RECORD, Volume 27, No. 1*

Dallas Spring Meeting
May 30–June 1, 2001

Session 40PD
Trends in Corporate Post-Retirement Medical Plan Designs

Track: Health/Pension

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Summary: Panelists cover recent developments and future possibilities for employer-sponsored retiree medical plan design. Experts discuss trends in plan design over the last few years and their vision of what they expect employers to do over the next few years. Case studies are presented along with prognostications of long-term expectations.

MR. DALE H. YAMAMOTO: I'm with Hewitt Associates. The panelists are two people that have been working on retiree medical benefits for a good portion of their careers. They're going to share some knowledge and background on what they're seeing their clients doing as far as recent trends, and also some prognostication of what we think is going to happen in the future.

During the career that I have had in working with retiree health care designs and employers, and trying to figure out what they want to do with their programs, this is probably the second time in the history that there's been something hidden out there that has some influence over the efforts of what employers are doing. The first one was FAS 106. It was the accountants that said, "Guys, you have to really account for these benefits while they accrue," so it opens employers' eyes up as to what their obligations are. I think the second one was what happened to Erie County, the small county in western Pennsylvania, that has all of a sudden said, "When you take a look at these programs, you really have to account for them. You have to pay attention to the age discrimination in employment act."

There are a lot of legal experts that disagree with the decisions the court made, but it's here, it's out there, and it's raising the discussion right now as far as what employers would really need to do or want to do with their retiree

Note: The chart(s) referred to in the text can be found at the end of the manuscript.

medical programs to kind of a heightened effort. I think before the court case there was a lot of discussion. At least in the consulting that I've done, employers have started to take a look at other reasons, primarily financial reasons. They're reaching caps that they might have set because of FAS 106, and they're seeing double-digit health care trends again. They want to attack it in some fashion, and the retirees are a natural progress, but I think the Erie County case is bringing up a whole different discussion.

Our first speaker, Erich Blumberg, is with Hewitt Associates in the Dallas office and he's going to talk primarily about what we've seen in recent history. Then Ed Pudlowski from Ernst & Young, also in Dallas, will take you to the future and look at the future state of retiree health care.

MR. ERICH BLUMBERG: I'm going to discuss the situation through our current state. Every year Hewitt does a survey. We send it out to around 3,200 employers and this last year 650 responded. A lot of the questions centered on what they are doing with retiree medical programs and what they are considering doing in the next three years. These were pre-Erie decision surveys. This new decision and the impact it's going to have is not included in the survey information that we have here. Then Ed is going to take us through some of the future state of retiree medical.

What are employers saying? The simple question is, "Do you provide benefits?" When we talk about benefits, it's not "Do you provide access to a plan at full cost," it's "Do you subsidize and sponsor retiree medical programs?" From the surveys this last year and 2001, there is a slight advantage for the pre-65 retirees, of whom 61 percent receive post-retirement health coverage, versus the post-65 retirees, who are at a little more than half.

Of the question, "Does your organization offer Medicare + Choice?" only a quarter indicated that they are utilizing it. Then we asked the question, "What do you plan to do in the next three years?" It was fairly unanimous that nobody was going to increase benefits and that everybody was going to look at some form of retiree cost sharing to manage costs. The next approach, which is gaining a lot of momentum, especially as you approach the Medicare caps that you may have in place, is a shift to a defined contribution (DC) approach. I suppose you could let retirees purchase their own coverage. That sounds very exciting, but we know that's not an option today. At least there is a DC pricing approach in which you provide employer-sponsored plans for them to pick from. Offering only managed care as an option is also an alternative that's being considered, reducing prescription drugs and terminating coverage prospectively.

I would say the employers I've consulted with have been more aggressive than the nationwide averages. Most of the employers that I've worked with on retiree medical programs have terminated coverage prospectively for anybody hired after last year, this year, whatever it may be, and added caps on to their active populations moving forward.

The post-65 frontier is similar to the pre-65 results, so expect them to make these initiatives and changes to both pre and post. I would say on the post-65 side they're a little more aggressive in terms of how they plan on getting out of retiree medical or shifting costs to retirees.

I think it would be interesting to note the answers to the question, "Are Medicare Choice plans effective?" If you ask that question to employers and talk to yourselves, Medicare + Choice isn't something that employers are really looking for. That's not necessarily true. Three-quarters of the people said they were at least neutral or positive about the impact of Medicare + Choice, even with the dramatic terminations that occurred last year. This definitely provides some support around Medicare + Choice and how employers perceive it. Three-fourths of the respondents said they weren't even offering Medicare + Choice, yet those that do were very happy with it. Of reasons for discontinuing it, it wasn't disruption, it wasn't administration, it was just that the health plan sold out. I think that's the reason why employers aren't offering Medicare + Choice. I think the point here is that if it's out there and available, there's a good reason to offer it to retirees. If you're consulting with any employers or looking at a health plan to stay in the market, this is a good opportunity to utilize some of this information to possibly influence some of the corporate executives into accepting that it isn't such a bad idea to offer a Medicare + Choice plan. When we consult with clients, I tend to be at least pro-Medicare + Choice if it can be an affordable alternative for retirees.

What are employers doing currently? Not much. I guess that's probably not a surprise. They're probably not doing much because not much has changed. The caps are in place and they're not expected to hit until 2005, 2008, 2010, whenever it may be, so they're not getting scrutinized on cost. Employers and retirees are happy with the plans they have. But caps are looming and if we were to project using some more aggressive trends than we've seen in the past five months on some of these programs, I would guess the caps have moved up maybe one to two years from when they were projected to hit. In the next one to two years we're going to see a dramatic change in how employers have approached post-retiree medical.

Another survey from a different database examined trends in retiree health benefits. In 1991, when FAS 106 was adopted, 88 percent of large corporate employers surveyed sponsored pre-65 retiree health care and 80 percent of them sponsored post-65 retiree health care. Those numbers gradually declined over the years, with the percentages moving to 73 and 62 percent for pre- and post-65 retirees, respectively, in 2000. Overall, we've seen probably a 25 percent decrease in the retiree medical programs available. The decrease is slightly higher for pre- versus post-65 retirees.

Interestingly enough, on the Erie decision, I think our legal counsel would say that the employers have the greatest risk. There's a clear opportunity for utilizing the Erie decision as age discrimination for our employers that offer pre-65 retiree medical coverage but not post-65. The other ones obviously require calculations of

equal cost, equal benefits, etc., but if you don't offer it to the post-65 group and you do to the pre-65 group, there's clearly an opportunity for the Erie decision to be at least looked at.

What are the trends in retiree health benefits? If you look at just the *Fortune* 100 companies' annual reports and you see how many are utilizing retiree caps, you'll find that most—59 to 60 percent—have adopted an approach that limits their subsidy. Of those, you'll find that half of those responding companies have a cap on pre- and post-65 subsidies. Six to eight percent of them just offer them at full cost. The trend that I have seen, just in working with the clients, has been when they do prospectively terminate their retiree medical coverage, they continue to offer access only to their retirees and there's a considerable amount of issues that go along with doing that. For example, if you have a blended HMO rate with active and post-65 retirees (this seems to be an area where I see the most issues) with a $200 single rate, and you ask an HMO to split it out, the HMO won't take kindly to having to price a pre-65 group on their own, so they won't give you very favorable rates. If your costs are going to go up dramatically for the pre-65 group, even far more than what an actuarial morbidity table would tell you the results should be, it's very difficult to consult with a client. But if you don't, then you're going to have to set the retiree contribution yourself based on some assumptions. And if you're charging full cost, you'll actually be charging the retiree more than what you're paying the HMO. The Department of Labor might have a problem with that. You can see the balancing act that you have to do. You have one side saying you're not going to get a very good deal from us if you do try to price it separately, and so you try to do something a little more fair and leverage your volume, and another side says if you're not charging them the $200, then you're collecting more than you're paying the HMO. A third party, the accountants, will say if you're charging $200 for the retiree and not the full actuarial cost, then you have the FAS 106 liability. All three of those make it almost impossible to manage well a fully paid retiree medical program.

What are employers doing to hit the cap? The majority of employers with caps have yet to have their caps triggered. Many employers are taking action to defer the caps. These actions include modifying retiree medical plan designs, incorporating catastrophic plans or drug-only designs, and introducing Medicare HMOs, although this is currently controversial as carriers withdraw from markets. What are employers doing when they hit the cap? We studied 18 companies that have hit the cap over the last five years and have found half changed their cap, raised it, and took a one-time hit on the FAS liability. The other half danced around it a little bit. What I mean by dance around is they made a bunch of plan design changes to try to lower their costs so they could project out a little further with their caps before making any changes. I guess the point is when you hit the caps, very seldom do the employers, at least those I've worked with, push the costs off to retirees. Conversely, there are other things they're doing. They might offer a lower cost plan so people can at least have an affordable option. Again, look at the Medicare HMOs.

The other alternative is to retain caps to retirees. That's the approach nobody is

taking. I shouldn't say 'nobody'. Some of the 18 employers, less than four actually, charged retirees the full cost. Raising the caps seemed to be the most popular method. We didn't have any of the 18 that retained caps for certain populations, but it's an idea out there. Another idea is to retain caps, but produce low-cost options.

Looking forward, as employers look to the future of retirement, what's out there? What are we going to do? What is out there involves a lot of risk, a lot of cost, and a population that's aging quickly. The front end of the baby boomers is now 55. The Internet provides some opportunity to, at least maybe, educate retirees better and provide, perhaps, purchasing alternatives. But again, there are a lot of mixed emotions and issues out there with retiree medical.

What about potential employer actions? There are a lot of issues that employers are having right now. Each employer has unique objectives, but those surrounding retiree health care typically fall into one of five categories.

1.) FAS 106 Management
2.) Minimization of Micromanagement
3.) Keeping retirees satisfied
4.) Flexibility to meet a variety of drastically different needs
5.) Employer commitment while minimizing obligation and exposure

There are a lot of things that balance what you can do as an employer of a retiree medical program. Plus, there are pending lawsuits. There's nothing to say that any changes, even if you've fully disclosed that you have the right to change a retiree medical plan, won't result in a lawsuit. We've seen several employers that have been sued as a result of dramatic changes in their retiree medical programs. Anybody can be sued.

Chart 1 shows a sort of a spectrum of opportunities in the realm of potential employer actions matching retiree responsibility versus employer commitment. I would guess the capped obligation is where we're at today. The DC is an approach we're seeing adopted more often when caps are hit, or at least discussed. Terminating coverage is an option if you really want to get out of the retiree programs. I have talked with employers that have talked about the prospect of terminating coverage. Telling everybody that if they don't retire by next year they're out of retiree medical, is the most aggressive approach that an employer can take. Some employers have said they're not going to honor the caps, they're just going to start charging 100 percent of the cost. Again, these are the ideas where lawsuits are definitely possible.

One thing that employers always seem to ask when we start talking about post-retiree medical is if there is a way to allow employees an opportunity to fund and pay for their retiree medical coverage. Is there a way to let them have money they can set aside on their own—just provide them access, but they pay for it? No, there's not a good alternative. Write your legislature and try to get something enacted, but nobody is even mentioning an option for people when you talk about

legislative changes. Obviously the three things that you look for are tax-free contributions, tax-free growth, and the ability to use the money to buy tax-free retiree medical. The 401(k) plan and the Voluntary Employees' Beneficiary Association (VEBA) each have some advantages, but neither of them provides a clear-cut alternative.

Later we're going to get into some case studies of employers that do some pre-funding and allow the retiree to contribute to their post-retiree benefits. If you're talking with employers and consulting them, or looking at alternatives, there's just nothing out there right now that is easy and that covers a spectrum of an optimal investment for retirees.

Now let's examine design alternatives and managed care migration. The first thing when you redesign a post-65, pre-65 retiree medical program is to decide what to do with your pre-65 retirees. Most employers would give them the same thing as actives, and charge them, as a percent of their cost, a lower percentage than what an active employee pays. I would say that's typical. I'm not saying everybody does it that way. The first thing you want to do is separate the two. You don't need to do the same thing for both groups. There is a design opportunity there to treat your retirees different from your actives. There's nothing to say that you have to continue to do what you do for the actives to the pre-65 retirees. The first approach is to design a retiree program, not just carry forward your active benefits. In the post-65 frontier, obviously the only alternative that seems to have 75 percent favorable ratings from employers is the Medicare + Choice offering. Keep in mind that the Medicare + Choice program currently is in a state of turmoil, with plans eliminating or reducing service areas and increasing rates dramatically.

We are seeing auditors come back and begin to ask for more aggressive trend assumptions on our FAS 106 calculations, and again, some of that is going to provide some influence on how quickly employers start looking at new design alternatives.

The caps obligation is one design. This (Chart 2) is just an illustration of the impact that it could have. A typical approach would be to say we're going to cap our obligation at two times this year's cost. A lot of employers have done that, and this would be an example of what the cost increase would be. Again, very few employers that we've been working with have taken the red line. Once they hit the cap in 2010, they've readjusted and reevaluated their caps.

The DC model is another design option. A typical approach that we're seeing (and we have case studies on this) is where you would have years of service times a fixed amount. That's what you use to buy retiree medical coverage. So all retirees get an account defined as $250 times years of service, and that money is going to be used to pay for your retiree medical.

Another alternative that we've seen employers utilize is to terminate coverage, but increase pension benefits. Don't just take away benefits, but offer an alternative.

This seems to be an approach that is attractive to employers that just want to get out of the retiree medical by offering some sort of offsetting cost or benefit to the employees without upsetting them.

Clearly, there is no one solution for all employers. A balance needs to be struck across several objectives. The right solution can depend upon such things as the active health care strategy, a company's financial position, the impact of retiree health care on hiring/retention, the potential PR impact of making changes, and potential legislative changes. I would say that if I were to ask consultants at Hewitt, "What are your employers doing? Are you seeing as much terminated coverage as I have seen?" I would get mixed signals. There are several large mergers that are going on right now where the retiree benefits are being redefined and they're not being as aggressive as I would have thought. I guess we see a slight trend towards termination of retiree medical programs, but that's not the right solution for some employers. Some employers that have made the decision they're going to continue to offer a benefit like that to their employees but are still battling it out and trying to figure out what's best for employees.

We should look at DC—what it could be and what it should not be. I think this probably goes along the lines of what employers are doing to move from a pension benefit to a cash balance (CB) plan. That scenario has the same types of pros and cons, and utilizes the same type of approach that you would take. You don't want this to be a PR disaster; you don't want to use it to reduce benefits. You want to utilize it to be a new strategy for you to provide benefits to employees that hopefully equals current cost for both the company and the employee. It doesn't have to be a plan designed to reduce the employer's expense, and I would encourage anybody that's designed these programs to not have it be such. Employees are smart, they figure these things out, and they know when they are losing benefits when you move to something new like this.

We have some more survey data on the subject of employers having or considering a DC approach. A third of the employers said it is something they would consider and we looked at some of this data earlier as well. They were also asked, "How would you implement this, would you go back to current retirees and offer the contribution to them or would you just do it to the active employees?" By far, most of them said they would grandfather this to the actives and leave retirees alone. Why do they do this? To control cost.

I think a fundamental shift that we're seeing in both active and retirees is the return of control of the health care to the employees. Employers want to get to a fixed subsidy approach. Let employees figure out how to deal with trends, let them figure out how to deal with the different health plan options that are available out there. I think we're seeing this same kind of mentality with the retiree medical programs. The issue is going to be access. How do you balance this fixed subsidy approach with access? How do you limit your liabilities and keep from being sued? That's an important issue.

The landscape of retiree health care is changing rapidly. Both public and private sector changes will shape the marketplace. There are opportunities for employers to create a competitive advantage through aggressive management of retiree costs. Each alternative involves risk, but there are also risks in doing nothing.

Ed is going to walk us through some of the other things employers are doing to move forward.

MR. EDWARD PUDLOWSKI: What Erich has done so far is to try to give you what employers' reactions are today. What I want to do right now is start talking about some of the factors that will influence how employers will think two, three, five, or ten years down the road. I want to go through a lot of background. One of the major areas that we need to consider is the growth of the over-65 population. This is going to have a major impact on how employers choose to offer retiree medical coverage as they go down the road. The growth rate of the over-65 population will increase dramatically over that of those that are 65 and under in the coming years. In fact, as Erich mentioned earlier, the baby boom generation is now reaching the age of 55. By the year 2012 there will be a huge spike when the first wave of the baby boom reaches age 65. That's going to have a dramatic impact. Looking at the average number of workers per Medicare beneficiary, right now we have about four workers per Medicare beneficiary. By the year 2030, that's going to drop down to about 2.3. What that means, obviously, is that those people who are in the work force and producing are going to have to produce much harder to pay for the benefits of those who are over the age of 65, unless we have some type of dramatic shift where we have more people over age 65 being employed. It's either importation of a younger work force or exportation of the work out to areas where we do have a younger work force.

There are some companies that have benefit managers specifically for their retiree plans (we're going to talk about the case studies later). They have benefit accountants specifically for their retiree medical plans because, especially in the steel industries, their retiree population is much larger than their active, and these companies are dying under their own weight. One of the other factors that's going to affect it is the availability of Medicare.

In Chart 3, the low-cost alternative has us going from a ratio of assets to disbursements of about one right now to about four in 2010. You can see how sensitive those assumptions are when you go from the low ratio all the way up to the high ratio. The ratio comes almost all the way back to one. The low cost ratio is making a projection of about a four percent per year increase in costs in the out years. The intermediate estimates are looking at about six percent and a high cost is looking to be at about nine percent. This, in addition to what they're considering expanding with regard to prescription drugs, I think is going to be key.

One of the biggest areas is legislative activities. Right now, with regard to Medicare, we're looking at the possibility of offering a prescription drug benefit along with a number of other things, but there's a lot of concern out there. Senator Orrin Hatch

(D-MA) had indicated that the cost for this could be as much as $1 trillion over the next ten years. That's pretty significant. I think he's probably trying to throw some scares out there and some of the other costs I've seen have been more in the range of say, $300 billion over the next five years, but either way it's a pretty significant cost for the federal government to take on.

So far what we haven't seen in any of those proposals is any type of coordination with the employers' plans, and I can't believe that the federal government will simply take over benefits that employers have been providing all along. We don't know where that will head. There is likely to be some delay in even getting it implemented. There are probably some very good reasons why the democrats would like to extend this to next year during election time to show that nothing has been done and you need to elect more democrats, and the White House would like to look at alternative reforms in addition to prescription drugs—things like altering Medicare + Choice, looking at some self correction programs, and even some Health Insurance Council (HIC) reform in addition to prescription drugs. The ability to add those things in may complicate the ability to get these things passed this year. Next year may be more likely.

There's a lot of concern about prescription drugs and the cost of prescription drugs in plans, especially for retirees who use anywhere from two to four times as much as an active population. Right now, there is legislation introduced by John McCain (R-AZ) I believe he calls it GAAP—that to a lot of accountants, I'm sure, is a horrible acronym, but it stands for Greater Access to Affordable Prescriptions. Basically what he's trying to do is restrict some of the petitions that allow for the delay of generics into the marketplace. He's trying to remove the 30-day stay against generic equivalents of branded products coming out during patent litigations. These are ploys that some have said the prescription drug industry has been using to try and delay the onset of generics into the marketplace. There are some things out there that may be able to help mitigate some of the increases in the prescription drug costs that have been experienced by the retiree medical plans.

On the subject of Medicare + Choice, a few years back we had the Balanced Budget Act of 1997 that created some additional funds to increase the Medicare reimbursement rate. That also created some shift from some of the areas that were receiving high Medicare reimbursement rates to those that received very low ones. The result hasn't been what they expected. We're not seeing an influx of new Medicare HMOs into the marketplace and, in fact, we're still seeing carriers pulling out of the marketplace. The expectation for 2002 is that it will continue. As an example, in 1999, 80 percent of the plans offered out there were for zero premium. That's now dropped about 45 percent in 2001. All the plans out there that cost over $50 accounted for about 11 percent in 2000. It's now about 24 percent in 2001. Not only were we seeing them pulling back on certain benefits and placing more limits on prescription drugs, we're also seeing them starting to increase premiums, which is making those benefits look less and less attractive. Erich's point is that they are still more attractive than the employer-sponsored plan because of the subsidization from the federal government, but they're less attractive than they're used to, and

employers are very concerned about offering them to their employees for a couple reasons. For one, what do they do if a carrier pulls out of the marketplace? Secondly, what happens if that cost starts to rise much faster than the rest of their programs and they haven't accounted for it in their actuarial valuations?

On the subject of patient protection legislation, there have been a number of studies done by the congressional budget office. They estimate that the impact of patient protection will probably increase health plan costs by about four percent. That's pretty significant to an employer who is already facing an underlying trend in the double digits. HMOs are trying to make up some potential losses through renewal increases. Then there's also some consideration of expanding Medical Savings Accounts (MSAs), which may provide some additional choice for employers. They're talking about making it permanent, so it's not something that has a sunset law; removing the caps on the number of individuals that could be included; making it available to all consumers, not just individuals and small employers; and allowing for both employer and employee dollars to be allocated into the savings accounts.

Dale talked earlier about the Erie County decision. It is extremely significant and is going to have a major impact on employers. What we're seeing today, though, is that most employers are taking a wait-and-see attitude. What they're saying is this is only a decision that's taken place in the Third Circuit, which is New Jersey, Pennsylvania, and Delaware. I think they're just stunned by the decision more than anything and are a bit reluctant to act. What probably scares me a little bit more is that the decision has been incorporated into the Equal Employment Opportunity Commission (EEOC) policy manual and that has implications regardless of what circuit we're in.

The Erie County decision made two very important statements. The first one is that the Age Discrimination in Employment Act of 1967 (ADEA) applies to post employment benefits. If you read through the decision, one of the things that you find is that what Erie County didn't decide to do was say that you needed equal benefits between retirees and actives, although it was implied. What they also said is that you need to have equal benefits between those over age 65 and those under age 65, because what happened in Erie County was that they had a point of service plan available to people under age 65 and a Medicare Choice HMO available to those over age 65. What the retirees really disagreed with Erie County about was the fact that they didn't have a choice of providers and that's what initiated the lawsuit. I think that's the first big decision. Now, we've got to go and try to make sure that we're providing equal benefits or equal cost to post-65 retirees as we are for pre-65 retirees. The other issue gets down to an equal cost and equal benefits issue. When looking at equal benefits, the court has said that you can factor in what benefits Medicare provides. If you simply have some type of coordinated plan, it would seem to pass that test. On the equal cost side, however, the courts have said that you have to look at what the employer is contributing for coverage and look at the employers' costs, which means that you don't get to factor in the cost that's being provided by Medicare to the beneficiaries. Under that type of scenario, I don't think you'd ever find a way to meet the equal cost rule, unless you were to pump up the

post-65 benefits to a large extent, and that would be contrary to where we're seeing most employers go today.

Let's talk a little bit about the providers. The Beneficiary Improvement and Protection Act that was enacted in 2000 provided some additional funding for Medicare to the providers. Basically, what they did was up the reimbursements that providers get through Medicare by about $34 billion. What our health care clients have said to us is that's not enough. That's just not enough to cover our financial burdens. We've got the Health Insurance Portability and Accountability Act of 1996 (HIPAA) coming down the road, so we've got a lot of issues with regard to patient privacy and all those regulations that we need to meet. That, and all the systems and infrastructure we need to change around in order to deal with it will create an additional financial burden. They're experiencing a nursing shortage. We're doing a lot of work with corporations now just trying to help them brand themselves as an employer so they can attract nurses from other facilities, but there are just not enough nurses to go around. They're looking for alternative means of staffing. Energy costs are rising everywhere, especially in California, and are affecting them. Aging physical plants and credit ratings are affecting their ability to get additional capital for funding. Many providers are being downgraded, mostly hospitals, as a result of some reimbursement reductions from the payers. We'll talk a little bit about the consolidation going on there. They're becoming a little bit tougher on the providers. There's some under-utilization. The retiree population is not using the benefits as much as they used to. Now, that may be a good impact on employer-sponsored plans, but it's also having an impact on the providers.

There have also been some bankruptcies, bond defaults, and fraud that have been out there also affecting a lot of health care providers' ability to get the appropriate credit ratings. There's been a lot of consolidation of providers, too. That consolidation, because it's been under-utilized and because they have capacity, will really make them a stronger force in their ability to ask the payers for additional reimbursement. For instance, the situation in Erie County, Pennsylvania, illustrates a point. Western Pennsylvania is just a bunch of small communities, and each community has its own churches, bars, and hospitals. Each of those hospitals had its own separate mission and they were all struggling to try to maintain their mission and still be financially viable. What we're seeing now is more of a movement towards consolidation because they can't maintain that financial viability. As we start to see the providers consolidate, they are going to have more purchasing power, or more market power, with regard to the payers in each of these communities.

By the way, the providers are looking to congress and the legislature to get some additional funding on top of the $34 billion, and that's very unlikely. Thomas Scully, the candidate for the administrator at HCFA, has stated that it is really unlikely to occur.

When we look at the carriers, we've had consolidation there as well, which will probably create less purchasing power by employers in the marketplace. We've

seen Aetna merge with Prudential recently and we've seen a lot of consolidation even with the Blues. Some of them have been Blues to Blues consolidations and some of them have been non-Blues carriers with Blue carriers like United Health Care and WellPoint. We mentioned earlier Medicare + Choice pullbacks and what that's creating. There are fewer carriers in the marketplace and therefore, more power for those who stay. The new Medicare reimbursement rates really haven't done much to support any new influx.

I don't know how many have ever looked at medical inflation. Chart 4 shows the cost component as measured by the medical combined premium increase (CPI). I think it's interesting that you can see in about 1997, we hit pretty close to our all-time lows. We barely went under two percent back in the late '40s and early '50s, and touched upon it again in the '60s, and again, as early as 1973, and that's the last time we've gotten down that low. If you are a stock analyst, you'd be looking at that two percent line as being a resistance line, a line this market just can't operate below. This would indicate to me that our trend is going to go nowhere but up with regard to medical inflation. That seems to be supported by a lot of things we're seeing today, such as double-digit inflation.

One of the things that is leading that double-digit inflation, as many would contend, is prescription drugs. Prescription drugs have been increasing anywhere from 17 to 25 percent depending upon who is measuring it and how it is measured. One of the leading drivers there is direct to consumer advertising. You can see that in 1993, prescription drug manufacturers were spending less than $200 million a year on direct to consumer advertising. That's now up to close to $2 billion dollars, a dramatic increase. They're getting pretty innovative about how they advertise as well. Today, if prescription drug manufacturers tell you what the drug does in their advertising, they also have to tell you what its side effects are. Some of those are pretty embarrassing, like gas and those types of things. They don't like telling you that. You see some commercials where they just show a drug, but don't tell you what its benefit is. They somehow try to imply it, but they don't have to tell you what it does. One company came up with a pretty interesting approach. They actually broke their advertisement up into two pieces. They separated the product and what it does from what its effect is. What they do is they show a pudgy baby and they show that the pudgy baby grows up into a pudgy adult and that's all that they show you. Then two commercials later, you see the same pudgy baby and the same adult and they tell you about the drug, but they don't tell you what the drug does. It's pretty innovative. They're finding ways of getting around a lot of the advertisement requirements and you'll probably see more and more advertisements like that.

You may also notice one product out there that, in its prescription form, is really meant to cure a very bad fungus that you'd have on your foot. It also has a very nice side effect. If you have yellowing toenails it clears them up and makes them look very nice. So if you want to go out to the beach in the summertime and show your toes off in the sand or in your sandals, you'd probably want this prescription. What a lot of physicians are doing is prescribing it for patients who are complaining

about this yellowing of the toenails, but are prescribing it to cure fungus on their feet. There's a lot of that type of thing going on that really has an effect and you'll see it advertised as such on TV as well.

One of the major factors that is obviously going to influence employers' decisions is the economy. Quite frankly, we don't know what's going to happen with the economy. I have my guess. I'd be willing to bet you have yours. How many of you think that five years from now the stock markets will be higher than they are today? I expect most everybody would think that.

Technology is going to have a major impact, too. Russell talked about some of the medical advances and, of course, we've seen how that's all had an impact on the cost of care. I think the Internet is also going to have an impact. The Internet is just an alternative distribution device. It's not creating anything new; it's just creating a different way of getting the information or products out to people. What it's doing is getting that information out to wider audiences and getting it out to them faster than it had before. It can really be the key to driving the movement towards consumerism or DC approaches. That may be good and that may be bad. The more information you have about the medical system, the more you're likely to use it and therefore, drive up costs. I tend to think that there's also the possibility that the more information you have about how to treat yourself and take care of yourself, the less you're going to have the need for that type of care later. I think it can work both ways. We'll have to wait to see which way it goes.

Let's just try to take a look at what we have here. If we look at the things on the negative side of the equation for employers, those things that are going to effect their ability to provide a retiree benefit, we've got the aging work force; patient protection legislation that's probably going to increase their costs; Medicare + Choice reimbursements, which haven't lived up to what they would have expected them to do five or six years ago; the recent court decisions; the consolidation of the providers; the consolidation of the carriers that's going on; and medical inflation.

I'll put Medicare on the neutral side because I think it's just too unclear at this point in time to understand exactly where it's going to go. And technology, as we talked about, could take it in either direction.

On the positive side, I think you've got a lot of things with regard to prescription drugs and some of the prescription drug initiatives. There are also some of the Medicare proposals that exist out there, and maybe some medical savings account (MSA) expansions that allow for some additional things.

We don't know where the economy is going to go, but I would contend it probably doesn't make much of a difference. I think its biggest factor is going to be in terms of timing. Even if the economy goes up, I think it's a matter of time before all the negatives that we just talked about are going to cause employers to really think about how they deliver medical benefits, not only to their active population, but probably even more importantly, to their retiree populations. If the economy goes

into the tank much faster than I think most of you may expect it will, that will just precipitate that decision and move it in a much faster manner. At some point in time down the road, I think we are going to see some real changes in the financing and delivery of health care.

We've got some case studies to go through and Erich and I will bounce back and forth on those that we're familiar with.

MR. BLUMBERG: Because I'm in Dallas, I get a lot of calls from consultants around the country asking what in the world American Airlines does with their retiree medical program to get it so full. I get asked this question a lot about American Airlines benefits and actually, one of our consultants worked for American Airlines and participated in their retiree medical program. What American Airlines basically did was allow employees to pre-fund or contribute to their retiree medical program. You get a one-time chance when you get hired, do you want to participate or not, and you contribute X number of dollars that ends up being after 10 years, around 30 percent of the cost of the retiree medical program. After you retire, you pay nothing and you get your benefits, obviously, until you die. The employee contributions return if you leave the company before you retire. The thing I'd like to stress here is it is an opportunity for employees to help contribute to the plan. The difficult thing here with American Airlines and other employers that require employee contributions is you've aligned yourself with an obligation to provide benefits that are similar to what they were purchasing when they made that decision and that leaves you very little opportunity to make any changes to your program. You're frozen in time, and basically living in 1987 in terms of the medical programs that you offered the retirees.

Another case study that we have is on IBM. This is several years old. I'll state that right now, because I'm sure IBM has made some updates to the plans and programs that they have. Several years ago managed care was obviously a great idea, especially if you could get an elderly population in a capitated plan. That's the best of both worlds. You only have to pay a fixed cost and they can go see the doctors and go to hospitals as much as they want. So why not send people into capitated arrangements or managed care? This approach was actually taken by several other employers. Some paid $500 or $600 for an irrecoverable election into managed care; meaning once you took it you couldn't go back. It pushed people into the managed care offerings. IBM obviously had some communication campaigns, face-to-face meetings, fact sheets, and financial incentives to join the plan, and the $500 or $600 arrangements to move retirees into managed care. Still, an option for a lot of employers that are looking at retiree medical is to encourage people to utilize managed care. The impact of managed care is greater for a retiree population than it is for an active, yet, your enrollment typically for retirees is less in managed care than for an active population. A fundamental shift is that all of your single healthy people that are 25 years old are taking the HMOs because they're cheap and they don't care about the physician network, but your elderly folks and your retired populations aren't quite moving in that same direction. You'd like the opposite to be true. We saw a lot of employers taking initiatives and still

today see employers taking initiatives to move people in that direction.

This case study on a major pharmaceutical company illustrates a common scenario where the cap subsidy is at two times the 1992 cost and then a calculation is done to see when that cap would hit. All future increases are obviously supposed to be passed on to retirees. Another case study shows a capped obligation for a high tech company.

MR. PUDLOWSKI: As Erich started mentioned, we did some work for a major high tech component manufacturer that decided to have their obligation capped at 2002 levels. This is 2001, and they started realizing that they actually had to administer it and, like most employers that I've had exposure to that have put in the caps as Erich had mentioned, it really came down to whether they were going to be very serious about those or not and whether they were going to burden the retirees with those levels. This company chose to delay the caps because their business was doing very well. In addition to delaying the caps, they decided that they would also fund the retiree medical because of that excess cap that they added, and try to take advantage of some of the ability to get the liability off their books by pre-funding some of it. What's interesting is that probably not more than six to nine months after their decision, the economic slowdown dramatically affected their business and has reduced their expected funding levels. So they're not funding at the level that they had expected to six or nine months ago, although they did extend the caps and take the accounting hit that went with it. Of course, they were choosing pre-fund to try to mitigate some of that effect.

Pretty similarly, a major chemical company originally had caps set to go in place for 1996. They had put those in place when they adopted FAS 106 to get the positive financial effect on their books and they also excluded new hires from the plan. Shortly after, in about 1997, one of their major facilities was going to raise the caps as a strike issue and they felt they really couldn't take that burden on as a company. So in about 1996 they decide to extend the cap to the 2003 level and they took the accounting hit. Most accounting firms will tell you that they'll allow you to do that once if you've got a good reason for why you're going to do it and if it kind of supports your business, but if you do it a second time, then you're setting a pattern that you really can't live up to the caps that you put in place. Any time after the first time, you're probably going to have to value the liabilities as if there is no cap, because you haven't shown your ability to maintain them.

The other interesting thing about this company is that over one-third of their population doesn't have retiree medical. They're now considering options to include a retiree medical plan for those people because they found they had two different types of people in their company—those that had it and those that didn't.

Incidentally, we're working with a company right now who had done something fairly similar where they eliminated retiree medical for new hires, and they're in the same position. They're saying they've got so many people now and need to provide them something when they retire. They're looking at alternative programs for them.

They're probably more willing to consider a defined contribution approach for these people who have nothing today. I think that's a much different sense than we're getting from other employers who are not willing to look at that defined contribution approach because they're unwilling to take the leap from what they currently have today.

MR. BLUMBERG: Going back to IBM's defined contribution approach, IBM announced major changes in all the benefit restructuring in 1999. One of the ideas was to provide a credit to retirees that would build over time based on years of service that could be used to purchase retiree medical coverage. The credit would be given by years of service between the ages of 40 and 55. When an employee retires, he could take the money and use it to buy medical coverage. They faced tremendous shareholder pressures caused by several different articles that were published and also employee backlash, not necessarily due to this program, but some other programs as well. I'm not exactly sure where this ended up, but this is the concept that they were going forward with in 1999.

From another case study, Pillsbury gave retirees an option as to how they would pay for the retiree medical once they did retire, instead of just a credit. So employees had four payment streams to pick from and once they decided on the credit and how to receive it, they had an option to pick from four different types of plans. This one provided a little more opportunity to define how you get your credit back and what length of time you'll be guaranteed to have that credit. And you could buy from different things besides just health care, such as dental, life insurance, etc.

First Chicago is an example of a company who decided to terminate retiree health care plans and use enhancements to their pension plan to offset some of the issues that might have developed with removing the retiree medical plan. Of the 1,100 companies in our database, we found 19 that do provide some sort of dollar amount for retirees to go purchase retiree medical coverage, but yet, none has an employer sponsored program attached to it. That figure sort of substantiates how many employers look to just providing people with credits and telling them to go buy medical coverage anywhere on the open market.

MR. YAMAMOTO: I have a general question for the panel. I want to ask each of you, of your clients, how much discussion have you had about the Erie County decision and how it affects their programs?

MR. PUDLOWSKI: A lot of clients we've had discussions with on that issue have been ones that are actually in the Third Circuit and they were concerned fairly early on. They've asked the question, "Should we just kind of wait and see what happens or do we need to react right now?" I think their sense is they're just waiting to see if they need to do something. There's a sense of concern that exists out there, but no real sense that they need to take action right away. I think the first step they need to take is to assess whether they think they have a real issue or not, and I don't think a lot of them think they do. I think they believe the particulars of their

case are different than those of the Erie County case.

MR. BLUMBERG: Just to reiterate the same point, I would say that half my clients probably don't even know about the Erie County decision. One thing is to educate them about what the decision means and how it could impact them. That way, they're prepared before the big article hits the *Wall Street Journal* and the CFO comes and asks them what they're doing about it. Literally, I would say three-fourths of the employers I work with don't even know the decision has been made. Of the one-fourth that do know, I've had one client that's very concerned about the implications. That client has asked to get our ERISA attorneys and legal counsel involved in at least reviewing what the implications are and has presented a white paper to senior management.

MR. YAMAMOTO: That just changed my question. How many of you before you walked in the meetings here in Dallas were aware of the Erie County decision? Almost everybody. Now, I'll ask the question, "How many of you have talked to either your clients or your policy holders about the decision and its effect on their plans? How many plan to next week?"

MR. STEVEN BERNA: (Trustmark Insurance Co) I'm a health actuary, so I'm a little bit lost here in pension land. Our plan has terminated in a future date retiree medical. We're also seeing increased interest in phased retirement. I see those two trends on a collision course. Are your clients who have termed retiree medical, either now or in the future, worried that they're creating a class of people who are going to buy time? Are they worried they may be creating a class of people who are going to keep working until they're Medicare eligible, but in a sense create their own phased retirement plan, working full time, but maybe putting in half the effort?

MR. PUDLOWSKI: We're seeing it happen today actually. We're seeing employers who are coming to grips with the effects of some of their retiree medical plan terminations that they had a few years ago. Quite frankly, what happens is that the issue has been brought up and it has been discussed, but I think there's a bit of short-sightedness to some extent or an unwillingness to recognize it. They understand the implications, but it's not affecting them now. Terminating the plan now has financial effects on the books. The retirement window, especially in the past few years, hasn't been much of a concern with them because there's been a shortage of workers. They just didn't see the issue coming a few years down.

MR. BLUMBERG: I have the same comments as Ed. I would say that most employers that we dealt with felt that having some extra staff around wouldn't be such a bad thing, especially in a phased retirement piece that you're talking about. You can probably have somebody much more productive for 20 hours than when they're there for 40 hours. I would say that they would argue that they would approach the buy time and performance piece of this on an individual basis based on performance management, not through a global retirement program, but the concern is duly noted by all clients that do terminate the program.

FROM THE FLOOR: Have any come back and said, "Instead of this large liability, how about a smaller DC?" Is that just not happening yet?

MR. PUDLOWSKI: One of our clients today is doing exactly that—they had terminated it for hires after a certain date. They're now looking at putting in a plan more like a DC plan for them.

MR. BLUMBERG: When the employers that I work with terminated, they terminated and haven't put back in a credit. They are making attempts at keeping an affordable, fully-paid program available, and they're doing that in several ways. One thing they're doing is not isolating that group that's paying 100 percent of the cost and keeping their experience by itself. They're blending it with their overall retiree program, so that obviously brings down the cost to retirees. Also, they've got HMOs that are blended active rates and they provide those based on the current full cost of the HMO rate. They're providing, with their auditor's discretion, an affordable, fully-paid-for cost. Until their auditors make a big deal about what they're trying to do here, they're just going to continue down that path.

MR. YAMAMOTO: I think one of the things I'm seeing a little bit is more interaction between health actuaries and pension actuaries and sharing some of the duties as far as the design development. It's more of an integrated decision study, rather than just looking at retiree medical or pension and DC plans, but looking at everything together. I think a lot of people talked that talk maybe 10 years ago, but I think there are only a few more people that are actually doing it. I think we get some of the integration issues with developing retirement programs that are in concert with the retiree medical plans.

MS. PEGGY PEARSON: (Milliman & Robertson Inc.) I've got a technical question on how to comply with Erie County. I want to do it in two parts. The first is about an employer who wants to meet the equal cost test. There are a lot of employers that do, I think, what you'd call a DC subsidy, but it's higher for pre-65 retirees than it is for Medicare retirees. Let me just throw out an example. Let's say I have an employer who's contributing a small amount, let's say $150 per month, to the cost of a pre-65 retiree's coverage and only $50 a month after 65. Now, if you look at the total cost of the pre-65 and the total cost, let's say, for a Medicare supplement plan or something after 65, and the proportions are the same. In other words, if the cost for the pre-65 retiree just happened to be $450 a month, and it happened to be $150 a month after Medicare eligibility, would the employer be contributing one-third of the proportionate costs to each group? Would that meet the equal cost test or does it have to be the equal dollar amount?

FROM THE FLOOR: That's what everybody I've asked said including the attorneys.

MR. PUDLOWSKI: I've read conflicting reports and that's why I don't know the answer. One of the first things I've read is that you have to look at what the employer is providing in terms of cost to the retirees. As an example, if they were paying 100 percent for the pre- and post-65 groups, you could factor in the pre-65

costs more than post-65 and therefore there wasn't an Age Discrimination in Employment Act of 1967 (ADEA) issue.

FROM THE FLOOR: Right, that's a benefit issue. I agree that that would meet the benefits test. I want to go on to a benefits question. The contribution that the retiree makes, not the employer, is a benefit issue on the equal benefits side, not the equal costs. When you look at the contribution that the retiree has to make to get the coverage, the chances are that the post-65 retirees would be contributing substantially less, even for employers that contribute a rather modest amount for the pre-65, like $100 or $150 a month, and even if they contribute a smaller amount for the post-65 retirees. I don't want to talk proportion yet because I'm aware of the ADEA's proportion requirement. What I'm asking is if the specific dollar amount that the retiree is contributing is always less for the post-65 retiree, do you think it could meet the equal benefits issue?

MR. YAMAMOTO: I always got mixed feedback on that from counsel, too. If you just read what's in the regulations, it does say when you start to have a contributory program, the first thing that you take a look at is making sure that someone does not have to pay more as they get older, but if they did have to pay more, that they don't pay a greater percentage proportion of the cost of the plan. I have brought that to different lawyers and asked, "As long as the retiree's contribution does not increase as they get older, does that meet the test?" I've gotten some that said, "Yes, because that's the reading in the regulations." I've gotten others that said, "No it doesn't, because the intent of ADEA itself is that the employer provides benefits that do not decrease as someone gets older."

MR. PUDLOWSKI: One of the other things I think you need to factor into your analysis that came out in the Erie County case is that there were fewer differences in the pre- and post-65 contribution, and I think in Erie County they looked at it almost on a dollar basis. I'm not sure they did it proportionally. Is that your understanding, Dale?

MR. YAMAMOTO: They looked at it on a dollar basis, and the district court also said you have to include the part B premium because you have a Medicare risk HMO that requires you to pay the part B premium.

MR. PUDLOWSKI: That was going to be my point. You need to make sure you factor in those costs as well as the part B premium costs and anything else for coverage.

FROM THE FLOOR: Did you have a self-funded plan? Forget the Medicare Choice HMOs or something that would require a part B Medicare premium. I have some employers that only offer a self-funded plan. It's the same as the actives' plan; after 65 it's Medicare carve out and they require certain retiree contributions. They don't require the retiree to participate in Medicare part B, but they calculate the benefits as if the retiree was getting all those benefits. Would it be your opinion that if they don't require the part B Medicare premium, you wouldn't have to count that

as a retiree contribution? Because on the benefit side, Erie County and ADEA specifically says that you can count that Medicare benefit, and I don't think they say whether or not the guy actually gets it or not.

MR. YAMAMOTO: They said that you can count government benefits when you have the benefit test. They didn't make any comment about premium payments?

FROM THE FLOOR: No, not that I know of.

MR. YAMAMOTO: In fact, the Third Circuit itself didn't mention anything about Medicare part B premium payments. It was only when it was brought back down to the district court, which is just a few small counties around Erie County, that they brought in the Medicare part B premium issue. I guess it depends on how conservative a lawyer you are working with. One of the things that we have done pretty consistently when we're working with clients on this is to work with outside counsel, too. That's probably what you're going to find most of the time when you're really talking about the effect of this court decision on the client's program. It's always better to have the attorney/client privilege invoked, or hopefully invoked, when discussing these issues. If a client is found guilty of ADEA, any kind of damages involved with the case are doubled if they knew that they had a violation and continued to operate the plan the way it was. It's essentially an issue and maybe that's why I got the response I did about how many of you have talked to your clients about Erie County. I think a lot of us are dancing around the issue because it is a very sensitive legal issue with our clients right now.

Chart 1

Potential Employer Action

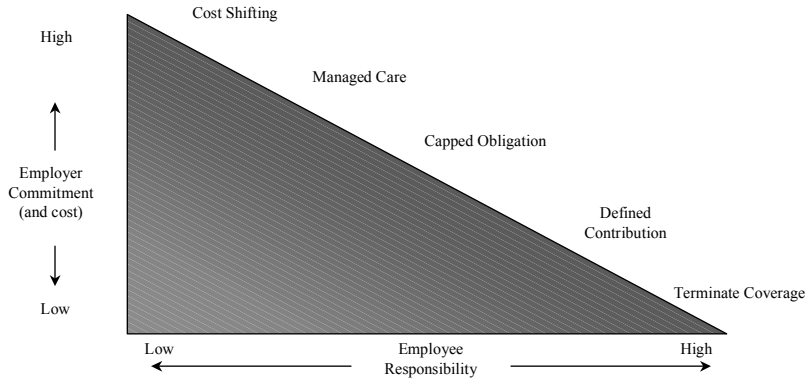

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Chart 2

"Design" Alternatives—Capped Obligation

- Mechanics of Cap
  - Define cap at two times current (1999) company obligation

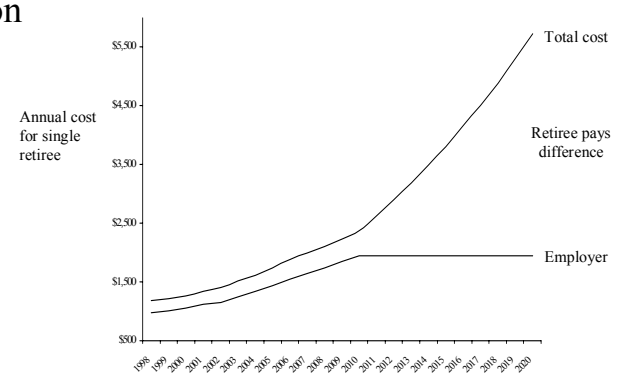

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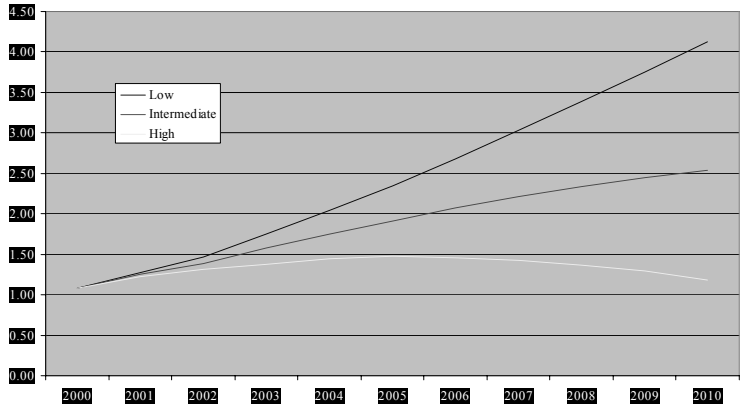
Chart 3

Medicare Trust Fund

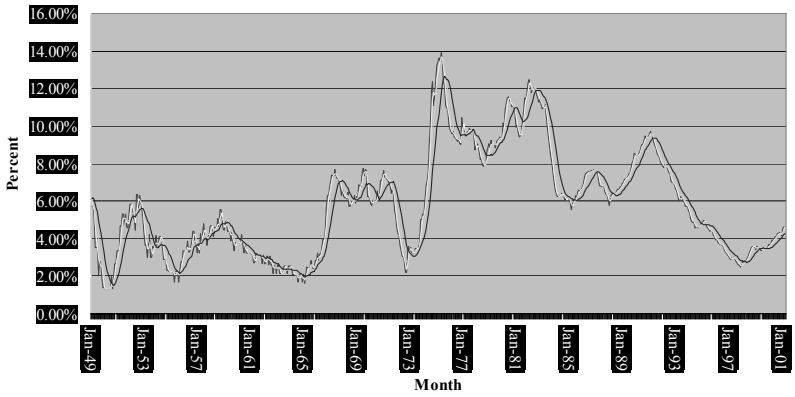
HI Trust: Ratio of Assets to Disbursements



Source: HCFA 32

Chart 4

Medical Inflation



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