adjust that to a standard age. We considered whether to adjust for geography, which may not be as big a deal for retirees as it is for actives. The retirees tend not to stay put. They may be more dispersed around the country. With plan designs, certainly if you're using experience from another employer, you have to consider how different the plan design might be and Medicare integration methods.

If at all possible, it makes a whole lot of sense to use retiree claim experience from employers that have similar plan designs and Medicare integration. It takes out one adjustment factor or lessens the impact of it. Then, of course, you must apply retiring aging to that claim cost.

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As I mentioned, we have a clearinghouse within Mercer where we gather and disseminate internally information on various plan designs, demographic features, results of the valuation, the pay-as-you-go claim costs, etc. From this we try to determine if we are in the right ballpark, or is what we're doing appropriate? You might say that it's kind of a self-fulfilling prophecy. If we're collecting our own information and assumptions and say, "Okay, our assumption is great," we aren't necessarily accomplishing anything; we certainly are aware of that. But, until somebody actually gets appropriate information that we can share with the rest of the actuarial community, that's a reasonable thing to do.

The valuation clearinghouse right now has built up to about 500 valuations. There are about 2,500,000 actives underlying in those valuations and somewhere between 500,000 and 750,000 retirees included, some of which I'm going to show you. If there is anybody out there from Mercer you may be a little bit surprised. This is preliminary. It hasn't been shared with anybody yet, and I'll also caution you that it hasn't undergone the type of scrutiny that we will put it to before we actually use it in the field, but it's an early glance at what we're going to be releasing soon internally.

One of the critical factors is the aging factors being used (Table 5). How much does medical cost increase covered charges with various ages? These are just some selected ages. This is the median that we have seen people using for 1992 valuations. There seems to be a trend away from using a flat standard percentage across the board, which some of us used in the earlier days before we had any indication. As we start to get information on larger groups and start to consolidate some of that, we're seeing numbers that tend to decrease. The rate of increase goes down, it appears, at the older ages, and that's been reflected in the valuation assumptions that we're using.

TABLE 5
Postretirement Medical Valuations Clearinghouse
Aging Factors

Age	Median Aging Factor	Age	Median Aging Factor
55	4.0%	70	2.0%
60	4.0	75	1.8
65	3.0	80	1.0

FROM THE FLOOR: Is this assumption also getting flatter over time, compared to tables that you used in the past?

MR. MCCARTHY: Yes, and I think it will continue to be a little bit flatter, especially on the younger ages, as we explore that a little bit more.

The next assumption is the discount rate (Table 6). Those rates are displayed in terms of what percentage of the valuations use various discount rates, and not surprisingly, between 1991-92 people lowered the discount rate, using something in the 7-8.5% range.

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TABLE 6
Postretirement Medical Valuations Clearinghouse
Discount Rates

Range	Percentage of Valuations	
	1991	1992
<7.0%	0.6%	2.1%
7.0-8.0%	19.4	41.1
8.0-8.5%	27.6	32.2
8.5-9.0%	33.5	13.7
>9.0%	18.8	11.0

Next is a gross-trend assumption (Table 7) and again, we're looking at a couple percentiles; I'll focus on the median range. I'm calling it gross-trend assumptions. This is what FAS 106 calls a health care-cost trend rate, so this is underlying on the charges. It does not, of course, include any aging or leveraging or impact of Medicare, etc. Certainly there's a lot more variance in the near term as people attempt to match this closer to actual employer experience, either on retirees, actives or both, depending on what information they have available. Within Mercer, we see people ending up using something in the 6-7% range. There is a fair amount of difference between how quickly they get there, as Andrea was pointing out earlier. It has significant impact on the valuation results.

TABLE 7
Postretirement Medical Valuations Clearinghouse
Gross Trend Assumptions

Percentile	1993	1995	2000	Ultimate
20th	11.0%	11.0%	7.0%	6.0%
Median	13.0	12.5	8.0	7.0
80th	14.0	13.0	10.0	7.0

FROM THE FLOOR: Is this medical CPI?

MR. MCCARTHY: No, this is medical health care-cost inflation.

FROM THE FLOOR: Over the inflation, or does it include inflation?

MR. MCCARTHY: This includes inflation. Again, if you start factoring in the impact of deductibles and coinsurance limits, these numbers will possibly go up considerably, if those features of the plan don't increase over time. It also does not take into account contributions that may be held level from the retirees. This is what FAS 106 calls the net health care-trend rate on charges.

Here is a little bit more real survey information. In November 1992 Mercer took a survey of not necessarily Mercer clients and not necessarily people that Mercer had done valuations for, but certainly people we had some contact with, asking them: Do you have a retired medical plan, have you valued it, what have been the results of it,

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what can you share with us as far as changes you might be likely to make or have already made? We had 780 employers respond. Roughly one-third of them had fewer than 1,000 employees, and the other two-thirds had more than 1,000 employees. It was interesting and feeds into some of the things Andrea was saying about the differential between the FAS 106 expense and pay-as-you-go expense.

I'll tell you about the top part of Table 8 first. The net periodic postretirement benefit cost (NPPBC) over pay as you go, this ratio, is how much we see people's expenses going up when they change the accounting methods. Eighteen percent of the employers said that they expected the NPPBC to be between two to three times their current pay-as-you-go cost. Sixty percent said that it should be in the three to eight times range, and 22% of the employers said it was going to be eight or more times what they were currently expensing for retired medical.

TABLE 8
Retiree Health Benefits Survey

NPPBC/PAYGO	Percentage of Employers
2 - 3	18%
3 - 8	60
8 +	22
Transition Obligation	Percentage of Employers
Undecided	62%
One-time charge	21
Amortize	17

There was a fairly significant difference between the smaller employers and the larger employers. The larger employers tended to be more towards the bottom end of the scale, while others were two to three times. This is basically a maturity issue. Those employers were more likely to have a significant number of retirees already collecting benefits.

On the issue of taking the transition obligation, either amortizing or taking it as a one-time charge, I think this 62% that were undecided is related to when the survey was taken. This was November 1992 before people actually had to bite the bullet and make a decision. Of the ones who had decided, more of them had decided to take a one-time charge, trying to put at least a portion of FAS 106 behind them, rather than amortize over expected lifetime or 20 years.

I have one comment for anybody who's working on this area. It seems to be very common in the clients that I work with that you'll go through the initial valuation and maybe a redesign project, and everything will be gauged against the NPPBC assuming a 20-year amortization. Then, very often it seems, at the end when they have to actually put a number in the books, somebody will waive a flag and say, "No, let's take the one-time adoption." I think the percentage that take the one-time charge will be significantly higher than that in the future.

It is sensitive to how good a year the client may be having or how bad a year, and I think it possibly goes both ways. If you're having a really terrible year, how much worse can it look? Similarly, we had a client that had an unusual income item that was nonrecurring, so they said, "Well, we'll just take it as a one-time hit right there, and wash it through there." That happened to be a public utility, and it didn't want to show a real big profit in any particular year.

One of the other things we asked in the survey was, now you've seen the numbers, what do you think you might do about it? Most everybody is doing something (Table 9). Only 17% of the respondents that had retiree medical plans said they weren't going to do anything at all. They were just fine with it. They would leave it alone. Everybody else said they're going to do something. The most common thing was to shift the cost over to the retirees, either in terms of increased contributions, increased deductibles or copayments. The managed-care technique is particularly targeted at the pre-65 retirees. It doesn't make a lot of sense to try to keep Medicare retirees out of the hospital from the employer's perspective, and that's what managed care tries to do and then a variety of other things.

TABLE 9
Retiree Health Benefits Survey

Action	Total
Raised retiree contributions	48%
Increased deductible or copay	44
Used managed care techniques	38
Tightened eligibility	29
Capped employer contributions	23
Changed Medicare integration	19
Used a defined-dollar approach	13
Cancelled benefits	12
Reduced lifetime benefit cap	7

Certainly if you add those numbers up, you're going to get a lot more than 100%, and that's because most people are attacking on more than one front. Only 21% of respondents pick only one approach to try and reduce it. Sixty-two percent combined somewhere between two to nine of these approaches to try to reduce the impact of FAS 106.

FROM THE FLOOR: Did you find anybody doing it, but especially by class, in other words, executives get nothing?

MR. MCCARTHY: No, I haven't really. I've seen more in terms of changes for current retirees versus changes for future retirees and often the active employees close to retirement will be grandfathered in or some sort of a window opportunity will be generated. I think an awful lot of people might be afraid of discrimination issues if that came out; it's something they keep in mind. I've seen people tightening up on the eligibility. Maybe that's a class sort of thing where they're saying you have to have 20 years of service; whereas, before we'd let you go out with ten and take retiree medical.

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In addressing these sorts of issues when working with clients, we like to keep in mind the basic structure of the plans and look at it in three different ways. First, what's the actual benefit design, in other words, does the plan have benefits, coinsurance, deductibles, that sort of thing? Second, who should be covered and what are the age service requirements, and are dependents covered or if they're covered are they going to pay the full cost themselves? Third, of course, contributions, how are we going to share this cost with the retirees? Very often we hear in our neck of the woods employers saying, "No, we don't have an FAS 106 plan. Yes, we let retirees continue their coverage until 65, but they pay the full cost, so it's not a problem." Well, when you look into what's the full cost, they pay the same as everybody else is charged, the average employee premiums. FAS 106 is basically clear if you read it, and the American Academy of Actuaries' guidelines are even clearer, that it is a hidden plan and has an FAS 106 value associated with it. I think that once you educate the employers that this stuff doesn't cost \$2,000 a year, it costs \$4,000, then they say, well, the company policy all along has been that there's no cost to the employer, so they're going to increase the contributions and require retirees to pay for that.

A final note, when looking at these redesign issues, you have to keep in mind whether the employer is looking to cut current expenses or is it looking to cut current cash cost? Certainly if you cut the cash cost you're not cutting the expenses, but there are a lot of things that people are doing that don't effect what they pay out right now. One way certainly is attributing the cost to later years of service, instead of a plan that allows people to be eligible with ten years of service accumulated at any time, you have to have ten years of service after age 45 or after age 35. It's comparable to a pension plan where people aren't participants until they're age 21. It's like taking it another step further, since there are no restrictions on that sort of thing. FAS 106 actually has examples of attributing service to later years. Of course, all you're doing is changing the timing of the expense.

A lot of people are looking at that sort of thing, though, and saying, we don't know what's going on with national health-care, the whole health marketplace is in flux, let's buy four to five years, and we'll see what happens then. We may have another bump at that point, or it may grow faster. Otherwise, the same sort of buying time can take place with terms of the contributions. We see clients saying, "I've got to get out from under this at some point, so for the next four to five years I'll let my share of the cost keep going up as it has, but then I'm going to cap it, and when my cost hits two to three times what my per capita cost is right now, then the retirees have to take the entire burden of increases." I don't always know if that's really what they're intending to do or if that's another buying time and if we change it at that point we'll reestablish ourselves in a plan and go forward. Of course, you do the same sort of thing on the benefits as you do on the contributions. It's a little more complicated, a little harder to communicate.

If you make those changes, all these things have to change the substantive plan, which basically means you have to communicate them to the retirees and the employees before you can take them into effect in the valuation.

MR. TOHER: We'll now open the floor to questions.

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MR. JOSEPH P. MACAULAY: I have a couple of questions and one technical comment. It's not the Academy stand, it's the actuarial standards for compliance guideline.

MR. MCCARTHY: Correct.

MR. MACAULAY: I seem to see a difference between McCarthy's and Feshbach's numbers in one thing. McCarthy's survey of assumptions would seem to indicate a much more significant increase in the GDP component. For most of your assumptions, the ultimate was 7% whereas with the 20th percentile being as low as 6% for the health care-cost trend rate. Feshbach's came down to basically 5-6.5%, the 6-6.5% at the end, which was a little lower. I was surprised to see the average ultimate be as high as 7%, which concerned me a bit. I had one other comment. I'm not sure it was industry specific, but about 50 of the top 70 companies seem to adopt retroactively, by size, to January 1, 1992, and most of them took the whole hit. It seemed to be a trend among companies in that size class when the chief financial officers got together. They seemed to all decide that about the end of the year.

MR. MCCARTHY: Yes, first of all on the ultimate trend rate, what we didn't display and what I don't have available here right now is that's sensitive to what you think your long-term GDP growth is, and it's the combination of the two that will determine the ultimate share of GDP, so that could account for some of the difference. As Andrea said, what she had was one particular example.

The comment on companies adopting retroactively, I think that's probably true. The survey information, as I said, was done in November 1992 where many of the companies had not actually decided yet what they were going to do even for 1992, and I think if you did a survey of actual financial surveys for 1992, the companies that did it probably took the full hit or more than 50%. Tom, is that consistent with what you've seen?

MR. TOHER: From what I have seen, the cumulative effect – we'll use the proper accounting term – is the prevalent path if companies can afford to do it. There may be special considerations.

MR. DONALD S. GRUBBS, JR.: I have two questions, first for Mac McCarthy. These per capita claim costs that you had, are those costs solely of the individual's coverage, or do they include family and dependent coverage?

MR. MCCARTHY: That was for an individual. It was basically average per participant, not per retiree including the dependents, etc.

MR. GRUBBS: On the actives we often don't know how many individuals there are or whether those are per individual or do they include family cost?

MR. MCCARTHY: Those were individuals only. Actually, those were employees only versus retirees only, in that example.

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MR. GRUBBS: For an employer, for that portion of the employees who get their coverage through an HMO, the employer does not have claim costs. It pays premiums that may not vary by age, maybe separate costs for the over 65, under 65. Similarly, for small employers, perhaps all of their coverage is on a fully insured basis. How do you handle those things? How does that make your FAS 106 costs differ?

MR. MCCARTHY: Well, I think Andrea mentioned that, in a case where you have more than one plan, you have to take that sort of thing into consideration; however, the plan costs vary in that situation. Certainly if you have a fully community-rated group, your cost would not change whether you had the retirees in there or not. I guess you expense the premiums that are charged in that situation. On the very small employers, where they're paying a fully insured premium, I always feel like I have to look to what would happen if I pulled the retirees out of the population. Would my average cost go down? I think most group carriers, when they're evaluating the premium for a group, look at the age and sex split of the population, and that's an important element in the claim quest. Even HMOs are now community rating by class, and that's an element of their calculation. Do you see anything different?

MS. FESHBACH: I agree.

MR. MARTIN E. STAEHLIN: I have three things I want to say. One I'll call a helpful hint. The second one is a comment, and the third one is a question. The helpful hint: I don't know if I want this on the record, but I'll say it anyway. Those of us who have the fortune of working for an accounting firm are not only getting to do a lot of these valuations, but we're also reviewing a lot of other people's valuations, and I'll say I think I've only had one ugly shouting match on the phone. The helpful hint is that, when another actuary is reviewing somebody's work, we're really not trying to second guess people, at least most of us. So, I'm not sure I'm speaking for all of Coopers & Lybrand, but this is my opinion. If you just do a little bit of planning ahead, I hope sometimes you'll get a call that says, "Hi, this is the client. There are other consulting actuaries on the phone, and there are auditors here. How would you like to talk about these issues?" I hope you'll get some preplanning time, and if you can just go down the more difficult assumptions and agree to disagree sometimes, that process usually works well.

MR. MCCARTHY: As a practice – again, I can't speak for all Mercer actuaries – but, it's our opinion in the Richmond office that you get together with the auditor at the earliest opportunity. When you have something defined as the substantive planner for assumptions, set and cover that at that time, rather than waiting until it's time to publish the statement.

MR. STAEHLIN: Right. They're going to release their annual statement that afternoon at 3:00 and they need an answer. The comment I wanted to make is on the aging factors. You had a very large client where you said the pre-65 retiree aging per year was less than the actives, when you compared your 55-59 to 60-64, and actually in that example your post-65 aging was fairly severe. We have a lot of situations where we see exactly the opposite. The pre-65 aging is quite severe, and the post-65 aging is very flat. That's on net claims post-65, not on gross claims, so you really just have to be aware of those situations. We have a database. We're

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trying to aggregate all our valuations, but a lot of times it's very important the type of Medicare integration that you have and the plan parameters.

MR. MCCARTHY: And as I've tried to correct Tom, I don't have any of the answers. This is a lot of the stuff that we all have to be looking at and aggregating things together to come to some conclusions for our models to use.

MR. STAEHLIN: The point I wanted to make is, if that post-65 aging is inappropriate, it acts like a secondary trend assumption because it acts like a trend over time, and you've seen the 1% increase and what it will do to the valuation. If that post-65 aging is inappropriate, it really will give you a big inflator, so it's important to make sure it's a valid picture.

MR. MCCARTHY: Another appropriate comment would be that it depends on what benefits you're valuing. As Andrea said, you might want to value the drugs separately from the others because of the different trends. Well, if you do that, you're going to have different aging on those benefits, in particular. One example that I've seen is looking at retiree dental. We had a client that was fairly large that had retiree dental, and if you looked at the cost by age for the dental you had a negative aging.

MR. STAEHLIN: I think that's a really valid point because Coopers & Lybrand started out with a lot of sectoring, and we have seen that clearly you need to look at the drug sector. I really would agree with that. Last, I'll get to my question, which was I think in your example, I couldn't divide it fast enough, but your example of what you have seen in your database is you have 20% trend pre-65 and about 7% post-65. Now, that was net claims, I know, but we have a theoretical difference. We think pre- and post-65 should be there, and I think we have some other Coopers & Lybrand people here that may be able to confirm this. We're seeing a bigger differential than we would theoretically expect. I was wondering if your data supported that, that there appears to be a much muted trend post-65 in the last couple of years that we've done these valuations. If it's true that most of those initial health care costs are 12-15% grading down, we very seldom see experienced trend in the 12-15% range, and that's going to create a lot of auditor concern over the next couple years. How do you justify the first three to four years of trends?

MR. MCCARTHY: You probably shouldn't take those 1992 numbers and divide by the 1991 and say that's the trend we saw because they may be on different groups. The median here may not be the same group that's the median the next year, so that's kind of dangerous. We do look at that in a different manner, looking at the average cost per person as opposed to medians. Second, for the trend, what we actually see in experience, should probably be higher than that because that is the health care-cost trend, not the net claim trend. Third, I guess it's somewhat geographically different, but I have quite a few clients that have a 12-13% trend year over year, net claim trend, in the southeast.

MR. STAEHLIN: You see that both pre-65 and post-65?

MR. MCCARTHY: No, I'm talking about just in general trends.

MR. STAEHLIN: Just an aggregate trend?

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MR. MCCARTHY: Just an aggregate trend.

MS. FESHBACH: One other thing to realize is that the Medicare balance billing restrictions have come in over the last couple of years, so you have a somewhat different plan, and that might be holding down what looks like the post-65 trend.

MR. MCCARTHY: I do support the notion that you could have a different trend pre-65 and post-65.

MR. MITCHELL I. SEROTA: On the plane coming over here I suddenly had some time on my hands, and I started to read through financial statements of various stocks that are having their annual meetings shortly.

MR. TOHER: Do you recognize the numbers they put up there?

MR. SEROTA: Yes, as opposed to most everybody else who is reading those things, but I saw differences between conservative approach and aggressive approach in accounting firms, and some accounting firms that were representing very large corporations, shall we say Fortune 500 corporations, let those corporations get away with, to my way of thinking anyway, incredibly aggressive assumptions. One even had the discount rate greater than the health care trend rate for the first year. I was very much taken aback by this, and of course, the bottom line was not devoured by any stretch of the imagination, which gets me to my next point. In helping out a client or trying to help out a client whose bottom line was devoured because of FAS 106 recognition last year, we decided to cut all eligibility henceforward and make it a closed group. This gets to Andrea's question, what happens the second year? After having the bottom line being devoured, it still got nibbled at or maybe noshed on, as appropriate.

We took a one life case to see what happens in the ultimate closed group. If you start off with something that was a generic set of assumptions last year, 15% medical trend rate grading down to 6% or 5% over the course of 10 or 15 years, or whatever, and then long-range return of, shall we say 7-8%, that initial spread works to your detriment in the first couple years. If you just assume that your actuarial assumptions were exactly correct, you took a 15% increase of the claims cost for the second year. It was only knocked down by an 8% discounting factor. So, you have a net of a 7% jump all the way down the line in the future years. The APBO keeps going up, and the client was quite upset to see that. It thought it was going to have this wonderful savings. They did not materialize, and the way things look the savings weren't going to materialize for quite a long time.

MR. LARRY BERNSTEIN: I was wondering if anyone knows what to do about active lives who have opted out of the plan because they don't want to pay the contributions, but they can get back any time with evidence of insurability. Do you keep them out of the FAS 106 calculations forever until they actually come in or come back or what?

MS. FESHBACH: I haven't faced that situation. I'm not sure what the rules are. But it sounds like you might very well have to make an assumption about people returning in later years.

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MR. BERNSTEIN: We have absolutely no experience on this.

MR. MCCARTHY: I've run into similar situations. Basically the way we handle it is to value everybody who is an active that potentially could become a retiree and receive retiree medical benefits, but you address it in terms of the participation assumption for the retirees. It's not based on data or anything else. It's very difficult to set those participation assumptions other than be sensitive to the fact that, the more you charge the retirees, the fewer people will elect to be participants, of course, the higher your per capita claim cost.