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Medicare Retiree Benefit Plans

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Summary: This session examines benefit plan design dynamics, including FAS 106 impacts, involved in Medicare retiree plans by discussing some typical examples. The situation is viewed from the perspective of the retired employee's plan choices and the cost implications to the retiree and the employer. Healthcare cost trends, especially pharmacy trends, are also addressed.

Mr. Dale H. Yamamoto: This session is intended to cover the employer-sponsored retirement programs for Medicare beneficiaries, though we will touch a little bit on pre-65 retirees. Fr the most part, we are going to limit our discussion to medical benefits for Medicare beneficiaries. John Bagley, one of my colleagues at our Newport Beach Office of Hewitt Associates, will start off, and I will follow.

Mr. John Bagley: Managed care. First, who really wants it? And two, is it broken? Does it need to be fixed? We won't be able to answer these questions for you today, but we certainly would like to talk through some of the possibilities, some of the trends, and other issues associated with managed care plans, specifically as they relate to retirees.

The answers to those questions certainly have varying opinions. I'm certain everyone in this room has one. If we were to ask some HMO or managed care participants how they felt, I'm sure the results of employee satisfaction surveys would also be mixed. We've got members who are dissatisfied with their managed care organization—they've got long wait times to set appointments and they have to go through a myriad of red tape just to see a specialist.

Does it have to change at all if we change perspectives to talk to employers? Many that I speak with currently are often concerned about managed care, whether it's working, specifically with point-of-service programs. Does the capitation, pre-paid fee model work, or is it breaking down? Does that answer change if we were to talk with providers? Day in and day out we see issues with providers, in terms of pushing back pretty strong against insurance companies and others and trying to get them into capitated arrangements. We've got provider groups that are going bankrupt. This is stuff you read about in the paper every day.

Does that answer change if we were to talk about insurance companies? Certainly there have been a lot of withdrawals in many key markets for insurance companies. Every day, another merger and acquisition seems to be unfolding before our eyes. These are some tough questions, all of which we will touch on as we walk through what we're calling the current state of retiree health care. We'll talk about some trends and other items. We'll follow that up by briefly talking through retiree plan design choice, we'll hit some specific employer concerns, and give some case studies to back those up. Dale is going to take us through some *FAS 106* issues and trends. Finally, we'll close with an interactive discussion about what the future holds for retiree health care and what that might look like two, three, or ten years out.

It's probably no big surprise that costs are continuing to rise. Costs are actually affecting retirees in a couple of different ways. First, from a premium perspective, we are seeing clear upward inflation in premium rates. Some of that translates over into retiree contributions and sometimes it doesn't, based on the employer subsidy. One significant finding is that currently a lot of managed care organizations do offer zero-cost or low-cost HMO offerings. This has been decreasing significantly and continues to decrease into 2000.

Regarding basic plan offerings of these managed care organizations, not all encompassing, but just the basic type of plan offering, some of these managed care organizations, on average, increased those premium rates almost 300%. Again, that might seem like a huge number, and to some extent it is. But we are talking about premiums that were, on the average, about $5. And those are increasing upwards to $15. So on a percentage basis that certainly is a lot. But from a dollar basis, it is still relatively small, but it's a sign that things are certainly changing and will be going forward.

The other venue that is going to affect retirees is through the plan design. Some significant trends that we'll also note cover the office visit and the specialty visit co-pays. We're seeing 20% upwards to 40% increases in the types of co-pays that are being leveraged on to retirees, and they often have to pay through out-of-pocket costs. That's the wrong way.

What we're seeing here is that although, on average, premium rates are increasing a lot, health care is very much a local issue, market by market. There are a lot of states that don't offer any kind of Medicare+Choice program. What we're seeing here is that the rate increases do vary, quite significantly, as you see represented here. The poor folks in Oklahoma, Louisiana and Kentucky certainly are experiencing some pretty dramatic rate increases. But it does vary quite significantly, and it is very much a local issue. Every state has its own issues as it relates to managed choice, managed care, in their retiree populations.

The cost decreases in annual health care of the mid-to-late 1990s are really a demonstration that one could use to support managed care and all that it has done. In the late 1980s and early 1990s high inflationary numbers certainly occurred. Healthcare costs soared to a high of 18.6% in 1988 and 17.1% in 1990.

But over the mid-1990s, even into the late 1990s we saw very low, if not moderate, rate increases. In 1994 costs actually decreased 1.1% and in '97 they rose only .2%. But again, the question goes back to what we are seeing currently. In 1999 costs increased by 7.3% and in 2000 by 7.5%. Is this something that we should be afraid of? Is this something that is going to continually be on the rise? I know a lot of health care actuaries are certainly concerned about it, and certainly build these types of numbers into their projections going forward.

Things certainly differ by delivery system. Again, this would advocate that managed care has worked insofar as it has reduced the per capita costs of your traditional fee-for-service programs quite significantly. I did bring up a point earlier, that some employers are questioning the effectiveness of the point-of-service delivery system. It certainly is not generally as heavily capitated as the HMO product, but many employers would ask, am I really getting what I'm paying for in terms of financial efficiency of that product? A lot of per capita comparisons will show very similar results between the PPO product and the point-of-service product. Obviously some of the differential in discount is made up due to the fact that there is some heavy capitation, in some cases higher administrative expenses. This is a conversation that we're having every once in a while with our clients because they obviously are concerned about it, they worry about it, and it does vary company to company. But it is a concern that might need to be addressed.

One big part, and this will come as no surprise to some of the inflationary trends that we're seeing today, revolve around prescription drugs. It's not so much in just the general inflationary nature of the prescription drug itself where you see that. That tends to be a bit more stable than some of the other elements in terms of the tendency of the drug mix that is occurring, as well as utilization. It's been brought up several times today in a couple of the other presentations that I've been a part of that although we see these high trends in prescription drugs, should this alarm us? Because what we do see, or what these folks are recognizing, is that some of the outpatient services are decreasing as a result of some different treatments and a different drug perspective. When you look at it in and of itself, it is very alarming when you start to see these types of trends. They are very significant—just huge.

What are companies doing in order to control some of these prescription drug costs? Some of the things that we've certainly seen include a new look at plan designs associated with prescription drugs. Many employers are increasing generic co-pays. More often they are starting to increase brand-name co-pays. They've introduced three-tier co-pays, formulary and non-formulary. There's even been some talk by some employers that have implemented four-tier structures, where the fourth tier is not covered or an exclusion list.

Many managed care organizations and, in particular, some of the Medicare Risk HMOs, are forever changing the annual plan maximums on prescription drugs $500 or less. In 1999, 42% of managed care plans were designed with a $1,000 maximum drug benefit; but going into 2000 and beyond that dropped to 36%. That has really changed quite significantly, and we anticipate that it will continue

down that road because the plans that limited coverage to $500 or less jumped from 21% in '99 to 32% in the year 2000.

In fact, one of the things that I found surprising indicated that, going into 2000, this will be the first year in which no Medicare risk plan is actually offering a no co-payment associated with prescription drugs. It was unfathomable to me to think that there are obviously some plans that don't charge for prescription drugs. In 2000, that's changed. There are no longer managed care plans that are offering a no-cost prescription pay type of program.

So a lot is changing in terms of plan design. What we're seeing here is that there is certainly a decline in the number of generic applications, most notably in recent years. But that is certainly being offset by a huge increase in the number of new drugs being introduced into the markets. What we are showing is that the pipelines are certainly full. There are lots of new drugs being introduced every day, which will only compound our problems associated with costs going forward.

Even though more patents are following day in and day out, what we find is that, surprisingly, the cost savings from going to generic will not come close to matching the increasing costs going into the industry as a result of the new drug offerings. That's a pretty big discrepancy.

Does direct-to-consumer advertising play a role in this? I'm sure it does. Patients now have visits and conversations with their PCPs, talking about the latest and greatest treatments and drugs. Surprisingly, post-65 and pre-65 retiree populations are spending more time online, researching their particular conditions or diseases, doing a lot of research that they normally wouldn't have done in the past. So the direct-to-consumer advertising is brought right to the physician's office, and it certainly has an impact.

The big drugs are getting bigger, without a doubt. Two sales forces of pharmaceutical reps will target providers who write a significant number of those prescriptions. Promotion costs, in 1999, from the drug companies was $6.1 billion. The drug industry is absolutely phenomenal.

Let's move away from cost and talk about plan performance and member satisfaction. We touched briefly on this, but there are quite a few organizations drawing from what they would consider key markets. That certainly creates disruption for the member and it creates headaches for the employers. Approximately 13% of those contracts were not renewed in 1999, going into 2000. How does that play out? Although 13% of the contracts not renewing seems like a significant number, I guess when you really try to break that down, you do provide some more comfort in that roughly 5% of the beneficiaries were affected by those withdrawals. Sometimes that occurs because a lot of these withdrawals were occurring in rural areas. Even less so, only 1.3%, or 79,000 of those affected, actually had to move back in to the fee-for-service or traditional Medicare programs.

Organizations today are, again, just retouching on the fact that these organizations are finding themselves in survival mode. No longer are they willing to buy into a market like the days of old. It's creating a need, a necessity to survive by merging; merging with other organizations that they can more easily build a network, or move into an area where they don't exist, or expand in certain locations.

There is a 20/20 report that stated on average, doctors spend fewer than 30 seconds talking with you before they have already diagnosed you, and they move on to the next patient. To me that's an alarming statistic—under 30 seconds. That's probably one of the biggest complaints that you see from members or any Medicare risk type of program.

Coming back to the capitation model, is it working? In California, we had a pretty big disruption when Med Partners declared bankruptcy. There are some organizations that had a significant membership or partnership with Med Partners that created significant headaches for us.

As a result of all of this stuff that is out in the marketplace, many insurance companies are re-thinking some of their strategic issues and where they want to be, and where they don't want to be. Although managed care enrollment has doubled since 1995, it still represents a very small fraction of total Medicare membership. As a result there are some markets where you are not going to build up enough market share. You're not going to have enough enrollees to sustain the business.

There has always been this conversation around—what's driving organizations from drawing particular markets? Typically you measure this stuff annually. They're starting to be able to release some of the specific information in that respect. And some of the evidence, or some of the facts, are quite surprising. One would expect that in those areas where payment levels are the lowest, you would think that's where you would have most of your disruption, with your withdrawals. But the facts thus far would suggest otherwise. Really, most of the disruption, most of where these enrollees become significant, are in the mid-level payment range of about $450 to $500.

The same would be said with low-payment growth rates, where again, you would expect in those areas, where you're only getting a 2% minimum growth rate, that's where you would find most of your disruption. But, they're finding exactly the opposite. In the moderate growth rates, where they are receiving 10%-plus on increases, more enrollees are being affected.

So it really comes down to, what are some of the other reasons that are actually making these decisions for your organizations? The fact that they don't have adequate networks in some markets. They cannot sustain the number of enrollees, or a small number of enrollees, they have in a particular markets. There are obviously some different reasons why organizations are choosing not to participate in some locations.

Administrative complexity. Boy, retirees today are faced with a myriad of choices. They have employer plans, often several HMOs, maybe a PPO option, maybe a point-of-service, that type of option, if you're pre-65, especially. You've got your Medicare-Plus Choice options, you've got some Medigap options, just lots of choices for the retiree, and that creates an administrative headache for the employer. How do they administer all these different plans? It certainly adds to the administrative costs of employers. Employers are continuing to grapple with ways of limiting liability, grandfathering groups certainly continuing to increase or rise. So what we see is that the more grandfathered groups you add the more administrative complexity enters into the equation. Forty-five percent of employers have implemented some type of defined-dollar-cap on employer subsidiary as another way of limiting this liability.

We're not going to get too much into the government's role in all of this. There have been several sessions that have really gone into much more depth than we're prepared to cover today, but this is just more of a for-your-information. I'm sure most of you have already read about a lot of these types of issues. Again, prescription drug coverage. The big question is, How are we going to pay for this? Roughly one-third, 35%, of Medicare beneficiaries have no drug coverage from any source. What are they doing today? Well, they're shelling out a lot of money. On average, $40 average cost per script, retirees are using 20-25 scripts per year, and that adds up to a lot of money for these folks.

Perhaps the government could extend Medicare itself, the whole package, to some different groups, regardless of age. This could include low-income groups prior to the age of 65 or an option to buy into Medicare at age 62 for displaced workers. There is a real possibility that the eligibility age for Medicare will increase gradually to coincide with Social Security at age 67.

Mr. Yamamoto: Now we want to talk a little about the different options that are out there, available to a lot of retirees. Going back to before the Balanced Budget Act of 1997, this is what the Medicare System looked like for that particular retiree. The choices that they had were the traditional features, which are Part A and B, Hospital and Medical Benefits. You had the option of some Medicare Risk programs. You also may have some Medigap options available through groups like AARP, Blue Cross, and a lot of other insurance companies offering Medigap programs. Or, if they're lucky enough, they had some kind of employer coverage, which may have been an extension of the active plans, a subsidy of a Medicare Risk program, or they could have been an extension of their current medical plan, a self-funded program that integrated with Medicare.

After the Balanced Budget Act, things actually looked a little bit simpler, but I think it's more complicated because under the Medicare program, they now have a continuation of the traditional fee-for-service and the Medicare Risk programs. But in addition to that, they have Medicare Select, the PPO program, but there have not been any plans offered yet. The first private fee-for-service plan is being offered, I believe, starting last month or this month. And that's going to be offered by an insurance company in something like 14 different states across the country,

primarily in rural states, where it made some sense with the reimbursement scheme.

The Medicare+Choice programs also have options of Medicare savings accounts, but again, there are no plans being offered right now.

Back on the Medigap side, you still have the same Medigap programs. There is talk about making different legislative changes. They are reforming those programs as well as the Medicare+Choice and self-funded programs.

One of the things that we are discovering when looking at how retirees, specifically Medicare beneficiaries, shop and try to come to some understanding of their health conditions, what should they do? What type of plans should they look for? What kinds of information are they trying to get at, if they find out they do have a disease? We are actually finding more retirees are beginning to use electronic means, like the Internet. We found through some studies that almost two-thirds of the retirees or 65% of people over the age 65 actually do access the Internet. And one of the most looked-at things is health care related information. They're looking at diseases and specific kinds of information. So if they've got some disease, they're looking on the Internet to find out what others have said about it, whether it's the Mayo Clinic, Dr. Koop, or whatever site that they have found out there on the Web, they're looking. They're looking for information that really is directed at them.

Of the Internet users, in general, 29% say they highly trust online health information, which is kind of scary. But only one-third of the retirees actually do some purchasing over the Internet. They are still scared about using electronic means. It's like giving your credit card number over the telephone.

One of the things that employer plans are doing now is trying to help retirees work through their choice, giving better communication materials about what is out there for the Medicare+Choice programs as well as the offerings that they make. We are looking at large employers in these statistics because they are coming from what we call SpecBook, and that has 1,050 very large employers, generally 5,000 employees or more. But out of that group, 65% of them offer some kind of post-65 coverage, and 45% offer managed care options to the post-65 retirees. And 90% of them have some kind of subsidy to the program. In other words, there's another 10% that have absolutely no employer subsidy. That's something that we have noted over time. And we did a look at companies that we had on the database from 1991 to 1998, just to look at the group of companies that haven't changed. So we had to take out a lot of companies that existed in '91, don't exist today, companies that exist today that didn't exist back in 1991. But we took a look at that common quorum of companies, and we saw a pretty remarkable trend—with higher retiree contribution levels as a percentage of the cost of the program. We also saw higher co-pays, in some fashion, whether it's higher deductibles, higher office visit co-pays, higher out-of-pocket matching, or whatever you're looking at. Whatever kind of plan design provision we looked at that really

shares cost between the plan and the retiree, we saw that the retiree got most of that cost shifted to them.

Let's discuss the three case studies that we had. This first one is probably something that a lot of you have already run into and have actually experienced something very similar to this. You have a client saying that we've got open-ended liability going back to *FAS 106*. What can we gain? They can't. They can double the current cost and even grandfather some of their current retirees and those eligible to retire. That would produce an overall reduction of about, in this case, 30% in *FAS 106* costs at this time.

Mr. Bagley: This second case study is a large financial institution who has been, in the last five or six years, just going through a tremendous growth mode. They've been acquiring smaller financial institutions, and some larger financial institutions, primarily on the West Coast, but to some extent across the country. And every time they've purchased one of these organizations it came with a different set of liabilities and a different retiree medical program. And they were starting to reach a point where trying to maintain all of these different benefit structures just became impossible, from an administrative standpoint, just from communicating, just from understanding, and to the groups with what was actually occurring. So again, in an attempt to limit this liability every time they went through a major acquisition, they decided to implement a cap in terms of what they were willing to pay out. And in fact, their new strategy going forward is to freeze the subsidy level that is currently being provided by the employer that they are acquiring.

That certainly has a significant impact on limiting liability going forward, but certainly isn't something wonderfully easy to communicate to members, to retirees, but it is a reality of the business that they're in—very low margins. They have to really work hard at providing a consistent message throughout the organization of what their goals and strategies are, and essentially limit them. They also have to have legal counsel, obviously, that believes in what they are doing. It certainly has created an easy open enrollment, much simpler to administer, and much easier to calculate.

This last case study gets back to this whole provider disruption issue. This is an organization that truly identifies its brand through its employees. Every interaction with its employee is a significant one, because it impacts its business. This is an entertainment client. It got caught in this whole Med Partner fiasco. As a result, it wanted to try to implement some strategies behind contracting, so that it could try to prevent to the extent it could, because some of this is outside of their control. And so some of the things that it did was fairly simple, but it certainly went out, and with all of its relationships, with all of its managed care organizations, certainly feel much more comfortable today than it had on how those provider contracts are maintained.

It has gone so far as to insist that the organization that this employer chooses to partner with have underlined contracts not only with the IPA group itself, but also with the underlying physicians. In case something does happen from the IPA

perspective, from a more global perspective, it feels it has a little bit more coverage and less provider disruption as a result. Then it also insists on some satisfaction surveys, requiring these carriers to frequently correspond with their providers and feed that information back to the employer. Its wants not only feedback about what's going on, but in cases where definite holes exist or miscommunications exist, it needs to work through a game plan on how to resolve those going forward.

Mr. Yamamoto: I'd like to talk a bit on how *FAS 106* is affected by a lot of the things we just talked about. I'm going to focus on three things of the *FAS 106* valuation. Number one is current trend rates and how that meshes with the assumptions being used in 106 valuations right now. Something else that we talked about is our caps. They, of course, have been implemented. How should that be implemented in a 106 valuation? These are things to think about.

Given that we've got more employers that are giving retirees choice in a lot of different programs, here are some things to watch out for when you have a client that has more than one option available, especially more than one self-funded kind of option. One of the first things I took a look at is their 106 trend rates. This is somewhat old, but it's the only financial statements we have available. Going back to 1998, we took a look at the assumptions menus by any one of the Fortune 500 companies offering retiree medical benefits, and then we took a look at what their 106 trend rates were. That's the first rate that was used in the current year, 1998. The next one is the ultimate year. I looked at three years of history for the client group that we're taking a look at. Back in 1996, the trend rate on average was 8.7% down to 5.3, and when you look at the pre- and post-65 trend rates, there are some differences, but not a lot. It's somewhere around that neighborhood.

Generally pre-65 fund rates have tended to be higher, on average when you look at the disclosures in the report. In 1997, we're 7.8 down to 5.2%. Interestingly enough, you still get the same 2000 for your ultimate years. That implies to me, I think, that people have kept the same assumptions, back when they first adopted 106. But 1998 was the first year we saw the average start to creep up a little bit, from 7.3% to 5.1%. So I think employers are starting to change the trend rates they use in the valuation. But again, it's gone down.

Taking a bigger look at that from an initial rate perspective, just looking at 1998, you can see almost normal distribution around that 7.8%, somewhere around 7-1/2% starting rate in 1998. Two percent of the companies are actually using 11%-plus, and 1% are using less than 4%. We actually have a client using pretty low trend rates, but we had it increasing over time just because of some peculiarities with their plan.

Ultimate trend rates are hovering around 5 or 5½%. Again, you don't see as much dispersion as we did with the initial trend rates. I think everyone has kind of narrowed in on that 5-6% range being something that everyone feels comfortable with and the year that the assumptions would ultimately hit, the final year, a lot of

them around 2001, 2003. There are actually a lot of the Fortune 500 companies out there that will be hitting their ultimate year this year.
How do you measure that up with what's been happening currently? Going back and looking at the 106's, we see in things trending down. We have the same period, 1997 out to 2000, actual trends are trending up. Again, in general, trends are higher. These are not assumptions, but are costs that we are seeing from our clients. The more general and broadly used statistics seem relatively low trends back in the mid-1990s and slowly increasing to our estimate for 1999. For active and the pre-65 group would be about 10%. We are seeing the post-65 group a little bit higher at 12%. The difference between those two is predominantly because of prescription drug benefits, which is close to two-thirds. Half of the value of the benefit for post-65 beneficiaries, given those trends we've already looked at, are anywhere between 15% and 20%. Combine that along with 8–10% medical trend rates and you end up with something that is more like 12.

John spoke of all the different trend rates that we're seeing for the Medicare risk types of programs, the Medicare+Choice programs, and I've had a lot of people just stop and ask, how can we continue to see 200, 300% increases in the Medicare+Choice program? You're seeing the trends in the first place, because of the leveraging that is going on. Medicare pays most of the cost breakdown. They're paying 90-95% of the cost of Medicare+Choice program costs. As they keep their costs down, they keep their subsidy level down simply by controlling how much is awarded to the Medicare+Choice programs. It means there's a bigger gap being created that someone has to pick up. That someone, generally, comes in the form of extra contributions to the plan. If the Medicare+Choice plan doesn't change the plan design, which John also alluded to, the fact is that we'll be seeing higher co-pays, which we have seen being introduced already. That's partly to keep the costs down and keep the cost increases reasonable.

If we think that Medicare+Choice plans are still a viable option and that our clients are going to maintain them in the future at whatever level that might be, then we need to ask a crucial question. How much longer can we see the increases of 200%, 100%, or whatever they are? I actually came out with a guess that I thought it could at ultimate time, and I'm not going to commit where that ultimate time is, but it's probably 10 or 15 years from now. But at some point in time, the Medicare Risk HMO is going to equalize, or come close to an indemnity plan, and then probably trend at that same rate going out into the future. So if you've got healthcare trend rates for the indemnity program that's rating down to 5% or 6%, I'm saying at some point in time, you're not going to see the 100% trend rates anymore, increases in Medicare+Choice plans, you're going to see that 6% kind of increase. And you get to that point in time where the HMO costs are about 80% of indemnity plan costs.

I just came up with that number out of thin air. Someone came up to me later and asked, how did you get that number? I didn't have the guts to tell them I came up with it out of thin air, so I sat down and tried to figure out some things logically.

What would impact the HMO costs, relative to the indemnity plan costs, to get to some kind of price difference at some ultimate point in time?.
In theory I'm thinking an HMO is going to have some lower prices available to them, even going out into the future. So that's a slight discount difference. That's saying that the HMO providers are getting paid less than the indemnity plan providers by that factor.

Another factor that might enter into the differences between an indemnity plan and an HMO is a risk difference between those that select an HMO versus an indemnity plan. I think anything that we would come up with would be something reasonable. I would guess HMO participants may actually be better risks at some point in time, but I also have the counterargument that at some point in time, going out into the future, HMOs will tend to have a better plan design and better programs. So there is a chance that some of the less healthy people actually consciously make a decision to go to an HMO. So I decided not to have any kind of risk difference between an HMO and indemnity plans. An HMO has better plan designs, which tend to get people who are less healthy because they use the benefits a lot, so they want more benefits being covered. But I think you also get the phenomenon that people who do use health care providers a lot don't like HMOs. Some of that mentality is going to change. We're counting on that, so I don't anticipate any kind of risk difference.

The utilization difference. We're planning that an HMO is going to be 8% more efficient than an indemnity plan. This number is based on some analysis we have done of plans that offer both HMO and indemnity programs and studying the utilization differences. The difference was 5-10%, so I settled on 8%.

Plan design differences. Out of that total dollar amount, how much is the plan going to pay? An average indemnity plan will pay about 85%. The average HMO pays about 94% of total plan costs, and this is fairly typical for the different plan designs that are currently available today. If you cross multiply those four numbers, you get $6,694 for the indemnity plan, $6,486 for the HMO. Given the same risk characteristics, Medicare, will pay $6,200 on average.

Adding drugs back in, I'm making another assumption that an HMO is going to be more efficient at purchasing drugs, so there's a 10% difference there. So add a thousand, add $900, and come up with $1,494 and $1,186. And I added the 7-9% difference. I actually did that without fudging any numbers, so I stopped.

Let's say ten years is the ultimate where I think we're going to get to that 79%, 80% kind of level. There are a lot of different ways you can think of trying to develop that trend line, between the first and the ten years, but, graphically this is one way to solve for the equation of what the dollar amount is ten years from now and figure out what the exponential trend should be for the HMO. I'm seeing some other ways to calculate that would be to take the gross cost for your health care costs. Subtract from that the Medicare reimbursement with some kind of computed Medicare reimbursements, so you add the differences there, and see what the trends on both of those pieces look like.

Actually, intuitively that probably makes a lot more sense to do it that way because in reality, that's what we're seeing now, relatively high trends in the 50-100% kind of level. We would anticipate that leveling off to get to that 80% level.

Moving into the issues on value of fixed dollar or cap plans, we have to measure what the subsidy of the plan is. How many of you have clients that have some kind of fixed-dollar cap to their program and you have to do a fixed evaluation? Do you ever do a claims development? If you've got a client that just said, we are going to pay $2,000 per head, what do you value? You're going to pay $2,000? On the subsidy of the plan, you're not going to waive the cap? What do you value? How many people just value $2,000?

I actually had that question posed to me in kind of a backwards way, because we had some actuaries internally ask, should we include a per cap claims development for any client that has a per capita program? (Because we're only valuing $2,000.) We're just valuing the cap as an annuity, just like a pension plan. It's not any different. And my argument to them for doing the per capita claims development is, the clients don't always get that per capita cap correctly. And a lot of times, we don't even know how they developed that cap, and how the cost gets passed onto the retiree.

So I think every time we do a valuation, if someone in your company is not doing the calculation to develop the cap for what the complementary retiree contribution is, you should become acquainted with this information. Make sure the client is doing it theoretically correct, as close as possible. It's going to vary from year to year, but I do have a lot of clients who say they have a cap, but I'm going to take you through an actual case study. The numbers are doctored a little bit, but it's pretty close to the way my client was thinking about how their cap was being applied.

They said they got an employer subsidy cap of $2,000 for pre-65 and $1,000 for post-65. But we never got any claims information for a long, long time. We trusted that we were passing on the right contribution to the client. I doubt that we needed to show what the best estimate of the employer obligation was. The reason behind that is, a lot of times, as I was saying, the actual employer obligation isn't necessarily the cap, because they may have been in control and calculated the total plan costs for that coverage group. But you want to make sure, just like you would on any valuation that doesn't have a cap, that you don't have any hidden subsidies buried in there. A lot of times, and this was true for this particular client, they're capped, and the way they calculated the retiree contributions underneath this cap was for the pre-65 retirees, so they used the blended active retiree rate.

Now if you're doing a regular evaluation, you would note that you can't use this blended active retiree rate to run our *FAS 106* valuation. We have to make some kind of adjustment, whether we collect claims or make an age-related adjustment between the active versus retiree rates. We know we do that, but a lot of times we miss it when we start doing the cap. And in this example, the client was paying

a total cost of $2,500 for the pre-65 active kind of rate; it had the fixed subsidy of $2,000, so it was charging the retiree $500. Now forgetting about the subsidy issue, if we were to develop a per capita cost for pre-65 retirees, we would probably have come up with something more like $4,500. Applying the same $2,000 cap, the retiree rate should have been $2,500. Where does the mismatch come in? If you're including a valuation and just value the $2,000 benefit, you've understated the pre-65 liability by that difference of $2,000. That's a pretty substantial deviation from where the valuation ought to be.

From the Floor: At the end of the year when you need to true up based on actual cash flow, do you typically talk with your clients and make the statement adjustments in the *FAS 106* calculation to unblend the pre-65 costs up to pure retiree cost, and at the same time also, then possibly advise them to decrease their active expense on a pay-as-you-go basis?

Mr. Yamamoto: Theoretically, that's what you're supposed to do. In practice, I don't think it ever happens. So in the end, when you do pay out the benefits to the last retiree, you probably have, over the years, built up some pretty big gains in your account. But I think, theoretically, if we're making any kind of adjustments that the client is not doing internally with the cash flow going on, and they are also expensing, there should be a reduction in that actual cost rate—something that will make up that $2,000 difference.

This doesn't surprise anyone that has done any kind of retiree medical work that some of the differences that happen with the fixed dollar and the cap benefits is that you end up at some future time, 20 years from now, in this situation. If you value the substantive plan, and you're keeping the cap level, at some point in time, and I picked 20 years in this case to illustrate to the client, you really think the same percentage of retirees electing the program today will still be selecting the plan. You're only subsidizing 18% of the costs versus 90%. Usually they will say no, we have to anticipate some people not electing the program.

I just want to make people aware that when we make that conscious election, saying that we're going to get some people not electing a retiree medical program, be careful. Retirees are smart. Anybody is smart in selecting medical plans. They are going to elect a plan if it's going to benefit them. For example, if they don't feel it's going to benefit them, if they feel that they can get by with some nominal Medigap kind of coverage, perhaps being covered by their spouse's plan that really isn't capped. Or if they can get by with something that is really nominal that they can buy outside, they're healthy and they don't need the employer plan, those are the people who are going to tend to drop the plan.

So let's look at just a simple case or a simple example of what would happen if we get fewer people going to a retiree medical program than what we have today. A way to look at that is, let's say we've got 100% of the people enrolled right now. We've got $5 million with 1,000 people being covered; you've got an average claim of $5,000. If you think that 20 years from now only half the people are going to elect the program, and let's say there's no health trend going on, so we can go on

using these numbers. The cost for the 500 people that are still there is not going to be $5,000. I'll almost guarantee that.

What I think will happen is, we'll get some adverse selection. We have seen that with active programs and flexible benefit programs. You get selection between a higher benefit option versus a lower benefit option with people opting out of the program. People who stay with the plans tend to be the higher risk types. They cost more. And the people that you lose tend to be healthier. In other words, you're going to lose half the people, but you're not going to lose half the plan. In this situation, you lost half the people, but you only lost $1.7 million in claims. So I'm estimating that the claims for a person will be $6,600, so in effect, what the difference is between $6,600 and $5,000.

Some insurance companies would consider that the selection adjustment that is going on is between 100% of the population being covered versus 50%. So it's something to keep in mind when you start developing the selection, thinking that participants are going to drop through the program. You also need to take that extra step. What's going to happen to the claims cost? It's not going to be just a linear kind of reduction in the claim cost. The ways to reflect that would be implicitly by just assuming that you are only going to lose, instead of 50% of the people, maybe you lose 25% of the people; that's going to get at almost the same number. Explicitly what you have to do is say we're going to lose 50% of the people, but your per-capita-per-claim trend is going to be much higher than it is right now. You have to back in to what that higher trend rate ought to be.

Another question I get a lot of times, especially when we're seeing more options being available for retiree programs is, How do I develop the rates? Especially when you have a client where you're only getting one big lump sum of health care claims spent by the whole group, and they are in two different options. And a lot of the times, what you're going to also get is, you get two different options, but one is a frozen group, and the other is where the new retirees are going to. The new retirees are going into a lower cost plan, higher co-pays, higher deductible, higher out-of-pockets.

I'm saying it's okay just to blend all the experience, come up with rates on an average for that whole population if you don't think the distribution of retirees 20 years from now, in the future, is going to be any different than it is today. If you have any reason to think that it is going to be different because the subsidy level is going to be lower in the future, you've got a group that's been grandfathered and they are in the higher cost kind of program. If you see any historical shifts that have gone on, you've got a large population in Plan A but it's decreased over time, I'd say it's not good to have a purely blended rate. Here's simple example. What happens if you have two different plans, one costs $5,000, one costs $4,000, in the year 2000, again assuming no trend just for illustration purposes. That's a pretty dramatic difference. And 80/20%, but ten years from now it goes to 40/60. We see a decrease in the cost of the plan. That's something that the client will probably want to see, and reflected in the *FAS 106* evaluation, is a decrease in costs if they are trying to move people to that lower cost Plan 2.

Mr. Bagley: We talked about some merging trends, we talked about some of the problems with managed care. I think Dale and I wanted to end our part of the conversation talking through some of the future possibilities for retiree health care. What's this thing going to look like tomorrow?

Mr. Yamamoto: Again, when plan membership drops from 1,000 down to 500 people, it does save you costs because what you're doing is, you are getting people who have redundant coverage out of the program. You get in people who are lower cost on the program because they could find better alternatives elsewhere. I don't mean there's anything wrong with it, it's just that they want to make sure that you don't overestimate what the potential savings are by just continuing to reflect that $5,000. That's the point I wanted to carry across.

Mr. Bagley: What we wanted to do was at least talk through some possibilities of what the future may hold for retiree health care, both the immediate and long-term. I think it's pretty safe to say that over the short term, we're certainly going to keep seeing a lot of the same stuff that's occurring in terms of introducing far more subsidies. It would be based on some type of years of service, either developing some type of cap on the liability or cap on the subsidy.

Technology improvements over the last five years have certainly facilitated the ability to come up with much more complex types of subsidy schemes, being able to handle different types of grandfathered groups. But that certainly increases the administration burden. By the same token, there is some more flexibility that comes out of this, as a hybrid of this whole technological improvement. That's what we're seeing today.

Mr. Yamamoto: One of the plan designs that was floating around over ten years ago was the program that Pillsbury put out, where they gave everyone a lump-sum amount for their years of service. And at retirement, they convert that to an annuity. I talked to clients ten years ago about replicating a program like that. Under their programs they say there is no way we could handle that administratively. I think things have changed so much in the administration areas that we actually are seeing more clients interested and re-interested in what Pillsbury had done. Trying to come up with different little twists on that, IBM has a program that did come out with something very similar to what Pillsbury did ten years ago. They see it as something radically different, but it really was just a twist on what Pillsbury did over ten years ago. We're just going to begin to see more of those, more complex kinds of designs coming out just because computers are bigger now, they can handle things quicker, and we've got so many programmers out there that would love to do stuff like this.

Mr. Bagley: It's true. I think we've heard a lot about this whole defined-contribution model. It's certainly been circulating quite a bit over the last year. I think Xerox was probably the first company to finally throw up their hands and say, you know what, we're getting out of this business. They went public with that in a couple of statements in newspapers. As you know, they did receive a lot of

feedback from their employees to the extent they had to retract some of the statements they were making.

But certainly, down the road, five years out, I certainly would be interested in hearing some of your feedback on this. But in terms of some of the limitations that currently exist, certainly a taxation model on how to handle the monies, I guess you take a step back. First of all, what's your definition of a defined-contribution model? Some may argue that some employers actually practice a limited form of the defined contribution model today. Any employer that, as part of their contribution strategy sessions, stipulate that we will only pay for a medical CPI increase on behalf of the employer, and effectively passes the rest of that rate increase on to employees, to some extent, is practicing a defined-contribution model. They are not specifically handing this person cash and telling them to go buy whichever product they feel they need to, but to a limited extent, some employers are already practicing this type of a concept.

So I do have to be careful in terms of just throwing defined contribution model, because it does vary in terms of who is defining the defined contribution model. But I think if we were to look to a full-fledged defined contribution model, that would be one where one day you provide some type of money voucher to the retiree or to the employee, because it certainly could occur for active populations as well a retiree populations. Allow them to either select from a select few plans in the market place, or allow them to just open up the entire market place, and allow them to select whichever programs best fit their needs.

That certainly does create some taxation issues and some delivery issues around how does this thing become administered. Who is administering it? The employer essentially gets out of the administration business, but that's a scary proposition when you're talking about a valued benefit that is important in the whole attraction and retaining of employees. And to just simply give that process up, and leave the employer out of that part of the business has positive developments, but it also has negative developments. I guess moving forward with that, it's certainly a reality. I would say that there is going to be a segment of the employer base that will choose to move under those arrangements. Certainly I don't think it's for everyone; certainly it's something that I think we will see more and more of. I don't know if anyone else has a reaction to the defined-contribution types of knowledge.

Mr. Bagley: I don't know of too many employers who are actually contemplating reproducing the retirement or retiree medical type of program. In any event, they're certainly looking for ways of cutting those costs, whether it is getting out of that business and just saying we're going to wash our hands of the entire event. That's probably more of a predominant type of stance that we're seeing today, and that would include moving to a model where they could get out of the administrative difficulties associated with their retiree program. I guess I'm not disagreeing with you, but that's certainly what we would see as well.

Mr. Yamamoto: Actually it was brought up at a management meeting for one of my clients, and they were discussing the issue. Why should we offer benefits? And actually the majority of the people with this plan came to the conclusion that because of the hiring practices that we have, we are hiring more relatively high-level people around their mid-forties. They actually ask the question, "Do you have medical coverage after retirement?" This is probably an unusual company in the fact that that's where a lot of their hires are at higher pay levels. They're not high enough to be executives, where they would be covered under an executive contract. But they're high enough that they want to attract them into the company, and get a good last 10 or 15 years of employment out of the person. They saw that as probably being the highest recruiting requirement that they are facing over the next ten years. But that may be a one-in-a-hundred company.

From the Floor: You mentioned two ways that employers are looking at controlling health care costs. You mentioned cost tax, and you mentioned service pro rates and employee cost sharing. Have you seen any backing off of offering dental or vision coverage for the pre- and post-65? Or requiring an employee payoff for that ancillary coverage? That's my first question.

And my second question is, we talk about the aging of the work force; I suspect that you have seen similar phenomenon among your clients in that they are hiring older people; not mid-career people, but older people, either people who have retired from the company and now they need them back, or just older people in the work force service industry. Have you seen any pressure on changing the eligibility for post-retirement health? Most of the clients that we deal with have pretty liberal eligibility when you get to be a higher age. Are you seeing your clients or employees giving a greater service definition? How are employers dealing with the issue of someone who might already be eligible for post-retirement coverage some place else, coming to the company and getting effectively, immediate eligibility?

Mr. Yamamoto: There are some general trends that we're seeing for our clients, like higher eligibility requirements. It used to be 55 and 10 years was the most common. Some people actually accidentally went to 55 and 5 with the vesting requirements, going down from 10 years down to 5, but most are 55 and 10. We're seeing a lot more companies, with more stringent requirements, like 60 and 15, something higher than 55 and 10, than there were in the past.

The other one is on the ancillary benefits, dental and vision. I don't have the statistics, but I know when I looked at that fixed group of companies from 1991 to 1998, many of them did drop a lot of the vision and dental coverage. We saw less of those benefits being offered than we did ten years ago.

Mr. Bagley: I was going to say probably more that are not offering it, but certainly in some cases, charging more for it.

From the Floor: Certainly in a number of areas, we've seen retiree health care provisions and benefits evolve from active medical benefits. One obvious example is the increased prevalence and acceptance of managed care and retiree health

care. I think another one you see is moving to an environment where the retiree pays the difference if the high-cost plan is elected. I know that a lot of employers are developing an active medical strategy right now that works along those lines.

Have you already identified other trends that you see right now for active medical care that you see evolving to retiree health care in the future?

From the Floor: There are some trends going on in California that you should watch for every place else in the country.

Mr. Bagley: That's probably true. One of the things that we are working quite a bit with our clients out in the California area I guess can be termed as HMO consolidation. A number of clients of ours used to offer 50, 60, 70 different HMOs and some clients still offer that many choices today. We're finding it's absolutely imperative to take a look at these program offerings on a market-specific basis and really determine what's called the financial efficiency associated with those programs, and whether it makes sense to have those HMOs offered at all.

And if they are to be offered, along side of PPO point-of-service product, how many do we offer? So I guess there is some general trend that I've been noting with our clients to actually consolidate the number of plan offerings from this huge, massive event that generally took place.

So we're sitting down and figuring out what, on an active employee basis, makes the most sense in each market. Not necessarily advocating any type of micro-managed process, where you have 25 different vendors in 30 states, but at least taking a critical review of your plan offering, from the managed-care organization perspective, and seeing which ones make the most sense to offer. That's certainly a key trend.

Mr. Yamamoto: I think one of the trends that we're seeing on the active side is health plans or managed care organizations getting away from the concept of your primary care physician because of the pressures that they've had on them with the current programs. They are also getting away from a lot of capitation kinds of contracts. But, at least what I've noticed in the active health care contract negotiations that are ongoing right now, for our clients, is scary. On average, we're looking at 13, 15% increases in HMO rates for our active employees right now. I see that tracking off onto the retiree groups, too.

Some of the things I'm seeing on the active side I'm translating into higher costs for the retiree. We're seeing higher costs with active employees because of a lot of the things going on. A lot of the external health care legislation that's happening is putting pressure on health plans to increase reporting requirements, increased things that they're giving to employers. Employers are scared with what's going on with a lot of the patients' rights legislation and just the entire rise in costs.

Mr. Harry L. Sutton, Jr.: I have a couple of questions about prescription drugs. You indicated it's 30 to 50% of the retiree cost, but on fee-for-service it was 100%

for some HMOs. One, are employers starting to drop that out of their retiree benefits, the change in benefits? And two, if the Clinton plan of providing universal prescription coverage is at a very low limit, would the employers provide drugs at that limit if they now have unlimited prescription drug benefits?

How do the employers react to the President's proposal to replace that basic level of providing prescription drugs for everybody on Medicare? They don't know what would happen to them if the government decides to spend the money on something else. How do you see the possible change in the prescription drug coverage for Medicare beneficiaries affecting employers' drug coverage plans?

Mr. Yamamoto: I can almost look to a report I have in my PC. We actually did a survey last December with employers describing the administration's program, and asked them directly, what would you do to your plan? Would you eliminate the plan, would you eliminate the plan but also subsidize the new Part B premiums? Would you wrap around the new Medicare program? We asked a lot of different possibilities, the way they could handle the plan. I think it was about 35% of employers who said they would likely drop their program and do something with the new Part B plan. And there was another 25% that said they would keep their plan. They wouldn't care what the administration did. They would just keep the program.

It's hard to say if they really would. If the new Part B program proved to be successful, then I think they would have to do something with that, to take advantage of the fact that the government is paying half the cost of that plan. You're just throwing away part of their money if you don't somehow coordinate with that program.

Mr. Bagley: An alternative you might see is what many of those employers that right now do a carve-out. They calculate what they would have paid, had there been no Medicare, subtract the Medicare reimbursement, pay the balance, and will continue to do the same. So Medicare pays 50%, the plan calls for paying 80, the employer's obligation now will have gone from 80 down to 30, and I see quite a few people doing that.

Mr. Yamamoto: Buried in the administration's plan, too, if you do something like that you will be reimbursed one-third of the cost of the plan instead of 50% if you pay the full cost of the plan. I think what they would do is they are going to figure out a way not to do that, and coordinate, like you say. In our estimate, we didn't anticipate anyone would accept that one-third employer subsidy.

There are a lot of other Medicare reform proposals currently in Congress and in different phases right now. Senator John Breaux (D-LA) has a program that's actually more expansive than the Administration's plan. The Republican party has some different things, like a catastrophic program. I think there is a good chance something may happen in the next couple of years for prescription drug coverage under the Medicare plan, which hopefully will lead to reduce the four-year obligation.

From the Floor: Just wanted to round out the numbers. Instead of 35% give or take that might drop the plan, 20% would keep the plan. What about the remaining 20%, plus or minus?

Mr. Yamamoto: They are going to do something, like Ethan says, to keep the plan, coordinate with the Medicare program, maybe even pay for the new Part D premium, the triple net premium.

From the Floor: Just going back to some of the *FAS 106* and trends. It just seems there was a pretty sizeable disconnect between current trend rates that employers are using in their evaluations, and actual trend rates that we are seeing today. I guess my question is, how do clients justify that, and then secondly, do you see current trend rates going there?

Mr. Yamamoto: I'm glad you asked that question, because I was going to ask. We didn't get any. I would like a show of hands from people that are doing a lot of 106 valuations, Do any of you have pressure from your clients to not increase the trend rates they're using right now?

I have. Anybody else? The argument that I've used with that is, we've got higher trend rates right now. They're above where we had them in the past 106 valuations, but we'll track here in 1994, 1995, etc. How many of the auditors came back to us and said, "All right. You got lower than expected trends, you got a 3%. Should we lower the assumption?" I didn't get any of those. I did get pressure from clients saying you need to lower it so we can lower the *FAS 106* costs.

From the Floor: I think what you said is exactly on point, because what you're seeing is that people are trying to claim this is an anomaly, it's just out of the pattern, and until you see a new trend developed. People try to drive through the rear-view mirror. We always accuse the actuaries of being the single profession that drives through the rear-view mirror. People are looking backwards saying, what was over a few years ago, and saying oh, what's going on right now? That's just a few bumps in the road; let's see where we've been.

It's the same thing with pension valuations when interest rates went up. It took a long time until the valuation interest rate went up and interest rates came down. It takes a long time. It's very sticky. Assumption sets tend to be very sticky, and it takes a while to figure out where you're sitting.

Mr. Yamamoto: Good point. I think when you do see trends like this, three or four years, there is going to be the added pressure to reevaluate how your trends are used in the evaluation.

From the Floor: Are people still using these trends in the *FAS 106* valuations just for the managed care plans, or for the Medicare+Choice plans also? Or are these rates just like for an indemnity plan?

Mr. Yamamoto: Go for the indemnity plan rates. I guess the scary thing is, when a lot of us put in managed care programs into retired medical programs, our anticipation was, health care trends ought to be lower than indemnity plans. So we may have indemnity plans trends are going from 10% down to 5%, but managed care plans with flat 5% trends, even though what we are seeing now are much higher trends. That's the primary difference I've seen; when we differentiate between indemnity plan trends and managed care trends is that the managed care trends that are being used in valuations, if they are different, tend to be low.

From the Floor: We talked about the premiums for the Medicare+Choice plans going from $5 to $15. Are you guys trending those same dollars the way you trend an indemnity plan, or are you making them what you really believe they may be?

Mr. Yamamoto: Our firm has a lot of actuaries and they do a lot of different things. I have to admit, the clients that I'm working with, I'm using some relatively high trends. That's what I'm using, personally, but I would have to admit, there's varied practices within our firm about what gets used.