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FUNDING STRATEGIES FOR POSTRETIREMENT HEALTH BENEFITS

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Recorder: JOSEPH P. MACAULAY

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MR. JOSEPH P. MACAULAY: The official statement at all Society meetings is, in general we're all speaking as individuals even if we have employers, and we're not making a statement that is officially a statement of our employers, so that solves antitrust problems.

My first speaker is Jonathan Nemeth. He's a Fellow of the Society of Actuaries who works for Actuarial Sciences Associates in the Boca Raton office. Prior to that he

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was with Empire State Blue Cross/Blue Shield, and prior to that the New York Insurance Department. He received his bachelor's degree from the State University of New York at Albany. The real reason for his being the appropriate person on this panel is he has probably done as many funded retiree health plans as anybody in the business. He worked in the utility practice, primarily of Actuarial Science Associates (ASA), and he has been involved in some very large funding schemes. I use the word scheme in the English usage connoting a pension plan, not in a pejorative sense.

If you are really looking at funding the retiree health obligation, getting the actuarial part of it done is not the whole story. I brought two other people here that I thought could help in giving you some ideas on what the rest of the story is.

My second speaker is Fred Morris. Fred is senior vice president of postretirement health care services of the State Street Bank in Boston. That sounds like a weird title for a banker to have. But State Street is the largest custodian of retiree health assets in the world, unless maybe some foreign governments actually have assets to back their social insurance schemes. The current number is approximately $4 billion, and it's under custody, under postretirement health care services, at the State Street Bank. About a quarter of it uses VEBA-owned life insurance (VOLI) type vehicles; the rest of it is in more straightforward VEBAs, and so on. Fred can discuss some of the aspects of what one has to do to get that part of it working.

The other thing that is a very expensive side of retiree health funding, if you're not in a collective bargaining situation, is the tax on the investment income. And at least one of the approaches for funding that is using a product known as VOLI, and that's one of the items in the investment side that my third speaker, Charley Morgan, is going to speak about. His title is vice president of OPEB funding at Prudential Asset Management.

He was originally a tax lawyer and worked on different items in both the tax and ERISA areas for the Prudential and then got involved in consulting, and eventually ended up working on this product line. He's done a lot of congressional testimony, IRS testimony. He has a law degree from Vanderbilt, and a bachelor's degree from Wesleyan. He's also a CLU.

MR. JONATHAN M. NEMETH: I work at Actuarial Sciences Associates, which is a wholly owned subsidiary of American Telegraph & Telephone (AT&T). Due to our regulatory background we have a lot of electric and telephone utilities as our clients, and these tend to be the type of companies who, for various reasons, are funding or considering funding a postretirement liability.

There's a problem out there. We have this huge health benefit liability, with very little health benefit funding at the present time. As a little bit of background, as we all know by now, *FAS 106* has become effective in the first quarter of 1993 which requires all employers with postretirement benefits to account for their postretirement liability on an accrual basis. I think prior to that time, since most employers were paying for the health liability on a pay-as-you-go basis, there really wasn't an understanding as to what amount of liability was out there. I think we've all seen in the papers the amount of hits that certain companies have been taking to their income

statements due to adopting *FAS 106*. General Motors had a liability of approximately $24 billion, Ford was in the $10-15 billion range as was AT&T.

On the funding side there is no ERISA-type requirement that an employer has to fund. So an employer has to consider from different perspectives why it would desire to fund its liability. For regulated utilities where rate recovery is dependent on funding, there's not going to be that much question that they're going to fund. For example, in California, in order for an electric utility to recover its *FAS 106* expense in rates, it has to fund the liability in a tax deductible trust. Funding is going to have a positive impact on cash flow due to medical inflation: costs are going to go up each year to the extent that you fund, and you're going to levelize the benefits.

The financial benefit of funding is generally the most important issue for many employers. In other words, is this the best way I'm going to spend my money? For example, employers always have a choice of what to do with their money. They can invest in the corporation and get a return there, or they could invest in some of the funding vehicles that we're going to be discussing. From a *FAS 106* perspective, the funding will reduce expense. In addition, it provides benefit security for your retirees, it also can be used to improve labor relations. Also, unions are much more likely to consider alternative plan design changes if they know there's going to be some assets designated to the postretirement health plan.

The real risk in funding is national health insurance, and maybe the other two speakers can elaborate on this subject. I think there's some feeling out there that there's going to be some sort of national health insurance program so why should a company even bother to fund when the government's going to be taking the liability away from the company. Well, my thought is that we already have a national health insurance program called Medicare, and that program has a lot of deductibles, coinsurances, and premium expense so that, even if there is a program, which there probably will be this year coming out of Washington, that the decision to fund should not be affected by what's happening there.

There's five main characteristics of the ideal funding vehicles: (1) The contributions would be tax deductible; (2) an employer could fund an entire liability *immediately* or at least have a certain amount of flexibility to fund a large percentage of the liability; (3) investment earnings should be tax free; (4) there should be no taxable income to the employees; and (5) the assets should offset the *FAS 106* liability. I don't think there's any funding vehicle out there today that in all circumstances can really meet all five of those objectives. However, as we'll be discussing, there are many funding vehicles out there that can meet most employer's objectives.

The two funding vehicles I'm going to focus on primarily are the 401(h) subaccount of a pension plan and a 501(C)(9) VEBA trust. The collectively bargained VEBA is a special case of regular VEBA. In addition, you can use 501(C)(9) trust with trust-owned life insurance (TOLI), which has its own advantages. Moreover, a strategy that I like and I've seen a few of our clients use is a combination of a 401(h) and a VEBA. When you put them in combination, there's a certain amount of advantages that can be reached. A 401(h) is a subaccount of a qualified retirement plan. It can basically be used to pay for medical benefits and other ancillary benefits. It's really quite a good funding vehicle: contributions are tax deductible; the investment

earnings are tax exempt; and the benefits are not taxable to the retirees. The contributions, however, must be reasonable and ascertainable. In general, I think that means you must use some sort of acceptable actuarial methodology to calculate your contribution. The contribution methodology is not set in the delayed retirement credit (DRC) code. In addition, you are allowed to use medical inflation in determining your contribution.

Usually a 401(h) is a very good way to fund. However, at least for most of our clients, there is a limit on the amount of contribution that can be made to a 401(h) account. It's called the "25% rule" or the subordinate benefit rule. The retiree medical and ancillary benefit contribution cannot exceed 25% of the total contribution to the trust for pension, postretirement health, and other ancillary benefits. I tend to think another way of looking at it is that you're limited by 33% of the pension contribution. If you actuaries like to check things, you'll see that 25% of the total contribution is equivalent to 33% of the pension contribution. For most of our clients the 401(h) account is very limited because they have fully funded pension plans. You can use it perhaps for funding a portion of your benefits.

The 501(C)(9) trust is similar in concept to a pension trust in that money set aside today can be used to pay future health claims. The rules and regulations concerning the funding of 501(C)(9) trusts are laid out in IRS sections 419 and 419(a). A 501(C)(9) trust can be used to pay many forms of benefits, not just postretirement health. For example, it can be used to pay benefits such as vacation, LTD, severance pay, active medical, and so on. The IRS rules and regulations for funding postretirement health benefits are sparse, and it's somewhat of an actuarial no man's land, since no actuarial methodology is laid out. However, there are certain rules that are clear. For example, the postretirement contribution must be funded over employees' working lives and actuarially determined on a level basis. Well, what does that really mean? There are many different interpretations of that rule. However, in general, I think most people would say that would exclude a projected unit credit type of funding method. In my experience most companies that I've seen have been using some sort of aggregate funding approach to determine the funding contributions.

A question that inevitably comes up when talking about funding over employees' working lives is the funding of existing retirees since existing retirees have no future working lives. Does that mean you can prefund your entire postretirement liability for retirees? In general, IRS officials have not looked favorably upon that concept. For management or for nonbargaining employees, limited funding is permitted in VEBAs since future medical trend cannot be anticipated in determining the annual contribution amount. In other words, you must use current costs in determining your contribution.

To give you an example of how this affects the funding of management and nonbargaining employees, without using medical trend your maximum deductible contribution is probably going to be at least one half of the contribution using medical inflation. So for noncollectively bargained employees the full funding is severely limited. For union employees there have been recent private letter rulings that in essence say that full funding is permitted. That means that, to the extent that an employer puts money into the trust that is less than the entire present value of benefits, that contribution would be allowed.

There are numerous advantages of a VEBA trust: It meets most of the ideal characteristics I discussed before; benefits aren't taxable to the employees; and it can be an offset to *FAS 106* expense. However, for noncollective bargaining groups the investment income earned on assets is subject to unrelated business tax unless it's invested in municipal bonds or some sort of life insurance. And, as I mentioned before, using current costs makes it very hard to fund the entire liability. On the other hand, a collectively bargained trust has unlimited contribution as long as assets do not exceed the present value of benefits. There is a question as to what constitutes a collectively bargained trust, and in general, the rules and regulations state that there must be good faith bargaining with arm's length negotiation of benefits. It appears that the trust and the contribution level do not need to be bargained. Investment earnings in a collectively bargained trust are not taxable, and the contributions to the trust are deductible.

One of the things that we've seen, especially for management groups, is the combination of a 401(h) and a 501(C)(9) trust. Individually, both funding vehicles are limited for different reasons. The 401(h) is limited by the contributions made to the pension plan. The 501(C)(9) trust is not allowed to use medical inflation. However, in combination an employer may achieve a larger level of funding. There are several different ways that I've seen it done. Since you're not allowed to use medical trend in a VEBA, you'd want to put your noninflationary benefits, perhaps your dental, which usually has a lower trend than your medical, into the VEBA. Alternatively, you'd want to put your inflationary benefits like your medical into your 401(h), since the 401(h) is allowed to take into account future medical costs.

This type of combination really should be used for nonunion people, since union employees have a very good funding approach, the collectively bargained VEBA. To the extent that existing retirees are paid on a pay-as-you-go basis, you might find that this approach might give you a higher deductible contribution than prefunding over the working lives. So often you'd have your existing retirees on a pay-as-you-go basis and only your future retirees funded in either the VEBA or the 401(h). Life insurance has different rules, and you would probably want to set up a different VEBA for that benefit depending on your limitations. You might want to use multiple funding vehicles. You might want to use a VEBA for certain noninflationary benefits, a 401(h) for inflationary benefits, and then a separate VEBA for life insurance. Determining the funding strategy for a postretirement health liability can be challenging since there is no clear guide on certain issues. For example, an employer can fund a 501(C)(9) trust up to what's called an "account limit." However, there are different interpretations on what an account limit is. We know investment earnings or assets that exceed the account limit are subject to income tax. So an employer looking at funding should be involved in determining some sort of funding policy that would project liabilities and the contribution levels using stochastic asset modeling giving capital market assumptions, interest return, demographics, and other actuarial assumptions to see how assets compare to liabilities over the next 10, 20 or 30 years.

For example, looking at a page we took out of a health policy funding study, by the year 2010, using the funding strategy in place, the market value of assets exceeds postretirement health liability, and therefore, you might have to adjust your funding strategy. We break our analyses out into several different groupings so that an

employer can see, depending on objectives, what sort of funding strategy it would need if it wishes to fund retirees, all employees, or only those employees who are solely eligible to retire.

I'm just going to talk briefly because I know the other panelists are going to have a lot more on this subject, on employee funding. It seems to be a concept that makes some logical sense. Most employers are shifting a tremendous amount of their cost to their retirees, especially future retirees, by implementing postretirement health caps and age/service-type contribution schedules. It seems to me that when employees are working, that is when they are able to save for future retiree medical. Some employers, and I think it will be more common in the future, are setting up funding vehicles so that employees can accrue money on a tax-advantaged basis to pay for their future retiree medical expenses. These employee contributions are voluntary. One idea is to coordinate the funding vehicle into an active flexible plan. In that situation, an employee can make an after-tax contribution to a trust to accumulate assets. There are various funding vehicles available. I have tried to provide just a brief overview of the different funding vehicles and some of the rules, regulations, and funding strategies associated with them.

MR. FREDERIC H. MORRIS: I'm from State Street Bank, and I head up a group whose purpose is to help employers who are considering funding their *FAS 106* liabilities. Our role primarily is as a custodian and as an investment manager.

The theme is new approaches needed when looking at funding the *FAS 106* liability. This is not similar to a pension. Jonathan has already covered some of that, and Charley will get into some of the other corporate funding sides. Funding *FAS 106* liability takes new approaches. To begin with, it requires a new approach inside a company to determine what the commitment to funding retiree benefits is, and what the benefits the company wants to establish are. Generally, this requires a team effort between the human resource people, whom I suspect you primarily interact with, and the treasury people who have to date handled the pension plans. This type of coordination, I have found from personal experience, is hard for companies to achieve. These groups don't report to the same person in many cases and they've really run separate departments. But the groups do need to get together; they have to determine how much of a benefit a company can afford to provide for its retirees and still remain competitive. On the other side these groups have to determine what kind of benefit they need to continue to attract and retain the better employees they want. Once the commitment has been established, the next decision stage, which again requires a different approach, is how to meet that future obligation, what kind of funding approach needs to be taken?

The first aspect that I'm going to talk about is the investment strategy. To begin with, you're not trying to match an inflation adjusted income stream, which is really what a pension fund is all about, the objective is to meet the provision of medical care, which is denominated in terms of a service not in terms of dollars. As background, the growth in medical expenses in the country has been at a very high absolute rate, we're all well aware of that. We're also aware that the government in its Medicare/Medicaid plans has been progressively funding less and less of the cost of the services it's providing with the result being a shift to the private sector to pick up the difference, thereby increasing the effective inflation rate that much more. And,

finally, the general inflation rate, which is for many investment strategists the bogey for a pension plan, is in this case only loosely tied to the growth in medical expenditures.

Looking at where medical costs have been, the general inflation rate has accounted for something like 20-40% of the major components of medical spending from 1985-90. The principal culprit I should say has been the intensity of health service utilization. That means, when you go to a doctor or you go to a hospital, you end up getting more services provided. If you go to the physician maybe you're getting an MRI, a CAT scan, maybe he has a share in a lab doing a blood test for you; you're getting more services. On top of that there is an extra layer of health sector inflation above and beyond the inflation in the general economy that has been driving up some costs a lot and others less significantly.

Let's look at the absolute dollars spent on health expenditures in the country during 1965-90 and break them down by the principal components since 1980. There's a 10.3% compound growth rate in medical spending in the country. The significant fact is to contrast that with the inflation for the same period measured by the GNP deflator which is 4.4% for the decade and only 3.4% for the last five years.

Let's take that 10.3% compound growth rate and break it down into its component parts. What you find is that 100% is the equivalent to the 10.3% compound growth rate. Physician services intensity, which are the additional services people are getting for each visit to a doctor, account for 40% of that growth in spending. At the hospital sector under utilization, people have been in fact staying in hospitals fewer days per visit. Unfortunately that's been substantially more than offset by the number of services they've been receiving when they're at the hospital. So the net is still about 20% of the total growth in spending coming from more service provided.

In outpatient hospital, while people are spending fewer days in the hospital, the corollary is they're getting more outpatient care, and that has been responsible for a third of the growth in that category. Finally, the medical sector inflation is responsible for almost half of the increased costs for drugs and medical nondurables. That means, on top of the general inflation rate, half of the growth has been just additional layers of inflation; it's also been a significant factor for each of the other categories.

Where do all those depressing numbers come from? Tax subsidies, which are being discussed in the Hillary Clinton health group, effectively mean that an intelligent employer and employee would prefer to get as much of their compensation in health care versus wages as possible. As we're well aware, health insurance and current reimbursement methods push people into using additional care since they really don't see the cost in many cases of the services that are actually being provided other than as the premium that they may pick up a piece of.

Medical technology, MRIs, and new drugs obviously have been continuing to drive up costs and probably will continue to. Litigation has a major affect in that intensity; doctors are prescribing more services to cover themselves effectively from possible suits. It also shows up as just direct cost for malpractice. And, finally, demographics is a factor continuing to become more important: older people consume more health care.

So to put together some investment strategies to fund retiree health care, what does that mean? It means your bogey, what you're trying to achieve, is a group of investments that will have a high absolute return, not one that will hedge inflation. Because you have a long time horizon, typically companies are funding a piece of their future liability each year, but they'll probably have 20 years before it's fully funded in many cases. That kind of a time horizon says there should be a tolerance for volatility in investment returns, which is the other side of an aggressive strategy. As an administrative matter, you cannot use the commingled funds that people are already comfortable with in funding pensions because qualified retirement plan assets cannot be commingled with VEBA assets.

Both Jonathan and Charley are really focusing on the corporate funding piece, and I'm just showing the principal vehicles that we see being used. I also have a category called "other," and I'll just mention one because you may see clients, as we are, that have special purposes not applicable across the general corporate marketplace. There will be a variety of these special trusts.

I'll mention here, for instance, a grantor trust in which our client put company stock it had purchased in the open market. The client's special purpose was its belief that its stock was undervalued, potentially a risk of a takeover. By buying in that stock, (1) that put a block in friendly hands, and (2) the client would be expecting appreciation in the stock price. The trustee could then sell the stock at a gain that would be tax-free because a grantor trust is taxed as part of the same company, so the treasury stock has no capital gain implied. You'll see these special purpose trusts, but in 98% of the cases probably the 401(h) and VEBA will be the key.

Finally, companies (as they define the extent of commitment that they can make to retiree health care) are in many cases capping how much they're willing to be exposed to the rise in medical costs. What that means is the employees are going to have to pick up the difference when they are retired. It's nice to be able to not just cap the liability but to give companies an avenue for funding.

I've dubbed the employee pay-all VEBA as a retirement health savings account (RHSA). I'll start out with the negatives on its structure. There is no real legal case history on these plans, so that anyone establishing one is going to need to consider a determination letter or other strong comfort before really jumping into it. If done correctly, the RHSA should have earnings on a trust not be subject to the unrelated business income tax and should have tax-free payout for health premiums in retirement. Obviously it allows employees to put money aside while they're working so that they'll have it available when they are on a fixed income. The plans that we've seen have set up a severance payment or a death payment so that, if an employee leaves before retirement or dies, the funds in his or her account can be returned to the employee, at which point of course the earnings would be taxable, but at least the cash can come back if needed. Because companies are cutting back, I think this is going to become an increasingly popular supplement to the existing retiree health plan. Administratively it's not terribly complex. You don't have loans, and you don't have percentage rules to worry about as you do in a 401(k).

I mentioned that the two plans that I'm familiar with have been implemented in several companies, American Airlines, International Paper, and Chrysler, just to name a

few. In the International Paper case they started with employees fifty years old and older who are allowed to put $20-120 a month, again after-tax, into this retiree health savings account. The company did this at the time it was capping its upside future payments to its retiree health plan. The company for its part is matching 50% of the employees' contributions, but not putting that cash commingled into the RHSA. The employer match is not viewed as additional deferred compensation, it's purely for retiree health care. In International Paper's case it had 45% participation, which to that company was a disappointment for the first pass, and I think it underlined to International Paper the need to really educate its older employees on the need to start putting money aside for this important part of their retirement expense. International Paper is also going to consider some improvements to the plan, including investment discretion.

From a totally different approach, American Airlines put together a plan that is really integral to the corporate retiree health plan. American's objective was to say employees ought to be funding about one third of the cost of retiree health care. What American has done is put together a plan where employees must contribute to this VEBA if they want to be covered at all. It's still, I guess, technically voluntary and that hasn't been litigated, but the result was a 99% participation rate showing great enthusiasm. Other characteristics of the plan are of interest. When American set this up, anybody could get in and stay in for $10 a month. If you didn't sign up at the outset, including new hires, the after-tax contribution would be an actuarially determined number to meet one third of your retiree health expense.

Again, these are two quite innovative approaches to dealing with retiree health care. And, as I said, new approaches are needed for looking at retiree health-care liabilities and how to deal with them.

MR. CHARLES C. MORGAN: I'm with The Prudential Asset Management Company, formerly a lawyer, formerly a group insurance person, formerly someone who worked with human resource folks on pension plans and health plans. And that career, from ERISA to pensions to health care, makes my experience somehow relevant to retiree health-care funding. So we have formed a unit in The Prudential Assets Management Company to find solutions for retiree health-care funding. We thought of this as being an investment problem more than a plan design problem when you talk about actually funding. But, when you step back and you listen to Fred and Jon, you realize that it's more than just funding: it is plan design and financing. You have to bring together a multitude of disciplines in addressing this area. It's a very difficult task.

I have one point about insurance companies and their role in this area: we are uniquely situated to find solutions here. After all, we play in all the appropriate arenas, and we are doing insurance programs: we do provide health-care benefits; we do work with plan design; and we do provide investment management services. It is from that perspective that we thought we might be able, if we looked hard enough, to find some good solutions, because there is no single good solution.

Sometimes you wonder who the good guy is and who the bad guy is. Is the bad guy the employer trashing the good-guy employee's benefit? Is the bad guy the IRS jumping on the good-guy employer's tax deduction? Maybe the bad guy's really a

gal, Hillary Clinton. Your options: do nothing. A lot of us are still doing nothing. You can change a plan design and a lot of us are doing a lot of that, and sometimes it's euphemistically referred to as funding. It is easy to get confused in this area and think you're doing a funding program when really all you're doing is cost shifting to employees and doing a plan design change, the American Airlines point. Maybe you're going to do a combination: funding as well as plan design changes.

I think it's important to make a very important distinction between formal funding vehicles and informal vehicles. An example is the American Airlines idea of the cost shift to employees, the employee contributions to a medical account point, to what I think of as an informal funding program because we are not addressing an employer liability with employer money. So a formal funding program, a real one, involves a situation where the employer does not shift the liability to employees, the employer retains the liability, the employer is using cash or some other asset now to prepay that expense in some formal fashion. Now I think it helps, at least it helps me limit my confusion here, if I think in those simple formal versus informal terms.

Another important way of rationalizing your thinking is to remember that the traditional health-care plan has been a defined benefit plan. We are moving to defined-contribution concepts as we did in the pension area. The employee medical account and 401(h) accounts are examples of defined-contribution regimes funded by employees. Keep the distinctions in mind when looking at the solutions. Step back to basics and sometimes it helps.

You want a funding vehicle that can match the firm's hurdle rate. These treasury people aren't particularly interested in employee security on design issues. They want to know, with a limited number of dollars within the firm to spend on a limited number of projects competing for those limited assets, why should we put money here and return say 12%, maybe, over 15 or 20 years when they observe the pension plan and can invest comparably. Why would they do that if the hurdle rate is higher than 15% or if the ROE is at 20%? The company is not going to invest for security if the company looks at it solely as a financial issue. It's important to look at that. But you can perhaps beat that hurdle rate in a given situation if you take into account the tax benefits, if you can find a benefit program that will give you the deduction, will grow your asset tax-free, and will get into a diversified portfolio on a risk-adjusted basis, that can maybe beat that hurdle rate.

You get into arguments with whomever your audience is as to whether you ought to put employee security first or last. It's a no-win situation. All of us are employees. We are the enemy in a certain sense. This is our benefit. Employee security is important. It is tough to quantify in financial terms. Why would you fund now rather than wait? Most of us were waiting and saying, do nothing. There's less risk in waiting. I suggest that maybe that's wrong. I also would suggest that we are all funding these liabilities now. That's sort of a radical thought, but think about it.

Pay as you go is a simple investment from the plan perspective in one security, an employer promise. It's sort of a quasi-equity-debt instrument. But from the plan perspective, I have invested in a portfolio of one security. Now if I came to those of you who have worked on pension plans for many years and suggested that we ought to trash the portfolio and invest in the employer's stock 100% or maybe 100% debt

obligation from the employer, what would you say? That would be a radical thought in the pension world, common in the health-care world, but that is what we're doing in a very informal way.

Stepping back, there was an important point that Jon was making I think about Hillary Clinton, the Clinton task force, and national health care. Why would you fund now with all these changes pending? You mentioned Medicare. I think that's a very good point. Another analogy perhaps is Social Security. When Social Security came along, it did not kill the private pension business. We now have pension plans that are integrated with the Social Security program, employers like to supplement those benefits, it's important.

I think whatever evolves we are going to see a continuation of private health-care programs integrated with whatever Hillary Clinton and her folks come out with. The issue is, when we are done with whatever national health-care program we have, will the residual liability retained by the employer in its integrated plan be smaller than your funding program that you're putting together? Or stated differently, it makes good sense to fund towards a liability that's downsized after that integration effort. None of us can afford to fully fund these liabilities.

The real issue is, once your plan is integrated and downsized in terms of its liability, will the asset you set aside exceed that, and it's improbable it will. The tax deduction is a wasting asset, use it or lose it. If you don't put your money aside today and take the deduction, you're going to lose those tax savings today, another reason to move rather than wait. It is true that, if you can deduct money now, set it aside, grow it tax-free and spend it tax-free (there are a lot of assumptions in there), you can reduce your costs.

I borrowed Chart 1 from Jon and his associates at Actuarial Sciences Associates on a mutual deal we did for our client. It actually illustrates the cash-flow impact of funding. The dashed line is pay as you go. The dotted line is prefunding. Optimistic view means optimistic view on health-care trend. In other words, we're being optimistic that health-care costs are going to stop growing. In ten years there's a crossover point, and clearly, before the ten years, there is a cost to funding. What have you done? Over time you've reduced the cost of the cash-flow impact of this problem.

For the more realistic or pessimistic view on trend, the picture looks more like Chart 2. What have you done by prefunding? You flattened out the cost, the cash-flow impact on you. If you're working in a regulated industry, the utility industry for example, that is a very powerful picture to show to a utility commission that is worried about the impact on the utility customers of those rates. It's also a powerful picture for convincing the financial folks this is a smart financial decision because it does stabilize cash-flow both short and long term. It's sound budgeting. This is a long-term problem, it just makes good budgeting sense.

CHART 1
Future Cash-Flow Requirements
Optimistic View

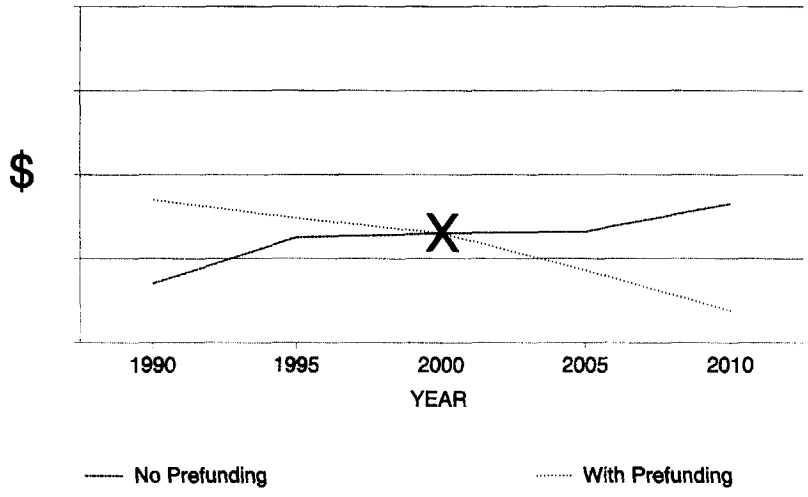
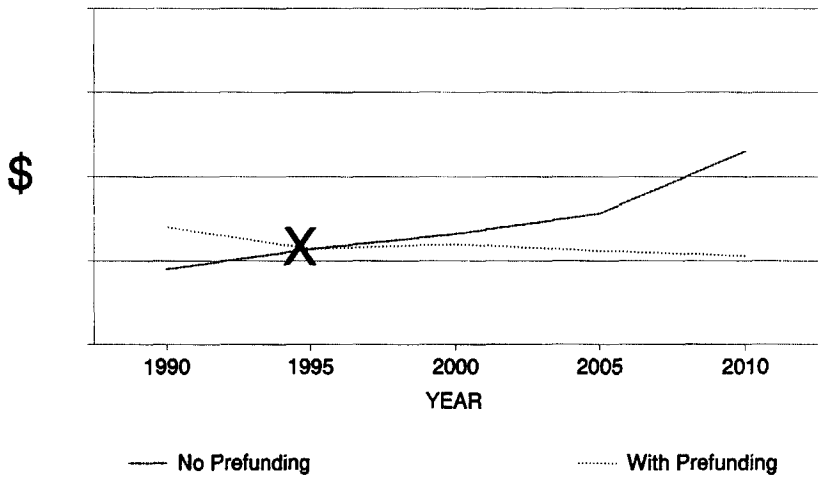


CHART 2
Future Cash-Flow Requirements
Pessimistic View



Cash does not grow on trees. Companies get it a couple of ways. They borrow it. They raise it through stock. They make profits through running their business. If you are in a volatile industry where your profits are way up one year, way down the next year, say you're an Alcoa Aluminum, if you prepay some of this cost in the good years, in the bad years you can tap that thing more and use the cash in the prepaid asset to pay for health-care expense. You reduce credit risk because that is that much less you had to go out and borrow and pay for this problem. You've set it aside in the good years. Plan asset treatment is important.

I would like to briefly discuss the poison pill. I think the whole point was a kind of a poison pill. One of the things I have seen is a design that actually triggers funding in the future at the point of a takeover. In other words, if you're cash rich or you have a lot of assets, you're concerned about a takeover attempt. If the takeover triggers the funding, you might poison that effort.

How do you discuss whether funding for employee security should come first or last? I think all of us from our own personal perspective think that the human resource perspective ought to come first. And always in these decisions you have this tension between the treasury area, looking at hurdle rates, cost of money, cost of capital, and best use of capital versus the less quantifiable more intangible perspective.

I already mentioned that collectively bargained plans are treated differently than salaried plans. Most of the discussion here about unrelated business income taxes and how to deduct this money and what kind of good investment vehicle you have falls in the salaried plan arena not collectively bargained. Collectively bargained is easy. If you're Harvard or Stanford or a nonprofit organization, it's just like collectively bargained; it's real easy. You can take trend into account when calculating your liability; you don't worry about tax deductions; and you get tax-free growth of the asset.

In choosing the vehicle, you must decide what your objectives are. Of course, you want deductions and tax-free growth. You want favorable accounting treatment. Some of the informal vehicles do not give you favorable accounting treatment. It is important to look at what you're really trying to achieve. You want something that's easy. Some of these things are very complex. There are employee considerations. You know health care, at least today, is tax-free. Your funding vehicle for providing that health-care benefit ought to not have an adverse tax impact on employees. A good one will not, some do. Think of a 401(k) plan. A lot of companies are looking at a 401(k) plan as a method for financing this expense. Not only does that approach have a cost shift to employees, but also the 401(k) plan is a taxable vehicle. To the extent that new employer money is going into that, that is a poor choice because the employee is taxed.

There are investment considerations. The treasury and financial people have a hurdle rate and want investment diversification. We are not diversified today on pay as you go. We made that point. You want something that's easy to work with, has investment flexibility and little expenses, and is easy to get in or out of for the employer.

Regarding employer flexibility, if you have a formal vehicle with tax deductions and plan asset treatment, getting out is tough. If you have an informal vehicle, you're going to have great employer flexibility, but you're not going to get deductions and plan asset treatment. This is a simple way of looking at the flexibility requirement and another reason for thinking in terms of formal versus informal terms.

You may not know what to think of these things. But, again, it can simplify things if you take all of those objectives and put them across the top, take all the funding vehicles that you can think of, you've heard about here, in other programs, put them down the left side and draw a simple matrix, good or bad, and then emphasize the objectives you want for your client and see which ones fit better.

Table 1 is a very small version of information found in Table 2. I'm focusing on three of the key objectives, and some of them were more often spoken about or used vehicles. The things that are selling group TOLI, or TOLI vehicles are: you get your deduction, you get your plan asset treatment, and you get tax-free growth of the asset. The reason 401(h) accounts have been mentioned and emphasized in combination with VEBAs is that they provide those things also.

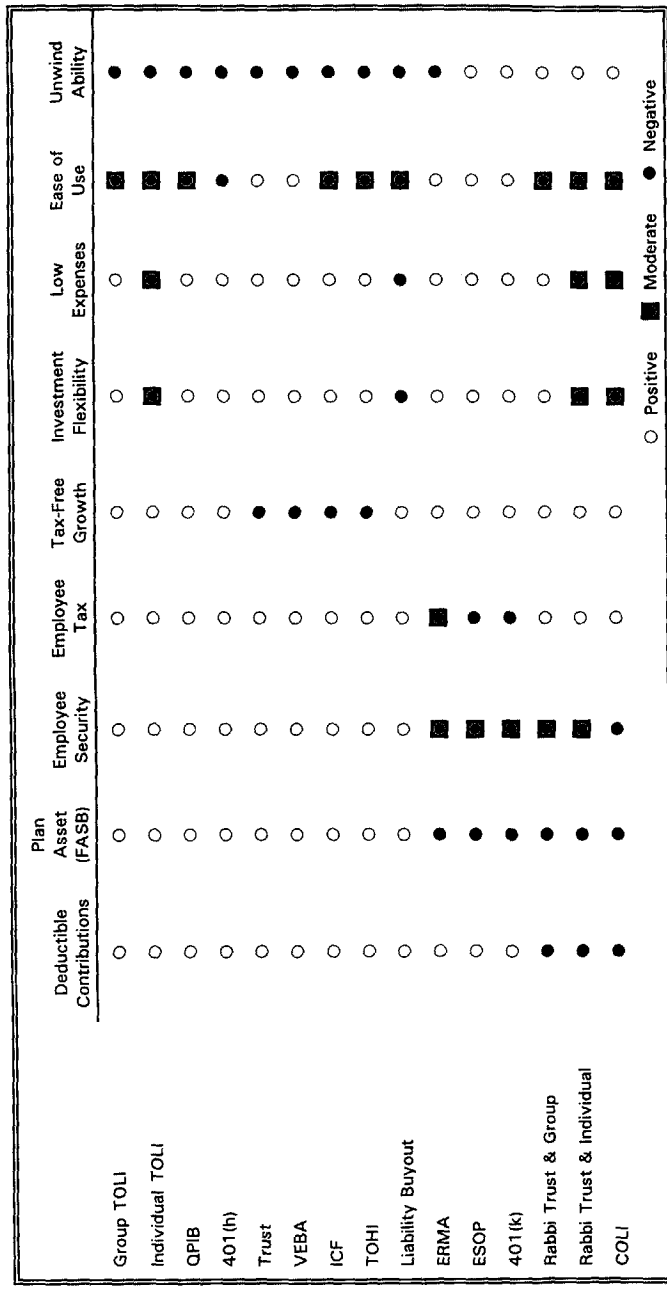
TABLE 1
Postretirement Health-Care Funding Options

Formal	Deductible Contributions	Plan Asset FASB	Tax-Free Growth
Group TOLI	●	●	●
401(h)	●	●	●
VEBA	●	●	○
ICF	●	●	○
Informal			
Sinking Fund	○	○	○
COLI	○	○	●
401(k)	●	○	○
ESOP	●	○	○
Rabbi Trust & Group	○	○	●

Source: The Prudential Asset Management Company Securities Corporation - April 1992

On a corporate salaried plan you do not get tax-free growth of the asset in a VEBA. If you work in an insurance company environment and you've provided group term life benefits or insured health-care benefits, you've probably discovered that you can take an amendment to the contract and prepay the postretirement segment of that liability through that vehicle and that's what I call an insurance continuance fund (ICF). That vehicle generates an income tax in the employer's return that's called deemed unrelated business income tax very similar to the VEBA problem, and that's why you don't hear about them very often.

TABLE 2
Comparison of Postretirement Health-Care Funding Options



The Prudential Asset Management company Securities Corporation - April 1992

ICFs go with group term life funding and postretirement group term life. People talk about corporate owned life insurance (COLI) and employee stock ownership plans (ESOPs). You may or may not get a deduction. You may or may not get tax-free growth. Ultimately some of those vehicles do tax the employee; 401(k), for example, does. COLI works wonderfully for what it is, but it is an informal funding vehicle. You get the tax benefits of leveraged COLI. If you hook COLI up with a health-care funding program and call it that, don't kid yourself; you really are not formally funding your program.

Group universal life involves cost-shifting. American Airlines could have done this, or any firm that's looking for a vehicle where employees might want to accumulate cash to pay for this expense after retirement. It is a fairly good vehicle with fairly clear tax results. Section 72 is fairly clear as it applies to this. Section 72 is not very clear as to how it applies to employee medical accounts. So, again, a part of the conversation is how risk averse is your client on some of these tax issues. A 401(k) plan, again, is an informal vehicle. What you're saying to the employees is, take some of your own money, put it in before tax, and when it comes out, it will be taxable. This is cash to pay this cost the employer has shifted.

You know you hear about companies that think an ESPO is a great solution. They're not funding vehicles for retiree health; they work for what they are. If you're going to connect an ESOP for political or employee communications reasons with your health-care solution, as professionals we need to remember the reality of what we've done. What we've done is invested in a vehicle that is not particularly secure. After all, if the employer goes belly up, the value of the stock goes down the tubes. You have not achieved your employer-employee security objective. But it might be good.

The HSOP is the Proctor and Gamble idea that the IRS trashed. Basically, Proctor and Gamble took a 401(h) account and connected it with an ESOP and hoped to provide medical benefits through this ESOP quasi-health-care vehicle. I include it only because it's been there and may get resurrected.

The Brec Corporation bought an employee retirement medical account (ERMA). All it is is a deferred annuity contract. We all sell deferred annuity contracts. The simple idea is the employees can put money into a deferred annuity, it grows tax-free, the employees put the money in after-tax, and you pull the money out under the annuity rules. You know, it's a good vehicle for accumulating assets. Again, it's not a formal vehicle though it's an employee-funded vehicle in a cost-shift environment.

Grantor trust has been mentioned already. Grantor trusts and the funded welfare plan area to me are weird animals. When I was involved in the creation of these rules back in 1984, they created a thing called a fund. You have funded welfare plans under 419. You have these unrelated business income tax (UBIT) and deemed unrelated business income tax rules. Those ideas don't fit very well with historical grantor trust ideas. But the treasury stock idea that Houghton Mifflin had is a very creative, interesting, and potentially good idea. It can't probably get plan asset treatment even if you have a separate trust for it because the SEC has said no. That may not be the final word.

Regarding taxable trust, I have often wondered why, if you have a VEBA and the investment earnings are taxable, why do you use a VEBA? Why not just dispense with all the rules that go with VEBA qualification because you don't need them and use a simple taxable trust? It's a radical idea, it seems logical, nobody's used to it, so nobody's doing it yet. We talked about ICFs, 401(h) accounts, ESOPs, and the VEBAs.

I agree with the point that most people are doing a combination of 401(h) and VEBAs. And VEBAs are the underpinnings for trust owned health insurance (TOHI) and VOLI, or trust owned life insurance, what Joe called TOLI. And after all, if you have a health-care program, why would you fund it with a life insurance contract? Why wouldn't you have funded it with a health insurance program? It seems logical. The tough problem is the question of whether or not the investment you've bought within the VEBA, within the trust, also will be characterized as a fund. If you have a fund within a fund, within the meaning of 419, you have deemed unrelated business flowing into the VEBA as unrelated business income, and you blow your tax result.

To have a health funding solution you have to have a pooling of risks. You have to have a forfeiture of accounts. Individual medical reimbursement accounts do not seem to work very well here, so questions arise on whether you get the inside build-up. This is a big point on health insurance programs. There are state-mandated benefits laws. Why are most health-care programs self-insured? Why aren't they insured? Premium taxes are one issue, and state-mandated health-care benefit rules are another. The last thing any of us needs to do is saddle the client with a suddenly insured plan because the client used a health insurance vehicle to fund its uninsured health plan. There's a big trap.

Well, we ended up with TOLI at Prudential as maybe one of the best solutions only because of all those other things not working quite so well. We looked at TOHIs and we weren't quite sure how they were taxed under Section 72, and we were worried about the state-mandated benefits law issue. So you end up with a life insurance solution, and people tend to say life insurance for funding health care is a crazy idea. Don't you have a mismatch of cash flows here? You have a health-care problem with cash expenditures and a very predictable rising daily or weekly need. You have to feed the checking account that you're paying out the medical expenses from. Life insurance is a poor solution. You get your death benefits at unpredictable times when people die, in unpredictable amounts or maybe predictable amounts, but unrelated to the health-care need.

One of the interesting things that I found in my practice is there are a couple of published studies that the Health Care Finance Administration (HCFA) has done on Medicare. HCFA found that 5% of the people in Medicare were getting 30% of the benefits. Why? Those people were in the last years of life.

The significant cost of last illness is consuming a disproportionate share of the Medicare trust expense each year. What does that mean in terms of a life insurance funding solution? There was a very good article in *The Wall Street Journal* that cited these HCFA studies, and it's a fair inference that each of us in a lifetime of spending on medical care will spend the majority of our expenses in that last year or two. If that is true, then what better vehicle is there than a life insurance contract that

produces a large chunk of cash at the time these expenses and bills are coming in? All of a sudden you start to see a match in cash flows that weren't that obvious.

Life insurance contracts also allow withdrawals up to principal. You can make a withdrawal from a life insurance contract up to principal to pay for the health-care expense. So a characteristic of the TOLI programs is a combination of cash benefit, death benefit flows from the decedents and withdrawals. And if you blow through your withdrawals, then there's still policy loans you can use to get money out of the contract without waiting for the death. So the cash-flow problem is really a non-problem with these vehicles if built right.

Quickly, on life insurance, the key issue is, how do you get around the insurable interest rules? Briefly, remember that this is a TOLI vehicle. Our VEBA owns the policy; the VEBA is the beneficiary. But the real beneficiaries are the people under the health-care program. Who do you insure in these programs? Everybody's got a different version. Typically, you insure upper management to provide benefit funding for the whole of the employee group. It's a unique sort of reverse form of discrimination, upper management providing insurance on their lives for everybody. That's sort of a neat new thing.

The insurable interest rules are there for two reasons. One is public policy against murder. After all, if I can buy a policy on Joe's life and murder him after having named myself a beneficiary, that's a great financial program for me. It's not so good for Joe, it's basically good for me, but don't forget the intermediary. And the second reason why insurable interest rules are there is for the insurance company. Insurable interest rules are there for insurer solvency. What was a good financial transaction for me was a lousy one for the insurer. If you build this life insurance contract to address that issue, you're most of the way to solving the insurable interest problem.

There is a key rule in the insurable interest world that you need to remember is part of the solution. Remember the conversation I just had about Joe and me. I can't buy a policy on his life because I don't have an insurable interest in him. He has an insurable interest in himself. He can buy a policy on himself, and he can give it to anyone he wants. It is a fundamental rule in most states since the insurable interest rules apply at inception, not at death, that you can buy a policy on your life and you can give it away to somebody who doesn't even have an insurable interest in your life. The trust doesn't, so maybe he can give it to the trust.

The good secure programs that have been purchased by very conservative companies worried about this issue involve several basic techniques. You must provide employee notice. You have to tell employees they are being insured. You must get their consent. There are two ways of doing that: positive enrollments or negative enrollments. In positive enrollment, you go to the employees and say you're not insured yet. We'd like to insure you, sign the consent form enclosed, return it to us, then you become insured when the consent form is sent in. In negative enrollment you go up to the employees and say you're insured. We're doing this, it's for your health-care program. With this program, employees, your health-care benefits will be more secure, without it they won't be, we need the insurance for a variety of reasons. Please assist us. Do not inform us you withhold your consent. But if you

don't like it, if you have something against this, send us a letter and we will remove you from the insured group. Which way you go depends on the state.

New Jersey, for example, mandates positive enrollments. In Georgia you don't even have to tell the insureds. The consent must be revocable. After all, once I make a consent, I might want to change my mind. In fact, my comfort level in giving you the consent in the first place is going to increase dramatically if I know I can change my mind. Most of us will forget about it. It turns up being a nonissue in terms of the practical administration of these programs, but it's very important to get the consent and answer the question on whether or not Joe did buy this policy and really did give it to this trust. This consent procedure is a key, and it aims at that rule.

Finally, if you're getting anywhere in New York state, you're going to have to have experience rating. The only thing that we were able to do to convince the New York Insurance Department that these things were sound was just to point out to the department that we were heavily experience rating the group insurance product we use, mortality charges were on a retro basis, additional premium was on a clause-type basis. Premiums go up if mortality goes up, but what happens? Investment returns go down. The investment professionals purchasing these products don't want investment results to go down. There is significant incentive to keep mortality low. We're all in it together, it's a solution that the insurance department in New York agreed worked. Now you have to get the law changed in New York. At least the insurance department in New York is behind a change in the law if you have all of those things I just mentioned.

You have to have a trust making sure that the life insurance benefits will be used to provide the promised health-care benefits. Well, that's okay. We want a VEBA for our trust anyway for the deduction and plan asset. So that requirement, which is needed for the insurable interest rule, ends up being a nonissue for us in our plan design. That's a quick overview of TOLIs.

MR. JAMES A. GEYER: I've got a question for Fred on the two examples he cited, International Paper and American Airlines. I'm curious as to what the employees see as to whether they get some sort of periodic statement as to an account balance, whether the account balance is done at book value similar to a 401(k) plan, and, also, what type of investments are they using? Do they invest in fixed-income vehicles like GICs or is it equity based?

MR. MORGAN: I'm not sure on American Airlines, maybe Charley can answer that one. International Paper does provide statements. The investment vehicle used is a fixed-income GIC-like approach, and they think that was a mistake in hindsight. Not only is the return not one that matches the health-care inflation, but also it's one that they believe decreased participation by employees. So, I think in talking to companies today about setting up additional plans providing investment choice you should provide some education on what type of choice makes sense and what considerations you should look at in making those choices.

MR. LARRY BERNSTEIN: Did I understand correctly that under VEBA we can use trends, but we can't use utilization factors? And, if so, what has the IRS said about this, if anything?

MR. MORGAN: The 419 and 419(a) rules say that the funding rules for a VEBA must be based on current cost. I think the safe position is to assume that means no increase in both utilization and trend, meaning claim cost. However, I'm not sure the IRS will rule favorably on the subject. But if you think about what the pros and cons of what the IRS's ruling could be, really the worst thing the IRS can do is make you go back and take it out. In considering the grand scheme of all the other questions, it's very unlikely that would be the only issue that the IRS would be questioning you on concerning your audits. I think it's an individual decision.

MR. MACAULAY: You have no experience on this.

MR. MORGAN: This is a significant issue, and it is a controversial issue. The IRS position is clear. You can't take utilization into account. The blue book, what we call the Joint Committee Staff explanation of the law, comes out after the law was enacted so it's not legislative history. It addresses it expressly and says you can't, it was intended you could not. But there are people who feel that the reference to medical cost -- the issue of whether it is costs to the employer or costs to the plan -- is a sort of loophole. I mean, after all, if I have a physical twice at $100 a shot, there's no increase in the cost of the physical ($100 each time), but certainly it was a doubling cost to the plan. It is enough of an open issue that in the audits of a tax return you have horse trading, and so there is a view that you shouldn't be giving up this chit before the audit, you ought to be taking it into account. I have seen many plans that are taking that utilization point into account when doing their funding.

MS. CAROLINE S. CARLIN: I want to play a wet blanket role here for a minute and make a couple of cautionary comments. Jon, you had mentioned the issue of how do we define how we fund retirees through VEBA. The IRS had been possibly a little lenient in full funding of retirees immediately. I just want to make sure that people here know that the IRS is aggressively auditing 4,200 plans right now, and that may not be true in the future.

MR. MORGAN: They're aggressively auditing, and it's appropriate to put the wet blanket on. But, again, back to the audit lottery, people are settling out at six and seven years. The IRS position out of the blocks says you have to go at 17 years or whatever the average working lifetime of employees might be. Employers are taking it at one year. If you don't take the aggressive position, you'll never settle at six or seven years.

MS. CARLIN: That is true. But I think for a new plan setting up now, given the history of the audits, the IRS just wants to make sure that people understand that it's not that easy.

MR. NEMETH: And I think it's an excellent point. I was just trying to point out some of the issues that are uncertain. Many of the rules and regulations concerning the funding of VEBAs are questionable, and I was just pointing out that was one of the issues that inevitably comes up. And you are correct that the IRS does not look favorably upon that. However, as Charley just said, it's something to consider.

MS. CARLIN: I have played the other role in the past and defended that position, too. But I just want to make sure that we're not overly positive here.

MR. MACAULAY: Well, my thought on this is it's our role as consultants to tell the client all of the approaches, the pros and cons, and that it's their tax strategy that decides where we go from there. But I think we don't serve the client well if we say 17 years.

MS. CARLIN: Yes, I agree. The other wet blanket I'm going to throw on the subject is on the life insurance owned by VEBA. People need to be aware that tax-free buildup is not certain, that there are continually legislative proposals to remove that tax-free buildup.

MR. MORGAN: Legislation can change all of these rules.

MS. CARLIN: Right.

MR. MACAULAY: But usually it does some grandfathering.

MR. HOWARD BENNETT SIMMS: Is tax deduction a wasting asset? If the 401(h) vehicle is used, I believe that the tax deductibility for each year is cumulative so that if you did miss it in one year, if I'm correct, you could take an extra tax deduction.

MR. MORGAN: The limitations are cumulative from when the account is established as part of the plan.

MR. SIMMS: So you could choose not to take the deduction even though you could have one.

MR. MORGAN: Your point's well taken. If you make generalizations, you're always going to be wrong in some specific area. And you're right, you never lose it, you end up amortizing it.

MR. SIMMS: Right. And another point there is that, if tax rates go up in the future, you may actually benefit by taking it in the future.

MR. MORGAN: That last is very important. If you believe tax rates are going up, you may want to defer some of this.