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RETIREE HEALTH ISSUES

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This panel will present a discussion of retiree health issues with a special focus on current developments with respect to Financial Accounting Standard (FAS) 106.

MR. ETHAN E. KRA: One of our panelists, Fred Lindgren, is a senior consultant at Coopers & Lybrand's Human Resource Advisory Group in Boston. Fred oversees and files *FAS 106* valuations and defined-pension-plan valuations. As a member of a major accounting firm, he was asked to review the valuations and footnotes of several of the firm's audit clients. Fred has been with Coopers for two years. Prior to that he spent six years at Mercer, seven years as an in-house actuarial staff member at DuPont, and two years at Prudential, where he trained under my supervision.

Also speaking is Bob Barry, Managing Director in the Boston office of William M. Mercer, where he consults on defined-benefit, defined-contribution, health and welfare issues. Bob has more than 25 years experience covering all benefits including the most recent eight years at Mercer. Prior to that, he spent 12 years at Alexander & Alexander and eight years in the insurance industry. It's a great pleasure to have both of these experienced practitioners with us to share their ideas. We'll begin with Fred Lindgren.

MR. FRED C. LINDGREN: Bob Barry and I will be sharing a group of topics on *FAS 106* and my half of the program will cover: (1) court cases, some recent challenges to an employer's right to reduce benefits under their retiree medical plans, and (2) Curtailments—some unexpected surprises when a group of employees is taken out of a plan or when a group of employees stops accruing further benefits under the plan. I have a group of six topics that I've called, "Living with *FAS 106*," which includes accounting under Statement of Position (SOP) 92-6, assumption changes, claims data, disabled employees, triennial valuations, and a definition of what constitutes a plan for *FAS 106*.

RECENT COURT DECISIONS

There are a couple of recent court cases that I would like to talk about. The first case is the *United Food and Commercial Workers Union* vs. *John Morrell*. What happened was the union contract promised lifetime benefits for retirees. When the current union contract expired, Morrell cut off retiree medical benefits for all those retirees. That obviously angered quite a few of the retirees. There are approximately 3,300 retirees and dependents. Morrell said, "No," so the union sued. The lower court ruled in favor of Morrell. The union appealed and last May the Supreme Court declined to hear the case, which basically reaffirmed or let stand the lower court's ruling that the employer did have a right to cease benefits for current retirees when that current union contract expired. The importance of this is it's another case that supports an employer's right or option to reduce benefits for current retirees. So if some of your clients are still considering paring back their programs, it is still indeed possible.

Another case of interest was the McDonnell Douglas case. What happened was, back in 1993, McDonnell Douglas announced that they would only be continuing their retiree

medical benefits for another four years; they would expire in 1996. A group of retirees were upset about this, and figured that this did not comply with what they thought was the agreement between them and their former employer. There were about 21,000 retirees in this case angrily milling around the aircraft plant. They wanted their benefits restored. This was settled by McDonnell Douglas at a cost of about $500 million. They did not agree to restore the retiree medical benefits, but instead, they agreed to increase pension benefits $100 a month for Medicare eligible retirees and $450 a month for pre-65 retirees. It didn't wind up being cash out of pocket for McDonnell Douglas; it merely drew down the surplus in the employees pension plan. I believe that was a voluntary settlement.

This also emphasizes the fact that in retiree medical liability or postretirement benefits, the obligation is very uncertain. It's established by the facts and circumstances of the various cases as well as by the communications that go to the employee. I would urge *FAS 106* valuation actuaries to every year gather from your client any communication material that has been prepared and given to the employee, as well as plan documents. There may be some of us who have done evaluation solely based on interpretation of the plan as provided by the benefits manager and we should accumulate a document file that has communications that establish what that plan is.

CURTAILMENTS

I'd like to talk about curtailments. First, in a work force reduction, let's picture a company that has a large retiree liability and a small active future liability. A company called, The Strictly Vinyl Record Company, shortly before adopting *FAS 106,* grandfathered the current retirees but limited the benefits for future retirees.

It has a large group of people carrying a very big benefit. Amortization of the transition obligation, since they still did have active employees, was based on the active employee, the future working lifetime and the 20-year amortization period. Amortization goes along fine until they have a cutback in the number of active employees, and if 25% of the employees are laid off, then 25% or more of those expected future working lifetimes are curtailed and a huge amount of transition obligation needs to be recognized as part of the curtailment.

Very small changes in the active work force can have a big swing in the annual expense, particularly in years when it might not be convenient to have that expense. Is there a way to avoid the tail wagging the dog or the needle wagging the groove in this case? Yes, there is. If these are deemed to be two separate plans—one for the retirees as of the date of transition and one for the actives as of the date of transition—then the changes in the size of the active work force would only affect the amortization that is being done for those actives and changes in the size of the retiree group would not happen because the retirees would be a closed group of people. The price to be paid for this categorization is that the retirees transition obligation would have to be amortized over their life expectancy rather than the 20 years, but it would provide a much more stable cost.

How do you get from here to there? If they had reflected this in their original accounting, that would be fine. An official plan amendment would not need to take place. If they hadn't, then they can split it into two plans and they should work with their accountants on this, but the transition obligation should also be split according to the liability of those

two different groups. There is a way to avoid having small changes in the active work force result in big curtailment charges.

Another situation that could arise is when there are plan changes that result in curtailment. Some of you may remember the 45 and ten technique where you change the accrual pattern of retired medical benefits from accruing over a full career. If the requirement is age 55 with ten years of service to get benefits, then we presume that the attribution period starts at the date of hire. If the plan says you must have ten years of service after age 45, then suddenly everyone who is under age 45 is no longer accruing benefits under the plan. The accrual takes place starting at age 45 until 55, and there's no impact on what the employee actually receives, but the accounting cost is lowered.

This works fine if it is done prior to adoption of *FAS 106*, but one must be careful about recommending this as a cost-saving measure after adopting *FAS 106* if one has already established the transition obligation and the liabilities. If you suddenly cut a large group of active employees out of the plan, they're going to get something eventually, but they've ceased accruing benefits, and therefore, there's a curtailment. Therefore, there's a huge charge and I would not like to be the actuary standing in front of the finance committee explaining to them that this cost saving measure has just caused a huge one-time charge.

MR. KRA: What would happen with the reduction in the accumulated postretirement benefit obligation (APBO)? In other words, we would be eliminating the amortization years, but we would also be reducing the APBO.

MR. LINDGREN: You would indeed have a gain due to reducing the APBO. If you took half the active work force and suddenly took them out of the valuation entirely, you would have a gain. Depending on the ratio of your actives to retirees, it might be that this gain would be quite small compared to the one-time charge. But yes, you would get to reflect that gain.

If there's a plan change to stop accruing benefits for any future retirees, you can think that might be a great cost saving measure and, in the long-run, it is. However that would also prompt a curtailment. Again, a curtailment is when future benefit accruals are ceased for a large number of active employees. Things that were useful techniques prior to transition can cause unexpected charges after transition.

LIVING WITH *FAS 106*

I'll run through a group of other topics: (1) plan accounting under SOP 92-6 and benefit obligations for plan reporting, (2) assumption changes, how much are you bound by prior disclosures? (3) claims data—problems in the process of getting data from insurance companies and claims administrators, (4) disabled employees and a discussion of the medical benefits for the disabled employees, (5) triennial valuations versus annual valuations, and (6) what really needs to be done each year and a discussion of the definition of plans.

I handed out an exhibit that shows a reconciliation of liabilities from one year to the next. This is a relatively new part of the *FAS 106* environment. It's prompted by the American Institute of Certified Public Accountants (AICPA) SOP 92-6, which was effective for many plans last year. It requires that if there is a funded welfare plan that has retiree

medical liabilities, those liabilities should be reported in the plan's financial statements. The requirements include: stating what obligations were at the beginning of the year and at the end of the year, and telling how they changed from the beginning to end. Also, tell what the basic assumptions were that were used in producing those liabilities and the impact of a 1% change in the trend rate on the obligations.

This information needs to be reported to the accounting firm who is preparing the plan financial statements. Basically, it is information already prepared just after year-end for disclosure under *FAS 106*, with the exception of one item, which is the impact on obligations of the change in assumptions. You may have calculated the impact due to a change in the discount rate, for example. Or it might have been lumped in with gains and losses and experience changes. But SOP 92-6 expects that you would isolate the change due to the change in assumptions.

Another interesting thing arises if the plan is funded under a 401(h) account within a pension plan. Is it a pension plan asset? Do the liabilities go on the pension plan financial or on the health and welfare plan financial? There is a bit of confusion about where this should arise. The consensus is it should be reported somewhere and generally, the best approach is to consider that the 401(h) assets are defined-benefit pension assets and the liabilities associated with those should be reported on the pension financial even though it is not required by the law. If there are other sources of funding for the health and welfare benefits, then there will be also a health and welfare report, which should reference the pension report. I would expect this will be clarified some time in the next couple of years and we will know exactly what to do.

Let's discuss assumption changes after year-end. Many times, right at the close of the fiscal year, we project forward liabilities from the beginning of the year. We reflect a change in the discount rate. We reflect actual benefit payments, rather than expected payments and we're done with our disclosure numbers at that time. A few months later we begin the annual evaluation. We look at actual employee elections of health maintenance organizations (HMOs); we look at actual dependent coverage; and we look at baseline cost. We look at how things have moved, and certain assumptions that we used at the time of disclosure might seem less relevant than they did when we were putting things together at year-end. The question is, how much liberty do we have to use entirely different assumptions?

I think the baseline costs, meaning the claims cost today for the pre- and post-65 people, can be regarded as a data information element, something that could be considered a gain or loss, and reflected as the data develops. On the other hand, trend rates and discount rates are two things that are disclosed at year-end, and if you have already put out financial statements that say, "Here is our best estimate using these assumptions," it's awkward to go back and say, "We really didn't mean to use those assumptions because the facts are now different." You made your best guess at that time. If you want to change the trend rate or the discount rate, it sort of leads you towards saying our disclosure numbers were not really valid. Maybe we should restate those. I think there are very few cases where it's appropriate to change the discount rate and trend rate.

The other assumptions, HMO elections, turnover, retirement age and so on, are sort of buried in the rolling forward process or the estimating process. You have some

flexibility to change those because they weren't stated in the financial statement in the first place.

Who has seen a case where the discount rate for expense for a year was changed after disclosure without being prompted by a major plan change or a curtailment or something? (None responded.)

FROM THE FLOOR: Actually, in the early years of FAS, we saw that, on occasion, companies would disclose year-end based on the beginning of the year notwithstanding that they should be expending next year based on the prior year-end. That continued for a number of years until the auditors finally woke up and said—you're not supposed to do that. The plan sponsor was informed that they were FAS positions and they negotiated with their auditors.

MR. LINDGREN: Have we seen cases where the trend rate has been changed for the expense to be different from what was used in the year-end disclosure? A couple. How about where the mortality or turnover rates were changed for the new valuation? I see a few more hands.

MR. KRA: We should ask, how many people here actually prepare *FAS 106* disclosure information?

MR. LINDGREN: About half.

MS. KATHLEEN SIMMONS COST: Are you talking about disclosing December 31, 1994 numbers and then changing assumptions for 1994?

MR. LINDGREN: No. I'm talking about disclosing liabilities as of December 31,1994 and then for the 1995 expense, net periodic postretirement benefit cost, using different assumptions for that following year.

The next topic I would like to discuss is claims data. How successful have we been in getting the data that we request from the insurance companies or from the claims administrators? What do we ask for? We ask for information for a particular fiscal year for some past history for a split between pre- and post-65, perhaps for a split between retirees and dependents. In some cases, we ask for gross claims reduced by the portion paid by Medicare and the deductibles and so on. Oftentimes, it's just the portion that the employer is responsible for.

What do we get? I've seen quite a range of things. Sometimes we get what we ask for. Often what we do get is late. Sometimes active employees and non-Medicare retiree information is not differentiated. We will get retiree and dependent information mixed together. I'm wondering if there is a better way to collect the data. *FAS 106* has been around since 1990. The types of data needs haven't changed that much, but it still seems like it's a new topic each time we approach it. I look at the example of the compact disk industry. Before it went retail, producers all decided on the format to use. Everyone used the same format and was consistent. Everything is interchangeable. The industry was very successful with that. It wasn't like Beta versus VHS, PC versus Macintosh; Pampers for boys versus Pampers for girls; and so on. It was one standard. I'm wondering whether we, as a profession, can do that for the data needs for *FAS 106*

compliance. We have actuaries on both the giving and receiving ends of things. I can picture an actuary like myself getting an award five years from now from the SOA and the Financial Executives Institute for creating and establishing a standard set of data or standard type of data categories that would be used for transmitting this type of information. When you request the data, people know what the data is because they reported the data last year.

MR. KRA: I think one of the problems we face which differentiates us from the compact disk industry is federal antitrust laws. I think they got some exemptions before they went ahead. Unfortunately, our industry has not had a very high profile in getting exemptions from antitrust from our brethren or opponents in Washington.

FROM THE FLOOR: From my experience on the experience studies for the SOA, I think you could work through the SOA to do that kind of thing. You could put people from the practice area together to check into the antitrust issues. I would suggest the Society might be useful there.

MR. LINDGREN: The SOA rather than a loose collection of people who happen to be interested?

FROM THE FLOOR: Correct. I would form a research committee, and ask the Society to look into the issues. It might take a little while, but an antitrust exemption may result.

MR. LINDGREN: Point well taken. Another reason why this might not have happened so far, is if it doesn't happen, who pays the price for inconsistent data formats? It's generally the valuation actuary who has to go scrounge up more data. It's also the benefits manager who is trying to set premiums for his employees for the following year. It's not the world in general or the people who are buying compact disks. There is not a big penalty spread across many folks.

DISABLED EMPLOYEES

The next topic I would like to discuss is disabled employees. Many companies offer medical benefits, life insurance, and dental benefits for people who are on long-term disability. One employer I work with offers all three benefits, at no cost to the employee. It's not limited to six months or two years duration. It's for the entire duration of disability. They cover the spouse as well, and they cover people who have been employed even a short period of time. If you become disabled after about six months from the date of hire, you can still get coverage all the way up until you recover. This is not a *FAS 106* liability because these people are not yet retired. In many cases, they're considered to be active employees. They might even be accruing benefits under their retirement program. This does not necessarily belong in the *FAS 106* valuation, but it is not necessarily obvious to those preparing the *FAS 112* accrual.

Do you picture yourself as an accountant trying to confirm the *FAS 112* approval? I don't know if I picture myself as an accountant, but I guess others have. You would first go to the *FAS 106* actuary and say, "What about these people who are on disability?" The *FAS 106* actuary will say, "Those people aren't retired yet, so I don't have them in my numbers." Then you go over to the risk managers and you say, "Long-term disability?" They say, "No. We're fully insured for long-term disability. We don't have any liability there." Their comments are based on the income replacement part or the

salary continuation type of benefit, which is fully insured. However, the medical benefits for those people are not fully insured. This can amount to a large number if the benefits are not limited to six months or two years duration, which is not too uncommon. I would urge you to consider this with your clients. If you think that they provide coverage for people who are on long-term disability, first, determine which coverages are being provided. Second, determine how long those coverages last. Third, determine whether these people are considered to be retired or whether they're considered active or postemployment. If they are indeed not retirees, then you should quantify things so that the *FAS 112* numbers will be correct. *FAS 112* deals with the postemployment benefits rather than the postretirement benefits.

TRIENNIAL VERSUS BIENNIAL VERSUS ANNUAL VALUATIONS

The next topic I would like to discuss is triennial valuations, biennial valuations, and annual valuations. What needs to be done each year? There is no requirement under *FAS 106* that the full valuation be done each year. It is required that assets, if any, are correctly reflected each year. It is required that the discount rate be appropriate for the measurement date, but it is permitted to gather information at a date prior and roll it forward. There is no precise definition of how far forward you can roll, but in many cases if there are no plan changes or no amendment curtailments.

It may be possible to take one year's valuation and roll it ahead a year, make an adjustment for the discount rate and use that information for *FAS 106*. For example, suppose there's an actuary going to his client and saying, "Here's my estimate for the fee for doing the *FAS 106* valuation next year." The client says, "That's nice, but I just got a call from one of your competitors who said they can do two years for the price of one and they'll just use the data gathered for one valuation and apply it for the following year as long as there are no major changes." I would have preferred to have been the one who came up with that idea first.

Let's think about what actually needs to be reflected. It's really a continuum. The question is not, do you do the valuation or don't you? It's must we reflect asset changes? We must reflect discount rate changes. Maybe the trend rates should be reassessed each year. Head count changes may or may not be enough to warrant a full valuation. Changes in the actual claims may or may not be enough to go through a claims analysis. There might not be changes in the turnover retirement rates and so on. There are a variety of possibilities for doing some, but not all of the valuation steps on less than an annual basis, so that's something to keep in mind when deciding what cycle should be utilized.

PLAN DEFINITION

My last topic deals with the definition of a plan and I've run up against this issue when a company has a number of divisions that they account for separately and for which they keep separate amortization schedules. One division has a big curtailment and they wonder if they need to reflect that, since it's not significant within the context of the whole plan, yet it is significant within the context of that division.

The definition of the plan can be different for *FAS 106* purposes, for Internal Revenue Service (IRS) purposes, and for funding purposes versus IRS ERISA purposes. You can have divisions of a plan and account for them separately for *FAS 106* purposes, but when you file a Form 5500, they can all be considered one plan. If there is funding going on,

usually there is a trust document that will accurately define what is considered to be the plan. *FAS 106* says that if life insurance benefits are provided for postretirement benefits and if they are significant, then the insurance benefits should be accounted for separately from the medical benefits. Once again you can have divisions that are accounted for as if they are a separate plan.

I would urge you, as a person who has to review the work of some other actuaries on our accounting side, to be consistent. For *FAS 106*, take an approach and go with it and be consistent throughout. Amortization, gains and losses, and expected future working lifetimes should reflect everyone in the plan as you have defined the plan. You can pick a different basis for the ERISA financial, but be consistent within that definition when you do any ERISA-type accounting, because I've seen a mixture of approaches all within the same *FAS 106* valuation report. Pick an approach, be consistent, and preferably disclose that in your reporting.

MR. KRA: Going back to the large spreadsheet, the SOP 92-6, while it's clear that this applies to a single employer plan that has funded retiree medical benefits, I know that a number of people are raising the issue with regard to multiemployer plans where the obligation to provide benefits to retirees is contingent on continued contributions with respect to those retirees and the benefits can be cut off at any point in time. There is no prefunding, but there is a retiree benefit currently being provided. There's no promise in the future, and if the contribution stream stops, the benefits stop.

What is the rationale that anyone can develop for going through this entire complex costly calculation (which cost will have to come out of plan assets, thereby depleting the resources available for plan benefits to the retiree in this multiemployer welfare plan and usually collective bargain program) to provide these financials where there is no long-term promise, but there is currently a substantive plan? Namely, there is a plan; it is currently in place, and it continues as long as the contribution stream continues.

MR. LINDGREN: I do not have first-hand experience with the application of this ruling to multiemployer plans. I do see that the problem in the *FAS 106* type calculations is they were not necessary for any of the individual subscribers to the plans.

MR. KRA: The problem I'm looking at is a specific client situation where originally the auditor felt that there was no need to prepare this footnote disclosure. The individual auditor has since retired and his replacement says—oops, I think we need it and everybody is scurrying around saying, Why? What value added is gained for the expense and fees that will come forth? The actuary is hiding behind the veil of the auditors, and saying if you don't like it, go complain to them.

MR. LINDGREN: In the substantive plan, will we provide benefits as long as there are assets?

MR. KRA: No, the issue is, will it provide benefits as long as there are contributions that support the benefits?

MR. STEPHEN A. MESKIN: I think the value added of doing this as of the current state of the law is that if it's not done, they get fined ($1,000 a day for every day until it gets evaluated) unless the auditor is willing to sign off that it's a clean audit. There is the

potential, it's not absolutely certain and the labor department has not said we're going to make any decision on this definitively until after you have to put these things in so you had better start gathering the data, but it's unfortunately in the current labor law.

MR. KRA: I agree with you that maybe the only benefit is avoiding a government fine, but my question was a little bit more general. What value added, other than filing our required government paperwork, is engendered?

MR. MESKIN: If you want to talk on a metaphysical level, what is the benefit of doing a *FAS 106* for a plan that is being funded on a pay-as-you-go basis where the company decides to change it tomorrow to eliminate the benefits they can. I don't see that there is much benefit—I think it's the same question on a metaphysical level.

MS. COST: I'm still confused. You said the trend rates and the discount rates couldn't change.

MR. KRA: I think the comment made was that in both *FAS 106* as well as *FAS 87*, the end of your footnote disclosure of the funded status of the plan is done on a certain set of economic assumptions. Generally, in the discount rate for retiree medical, you have a trend rate for a pay-related pension plan, and you have a salary increase assumption. Those three disclosed assumptions, which are as of the end of the fiscal year, comprise the footnote disclosure of the funded status of the plan. Most readers of *FAS 87* and *FAS 106* agree that those disclosed assumptions must be used to develop the periodic pension expense or the retiree medical expense for the period starting the next day, January 1, for the ensuing year. So an end-of-year footnote disclosure locks in certain assumptions for the ensuing fiscal period.

MR. LINDGREN: Another way of saying that is that the right time to change assumptions is when preparing the disclosure information.

MR. MARTY STEELE: I guess before you come up with the idea of biennial or triennial valuations you need to check with the auditor, whether you belong to an audit firm or not. A lot of the audit firms say—it's all right to do it every once in a while, unless it's a big change. Until you've done a couple of them, you might not know what annual, normal changes are—given changes in assumptions and census. I think there are some firms that are starting to have guidelines on whether they require it every year, every two years, or every three years. Whomever is signing the audit statement ought to be checked with before the valuation actuary says it's all right to do something one way or the other.

The other point I wanted to make is that, although I agree with what Ethan said about the economic assumptions, depending upon when you measure health care trend, you can get very different readings. There are a lot of broad-based indices. D&H does one, but I think they've recently had 200-basis-point changes in six-month periods. Although the discount rate seldom, if ever, changes from the rate given in disclosure, the near-term health care trend rate will frequently change as much as 100 basis points between December 31 and the first quarter true up for next year's postretirement benefit cost.

MR. KRA: One follow-up to that comment. The actuary does not necessarily set the assumptions for *FAS 106*. Technically, the corporate employer whose financials are reported prepares its financial reports subject to audit by an audit firm. So the plan

sponsor of the corporation picks its assumptions subject to audit by the audit firm. The actuary may have significant input into that process, but technically they're not the actuary's call.

MR. ROBERT J. BARRY: Fred is going to get an award for consistency in data for both requests and submissions. My award, I hope, from the Society is that I'm going to come from off the curb and make everyone think at least of one new idea or one new question. I'm not going to go into the traditional actuarial mathematics, probably because it's way beyond my capability to even understand most of it. I am going to, however, touch upon some ideas that have to do with cost sharing. I believe that, quite often, we are doing things as actuaries with the best of intent, but if someone asked us to measure the area of the top of a table, we'd take a caliper and measure this side to one one-thousandth of an inch and we'd say that's about eight feet and we'd multiply it. I think to some extent that's what we're doing with *FAS 106*. The reason that I think we're doing that is because we've spent a great deal of time defining a substantive plan, substantive plan provisions, and what we should be valuing. But we haven't spent a lot of time or effort defining who shares in the cost of that and the basis for that cost sharing going forward.

I've been in this business a long time, but I don't have a clue about what the trend rate will be three years from now, five years from now, or let alone 20 years from now. I've had trend rates change much more than 200 basis points on things that I'm doing because I have no clue. The whole medical care delivery system changes so rapidly and is changing around this so that we're only guessing at what the future is. I haven't seen any statistically significant methodology for projecting into the future what medical trend rates might be.

With that as a backdrop to what we're trying to value and trying to build these inflation rates in, I think there are some serious questions that come to mind. We did our best to estimate what trend rate would be, and based upon the past, we expected the total cost of this plan to grow from $130 to $190. This is for post-65 retiree in a Medicare supplement type of plan. That's what we expect the cost to do down the road. In 1993 and before, this particular client had provided this benefit to its retirees free, there was no cost at all for this individual coverage for the actual retiree, with dependent coverage excluded. Subsequently and partly due to the fact that they suddenly had to start disclosing these liabilities and cost, they introduced a contribution on the part of retirees. In 1994, that contribution was $10. In 1995, it was $20. What is it going to be in 1996 and beyond? I can make a pretty good argument based upon those contribution rates that it can take one of two courses. The first is that it will just keep continuing to go up $10 a year, so it will be $30, $40, $50, $60, or whatever going forward. The second is that it will continue to double from $10 to $20, $40 to $80, and so on.

What is the future contribution actually going to be that we're going to request of our retirees? How do we get at that? Do we ask the plan sponsor—what do you think? He says—I don't know. What does it need to be for my numbers to be what they are? At some point, we can't just use what their intent is. Do we look at historical values? Do we look at what they think? What cost sharing might they end up at? Do we try to project something that is realistic and ask them what they can afford and use that? My point in raising this is just to get everyone here to think about— the wide range of what would be acceptable and how you get there. We can make strong arguments on both ends of the spectrum. In some ways, although *FAS 106* cures many ills in financial

reporting, to the extent that we had employers who did have retiree medical plans who were expending at zero before for actives, there at least was consistency there. Now there could be a great degree of inconsistency.

Similarly, in determining what is a substantive plan, the question arises as to what is the design that we should be costing out? Perhaps a plan sponsor has a history of changing deductibles, changing internal plan limits, changing the way medical benefits are reimbursed by the plan. For example, at one point in time maybe mental and nervous conditions were reimbursed at 50%, then they went to 80% and now they're thinking of carving them out to someone else and paying 100%. How do we reflect that going forward? How do we reflect changes in the way benefits are going to be provided in the future? Or is it appropriate for actuaries to simply take the plan as it exists today for this year and value that particular plan exactly as is and ignore all of the likely things that are going to happen in the future?

A substantive plan is in fact what exists today, and in theory, we shouldn't be anticipating this, but in trend rate, what is trend? You have to factor in not only inflation and what we expect in price changes, but we also have to factor in the degree of intervention, control, changes in practice patterns, and changes in utilization of health care going forward. That's what trend really means. In reflecting what the appropriate trend rate is, maybe we should give some consideration to expected plan changes in the future. I don't pretend to know the answer; I'm just raising it as an issue.

Second, there's Medicare. We can see that Congress is going back and forth on Medicare reform. There's the significant impact that changes in the Medicare reimbursement stream could have on our employer clients. If, in fact, it's moved to age 67, then a lot of plans out there that are providing pre-Medicare eligibility benefits only might be assuming huge liabilities. If, on the other hand, after we go around the cycle a couple of times with different political environments, Medicare is expanded to cover the elderly noninsured, then that's going to be a very large load lifted off the employer, perhaps paid somewhere else through general taxation. My point simply is that Medicare is a large part of the health care burden for retirees post-65 today. It's covering 70% of the cost. What we are projecting forward as a substantive plan assumes no changes. Is that really a reasonable thing to do? Are we doing an appropriate service by simply following the strict guidelines in *FAS 106*?

MR. MESKIN: In the context of doing a realistic projection, you may be right, but in the context of doing a *FAS 106* valuation, you're totally wrong. You can't take into account wished for or expected plan changes, changes in Medicare. Unless the plan sponsor is definitely making a change and has announced it, it's not supposed to be in the valuation. While it may be unrealistic, the *FAS 106* valuation has to take into account the current plan as it stands and the current law as it stands and there's no choice.

MR. BARRY: That's correct. That's my point. My point is that, if in fact we anticipate changes in the delivery system, then what do we apply as working rate trends going forward, what pieces of information should be built into the trend rate?

MR. MESKIN: I don't think you can take into account changes in the delivery system in the trend rate either.

MR. BARRY: I'm not sure. I don't know how anyone can define what the trend rate is; that's my point.

MR. KRA: I think that we should differentiate those items which are in the control of the plan sponsor and those items which are generic to the entire health care delivery system. Those items that the plan sponsor controls, I think we can only look to that which the plan sponsor has already agreed or decided to do. However, those items that are beyond the control of the plan sponsor and generic to the entire health care delivery system, I contend, should be recognized as part of the trend to the extent that there are changes in hospital billing systems and state regulation. I think that's just part of what's going on and is affecting the actual cost. We are not permitted to anticipate legislative changes, such as a change in Medicare or a change in Medicare reimbursement rates.

I believe that there was something specific in FAS that said that we're not permitted to anticipate those types of changes. However, I don't think it would be that unreasonable to anticipate that insurance companies change their claims processing systems and continually update and get better control of duplicate payments to the extent that's part of the expected trend, but I think I'll throw that open. I don't think that it's clearly defined. I'm just staking out a position that's open for discussion.

MR. PAUL J. DONAHUE: An example that occurs to me is that in the Medicare supplement, post-65 market there is an increasing shift toward HMO plans that formally met resistance among retirees for which the supplemental liability would be much smaller. It would seem to me that if an employer plan permits that kind of choice that it would be very reasonable to project increasing choice of the HMO plan and decreasing liability because of that.

MR. BARRY: That's a real good point. I don't disagree with anything that Steve had to say. My point is that there's an amount of reasonable discussion that could be had around the point of what you're trying to project in the future. It is not as clear-cut to what the plan is, or what the "trend rate" should be going forward. If we think about the elements that might affect that and factor them into our valuations, and I'm going to talk about Medicare-risk HMOs in a minute—then maybe we're doing a better job of coming up with the real liability.

MAXIMUM EMPLOYER SHARE—"CAPS"

Whenever there's a new pronouncement, standard, rule, law, or whatever, we, as actuaries, are very creative people. One of the first things we do is come up with new ways to get around it. Fred mentioned suddenly going from age 55 with ten years of service, to having ten years past 45. It can have a very different impact on an employer, but it's just a subterfuge of what we're really trying to get at.

Another thing that has really come into vogue is what I've called caps. Caps are maximum amounts that the employers will pay as part of their share of medical costs.

These things take the form of flat-dollar caps, flat-dollar-per-year-of-service caps, and both pre- and post-65 different caps. McDonnell Douglas, perhaps not naively, ended up with a cap of $450 for pre-65 coverage and $100 for post-65 coverage by simply going into a negotiation process. Those are caps because that $100 and $450 aren't going up

after day one and their $500 million settlement, I would venture to say, didn't hurt them relative to what it would have been had they not done what they did.

These caps take these different forms, but what do they really mean? First question I have is—are they real or are they a myth? Many employers put these caps in simply as a method of deferring the need to recognize inflation in medical care costs. We're going to put in a cap that limits our benefits at whatever the 1998 costs are expected to be. We're not going to provide an employer contribution above what that level is. In effect, by putting that plan provision in place, I've eliminated the need to build any inflation or any trend beyond 1998 into the calculation whatsoever. Is that cap going to really operate?

There are many consultants out there who have advised their clients along the following lines: let's assume you put a cap in today (meaning back in 1993) and it's expected to cover the cost through to 1996. If, at that point nothing has changed (the government hasn't changed what they're providing as far as Medicare and you still have the same problem) maybe you raise the cap at that point. Your auditors won't require you to continue to say, "That's a recurring event that you're going to have to factor in." Maybe you can get away with doing that twice. My question is, what is a cap and what does it really mean? When is it a reality and when isn't it? I don't pretend to have the answer to that. It depends to some extent on what negotiation process takes place between the employer and the auditors.

One thing that is important is how these caps are calculated versus the working rate. There's a big difference between putting in a plan that I'm going to cap the cost at $6,000 per head versus I'm going to cap the cost at whatever the 1998 costs are. If the 1998 costs are expected to be $6,000 when I first filled that in, the next year that might be quite different and those two things have different impacts after that first year. For those of you who have clients out there with caps, you just might want to think about how these different caps might apply going forward and how many times they can change them before they have to reflect that.

Next, we're going to talk a little bit about funding of these benefits. As you know, for a lot of reasons, not the least of which was revenue pressure, the IRS has really not come forward and said—gee, we'd love for you to fund these retiree medical benefits and so we're going to let you tax favor them and set money aside and not tax it at all. Because of that, and because of the relative inability to invest in tax-favored vehicles, there have been some interesting funding techniques that have come about. Two of these are corporate-owned life insurance (COLI) and trust-owned life insurance (TOLI).

In theory, in COLI, an employer has an insurable interest in the life of their employee to some extent. If that employee were to die, they'd need to replace them and they have some insurable interest. Because of that, the employer can be the owner and beneficiary of a life insurance policy on an employee and the proceeds of that life insurance can come back to the employer on a tax-free basis. The theory behind this is, I take a life insurance policy out on employee A, they die, I get the proceeds and I pay it out to employee B in terms of medical benefits, retiree medical benefits, or anything else that I wanted to fund using this technique. I get the benefits tax free, it's tax deductible, and so I get a high degree of leverage. In fact, these types of products routinely generate, depending upon the interest rates available, 16%, 17%, or 18% returns for companies that get into this.

There are a couple of issues. One is whether or not the employer truly has an insurable interest to the extent of the amount of insurance they're taking out on the individual employee's life. The second is, whether an employer can borrow back the funds in these policies, in essence making the life insurance a sham, so that money isn't really even set aside. It's just that they are giving money to an insurance company, taking it back and paying some basis points for the use of the insurance company's product. That's what I refer to in here as COLI and TOLI.

The current products available today are very competitive. Many of the commissions that were formerly paid on these products have come down to nothing. The loads are virtually nonexistent. As a matter of fact, there has been some press about some of the recent big companies that have done this, like WalMart, for example. WalMart just put a billion dollar premium into a COLI. They obtained that billion dollar premium from the insurance company. They were able to choose the way they invested it and they're paying the insurance company, in essence, 65 basis points for that to be considered life insurance. Those assets will then be used to pay a self-insurance life insurance fund, but because of the arbitrage on the tax-free benefits, it has a very high return. Those are the products that are out there today (until the IRS or someone else shuts them down), and they provide a financial vehicle that makes sense for many people. There are some significant challenges to those products continuing.

From an actuary's standpoint, in valuing *FAS 106*, if these products are, let's say in the trust and owned by a trust, how do we value them? You can value them as the cash surrender value of those policies as of the date of measurement or you could try to recognize and get the auditor to accept that there's a cash flow expected from these life insurance policies that will cover this liability. You in essence would build in your 16% assumption as the return on this asset. That is the expected long-term rate of return on this asset over time. In fact, that might be the appropriate discount rate for this stream of expected payments. There's a question mark there as to whether that's appropriate. I know I'm on the edge of much of this stuff. It's not unintentional, but that's the type of thing that's being considered by many people today. The point is to make you aware of how these products work and how they might end up being used. Ethan, did you want to add anything to that? Ethan is sort of a specialist in this.

MR. KRA: First, you must differentiate funding versus financing. Funding is dedicating specific assets for a purpose. Financing is just the financial strategy that provides the cash wherewithal that permits you to spend the money on that purpose, if you so desire. For example, a 401(h) is a funding vehicle. When you put that money in for retiree medical, it will be used for retiree medical and nothing else until the last person is gone. On the other hand, something like leveraged COLI is a pure financial device, because that money comes into the corporation and is very fundable. There are companies that have bought leveraged COLI or it has been proposed that they buy leveraged COLI to finance the commissioning of nuclear reactors. The same cash flow could be used to finance retiree medical or anything else. When that money comes in, the company can decide to do anything it wants with it. That's financing. That's one of the big differentiators you want to get into in discussing these issues with clients.

Second is, why has Congress been so reticent to permit the funding of retiree medical? Up until this past year, the Democrats have controlled Congress so I think I best express the viewpoint by paraphrasing a very influential Democratic staffer, Phyllis Sporsey, who

was the senior staffer to Representative Clay in the House on Labor. Her comments were as follows: "Who gets pensions in America? The better-to-do of the elderly. The less well-to-do of the elderly don't get pensions. So the better-to-do of the elderly are already getting a very major tax expenditure. Who gets retiree medical? The best-to-do of the pensioners. Do we want to expend more tax dollars or tax expenditures on the wealthiest of the elderly?" Her position was no, that if you're going to make money, congressional tax expenditures through the tax system, they should be on the poor rather than the well-to-do elderly. Therefore, she opposed any tax break for prefunding of retiree medical. That was the position staked out by some very influential people on the staff on the Democratic side of Capitol Hill, and that was a major driver in policy up until this past year. It's also a very big dollar item in cost.

COLI involves no trust, is usually leveraged, involves very little cash flow from the company, and generates very high internal rates of return; that's financing, not funding. TOLI is usually in a 501(c)9 trust. Real dollars are going in, and they're being invested. What Congress is attacking in the proposed tax legislation as well as the IRS in the audits, are the leveraged COLI programs. Nobody is attacking right now the TOLI programs. The TOLI programs are not part of the attack by the IRS or Congress. The IRS is attacking leveraged life insurance. We do know one very major case that is probably going to go to tax court and there are a number of others under audit. I don't know where the bill stands right now, but the bill that left the House Ways and Means called for effectively some form of repeal of the tax deduction for leveraged COLI for policies purchased, I believe, after the June 1986 cut-off. I don't know if there has been any recent negotiation on the Hill to try to change that grandfather date, but it would effectively kill the leveraged COLI programs that have been put in since mid-1986. That's where we stand on that one.

Insurable interest is very much a state law. In Georgia, the law is named after a very major food packager headquartered in Georgia; there is insurable interest in every employee's life. When you get to New York, it's very difficult to buy leveraged COLI on a large buy-based group because the New York State Insurance Department is very tough, much tougher on insurable interest.

MR. BARRY: Next time I'll be more careful with what I call funding. That's COLI and TOLI. Split dollars is another type of use of life insurance. This is starting to get more and more use by many employers. This is a methodology to shift the employer risk of providing postretirement health care or supplemental retirement benefits or anything else to the executive. A split-dollar policy is simply a permanent life insurance policy, and the employer and the employee share in the premium cost. The employee's share is very small. In essence, the cash value build-up is tax-free or tax-deferred and allows for value to be created in the policy that can then be transferred to the executive upon retirement.

That value is in lieu of what might be other retirement benefits. This is becoming more and more heavily used and to the extent that the employer has taken out this split-dollar policy and has committed to the employee to pay their share of the premium, it eliminates any *FAS 106* or *FAS 87* or whatever benefit its value is replacing. That's why it's seeing some of the popularity that it is.

Fred mentioned data. In our opinion, it's very important to reconcile data. We see a significant lack from the providers in (not that it is their fault always) their ability to track

separate claims for pre- and post-Medicare eligible retirees and to give consistent information to valuation actuaries. I think it's very important to track this. It's also important to note that it takes quite a few person years before you have any credible data on self-insured cases for you to forecast or develop working rates. We've been doing some studies recently for some very large companies. We're trying to track that and build what we think is an appropriate credibility spectrum. When you have 1,000 person years, you have about 50% credibility and you need 3,000 person years before you have 90% credibility. That just gives you a rough idea of some of the things that we've done recently.

MR. LINDGREN: Bob, would that be 1,000 pre-65 and another 1,000 for post-65?

MR. BARRY: Yes. Another thing to be very careful of is reserves. One thing to bear in mind is that with all the changes that are taking place in the medical care delivery system, especially for retirees, the change in payment practices is great, so you'll see a high degree of variability in how rapidly dollars are flowing through the system. You just have to reflect that and test it so that the reserves that you typically would get from an insurance company who is simply using a factor appropriately for their whole block of business might not be appropriate for any one of your clients. You want to take great care in just looking at the speed at which payments are made.

We do some work for the State of Massachusetts' plan, and despite the huge size of the plan, last year we saw a huge difference in the speed at which payments were getting through the system. Had we not reflected it in the reserve calculation, it would have made a big difference for them.

We've already talked about this a little bit, but one thing just to note on developing a working rate and measuring it against the cap is we think that some great care needs to be taken to make sure that there's consistency in how that working rate is developed. If it's coming from a third party, we think there is some testing required to make sure that it's "reasonable" because of the high degree of variability. Extra caution should be employed here.

Administration of a cap means if someone were to say, for example, "I'm putting in a cap of whatever the costs are in 1995 for our plan and we're never going to pay more than we did in 1995," at some point we have to determine what the employer's share of cost was for that year and convert that to some rates. They're not going to pay more than that share of the overall working rate in 1996. We need to set the contributions for retirees early in 1996, but we don't know until the end of 1996 whether or not they were sufficient. How you calculate the working rate is important in helping the auditor understand that the employer is not picking up any additional portion of the cost in 1996. That may be the intent and we have to make sure that the work we do in developing the rates follows that intent.

Let's discuss medical risk contracts. What do you project going forward? There are many new contracts where the HMOs are willing to accept Medicare reimbursement as total payment or they require a contribution from the retiree. I think a classic example is of a good HMO that came out with a product a couple of years ago whereby the retiree had a choice of their normal retiree plan, which was $92 a month, or they could take a retiree plan where they got basically full coverage, except drugs were limited to $1,000 a

year, and that was $39 a month, or they could have full coverage on everything, except no drug coverage and that was free. The retirees, they had their own choice. As an employer, I'm not going to try and value my liability. My retirees are choosing these various contracts. The first question is, what's the appropriate trend rate to build in the future for those premiums that I'm going to pay on that contract? That's a tough one. To some extent it depends greatly on whether or not that HMO is right in its bet that they'll be able to control costs so they do not lose money. It might be for example, that the trend rate that we assume for the zero contribution is much greater than the one that we have for the full cost coverage, because we expect that they're not going to be able to continue that practice going forward. How do you value these things going forward? It's not an easy answer. If suddenly age 67 were to become the age at which Medicare eligibility started, these people are going to have to rethink their whole Medicare risk contracts and what they're offering. How would we value that in a valuation is, to some degree, a matter of art.

MR. ROBERT G. PLUMB: Just to update everyone, we have a very similar situation to *FAS 106* called SSAP 24. It applies to all U.K. companies and subsidiaries. Therefore, if you have clients in the U.K. you have similar provisions. We have supplemental medical, so the actual costs are somewhat lower. Actuaries issue guidance notes which include some views on trends and, in addition, there are papers dealing with the developments of trend assumptions. We have in the past year had a court case where the employer some years ago had modified the retiree medical benefits. A group of patients got together and challenged this in a court case. The employer lost because the original announcements had been very specific, not only on the benefit level, but the insurer to be used had guaranteed benefits for the lifetime of the employee, and as a consequence, the court ruled that the employees were entitled to have this.

MR. KRA: I'd like to share with you a court case in which I was an expert witness. Since the court case was settled out of court, I'm reticent to divulge the names of the parties, but I feel comfortable, since it's well-settled, to at least describe the issues.

Around 1990, the company significantly increased the contribution requirements for retiree medical from a nominal amount to at least 50% of the total cost of the benefits. It was a very substantial increase in the contribution requirement to continue retiree medical. At the same time, the company significantly reduced the retiree life benefits, which benefited primarily former executives. This company had undergone significant change through acquisition and divestiture, and the retirees that were left behind that were affected, were from operations that had been significantly sold off or shut down so that the current management had very little connection to the people who were getting the benefits. A lawsuit ensued, led by the former executives. The ones who were suing, leading the charge, were the ones with the greatest loss on the retiree life benefits. Their loss individually far exceeded the value of the retiree medical benefits. They were losing hundreds of thousands of dollars per person of paid up life insurance. The case was going to court.

The defense position was basically the plan allows us to change benefits. There's the reservation of rights clause. The counterclaim by the retired executives was that they never meant to do that. The intention never was to do that and the executives would get up on the stand and testify to that extent. The response was, "But wait a second, back in

1984 you did change retiree medical benefits and you did cut them back. What we gave them was a benefit improvement."

The loss of first-dollar coverages was significantly more important and costly to the retirees than the increase in the lifetime maximum; therefore it was a benefit take-away in 1984. When that was finally demonstrated beyond any question, the two sides came together and settled out of court at something substantially less than what was being asked for. These cases can hinge on not only the written documents, but the historical pattern. You have to look very carefully at all the facts and circumstances.

The question very often comes up as to why fund? Bob was talking about funding. The first question I ever ask the client is, why do you want to fund? Then I get two red herrings. They say, "We have to fund to get the liability off the balance sheet." The other comment I get is, "It will reduce the *FAS 106* expenses because now we have more plan assets. It will be an offset to the *FAS 106* expense." But if you're funding to get the liability off your balance sheet, there is no Christmas tree with million dollar bills hanging on it with which you're going to fund. If you fund, that money comes from one of two sources. Either you're taking it out of corporate cash, or your borrowing or somehow getting it in the capital markets. If you're taking it out of corporate cash, yes, by funding you're reducing the accrued *FAS 106* expense, but you're also reducing corporate cash. You're not changing corporate equity; you're just changing the balance sheet. On the other hand, if you're borrowing the money, then you're replacing one liability, a *FAS 106* liability, for another liability debt to bondholders. In fact, you're replacing a very soft liability with a very hard liability.

I question the comment that I often hear: "We're reducing this accrued expense and getting it off the balance sheet." What you're doing is getting assets off the balance sheet or are you putting another liability on the balance sheet? The other is, "I'm reducing *FAS 106* expense, because remember—if you fund, you have an asset." That generates an expected return on assets. That is an offset to the *FAS 106* expense, so it reduces *FAS 106* expense. But if I put the money there, it must have come from somewhere. Again, if I took it out of corporate cash, I may have reduced *FAS 106* expense, but I'm going to reduce interest earnings. If I borrow the money, I may reduce *FAS 106* expense, but I will increase interest expense.

The bottom line is I haven't changed anything unless the *FAS 106* funding vehicle will generate a better after-tax rate of return than the cost of those funds or the alternate use of those funds. If I can generate a better after-tax rate of return, then I do reduce the *FAS 106* expense, so why would anybody ever want funding? Why should anybody fund? Just to bug the two major drivers. There are certain types of companies that will. First of all, if you can generate a better after-tax rate of return in the funding vehicle outside, such as perhaps a 401(h) vehicle because of the tax shelter, that is a driver to fund. On the other hand, some companies will get rate reimbursement only if they fund. For example, a utility may be able to put it in the rate base only to the extent they fund. They have a strong driver to fund—the "cost plus" where you can pass it on to somebody else. Also, if you fund, you're taking it out of cash, you're taking the liability off and shrinking the balance sheet without changing equity. You've now improved your equity ratio.