RECORD, Volume 30, No. 1*

Spring Meeting, Anaheim, CA
May 19–21, 2004

Session 19PD
Valuation of Retiree Health Benefits

Track: Health, Pension

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Summary: The panelists in this session discuss recent developments impacting the actuarial valuation of retiree health benefits. These developments include the following: (1) The proposed Governmental Accounting Standards Board (GASB) standard; (2) Comparison of the proposed GASB standard for public employers with the existing standard; (3) Financial Accounting Standards Board (FASB) 106 standard for private employers; (4) Potential impact of the proposed Medicare prescription drug benefit on employer-sponsored retiree health plans; and (5) Recent changes in valuation assumptions such as discount rates and healthcare trend rates. Attendees leave with a better understanding of current issues, with emphasis on the potential impact the proposed GASB requirements will have on public-sector employers and actuaries.

MR. DAVID P. KENDALL: Welcome to Session 19PD, Valuation of Retiree Health Benefits. We may also subtitle this "late-breaking developments," because we have had a couple since the presentation was prepared, and we will talk about those. We have a good group of speakers here today. We have Jin Ho Park from William Mercer and Dale Yamamoto from Hewitt Associates. Both Jin and Dale serve on the Retiree Medical Committee for the Academy of Actuaries. I work for a small consulting firm primarily specializing in the public sector and governmental clients. We are going to have some time at the end for questions, so please try to hold those till the end. Without further ado, I will let Jin start it off.

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

MR. JIN HO PARK: The first part of the session is about Medicare prescription drug reform, the Medicare Prescription Drug Improvement and Modernization Act of 2003 enacted on December 8, 2003. This is potentially the most significant change to Medicare since its inception. Under the act, the new prescription drug benefit, Part D, is effective January 1, 2006, with discount cards available in 2004 and 2005. Actually, they are available May 2004. Tax-free subsidies are provided to the employers providing prescription drugs to Medicare-eligible retirees. Tax-favored health savings accounts are also available for future medical expenses. Medicare prescription drug reform also changes the structure of Medicare.

There are other provisions that may be of interest to employers. Higher Medicare Part B premiums will be applied to some enrollees with high incomes. Medicare+Choice becomes Medicare Advantage. Medigap's standard benefits package will change to exclude prescription drugs. For example, Plans H, I and J include some prescription drug benefits now, but they will be removed for retirees enrolled in Medicare Part D. Also, there will be expansion of Medicare benefits to certain low-income, aged and disabled Medicare beneficiaries.

Limited drug importation from Canada is allowed under the act. There will be limited demonstration of premium support or competition between traditional Medicare and private plans starting in 2010. There will be increases in the Part B deductibles, which are $100 in 2004 and $110 in 2005, and these will be indexed after 2005. There will be subsidies for low-income beneficiaries, and there is no "Erie County" relief, although recently the Equal Employment Opportunity Commission (EEOC) approved the exemption for Erie County.

While the new law provides a framework for change, details emerge slowly over time. Interpretations of the law, and perhaps the law itself, may change over time. Responses from carriers and other vendors may change the Medicare landscape. Implementation of programs is scheduled from 2004 to 2010 and beyond. There are significant opportunities for employers looking to reduce the cost of retiree medical programs.

The diagram on the first chart explains prescription drug coverage under Medicare Part D (Chart 1). Initial coverage starts after the $250 deductible is met, and enrollees pay 25 percent, up to $2,250. There is a "doughnut" hole in the coverage in that there is no coverage until the enrollee reaches the out-of-pocket limit of $3,600. Amounts paid by the third parties do not count toward the out-of-pocket limit. After the doughnut hole, catastrophic coverage starts. Above the out-of-pocket limit, enrollee coinsurance is the greater of 5 percent or a fixed co-payment, which is $2 for generic and $5 for brand-name drugs. Members pay, roughly, 25 percent of Part D cost, and it is estimated at $35 in 2006. Part D premium amounts will be indexed in the future.

The federal government offers a subsidy to employers and other sponsors of qualified retiree health plans. Qualified plans must provide benefits with an

actuarial value greater than or equal to Part D benefits. Sponsors get a 28 percent subsidy of eligible drug costs from $250 to $5,000, which will be indexed in the future for eligible participants. The sponsor's plan will remain primary. The subsidy is based on total calendar year drug cost covered by the plan. There is yet no formal guideline from the Centers for Medicare and Medicaid Services (CMS), but CMS officials informally indicated that only drugs covered by Part D will be eligible for the subsidy. Deductible and cost limits are indexed in future years. The subsidy is only for participants who do not enroll in Part D coverage. Subsidies are not taxed to a plan sponsor. Recordkeeping and documentation requirements will be determined by CMS, but there are no details yet. Timing of reimbursements is also not known at this moment.

There are several options for employers. Employers can continue to offer their current plan as primary prescription drug coverage and receive the government subsidy if the plan is "actuarially equivalent" to Part D. Employers may also offer a wraparound or a carve-out plan that integrates with Medicare Part D. Employers can provide a subsidy for the Part D premium or choose not to provide any subsidy. The plan may need to be amended to coordinate with Part D. Employers can consider new Medicare Advantage plans, formerly known as Medicare+Choice, with or without the subsidy of the Medicare Advantage premium.

The history of Medicare+Choice plans is problematic. Employers may need to watch the development of Medicare Advantage programs. Employers can drop prescription drug coverage completely with or without the subsidy of the Part D premium, and then no supplemental prescription drug coverage will be available to retirees. In this case, employers need to review legal age discrimination and employee/retiree relations issues.

The table shown in the second chart here compares three options available to employers (see Chart 2). The primary payer is Medicare under the integrated plan and benefit reduction and the plan sponsor under the subsidy. Retirees pay Part D premiums under the integrated plan but not under the subsidy. Prescription drug coverage design may need to change under the integrated plan but does not need to change under the subsidy if it is actuarially equivalent. Retiree contributions, on the other hand, need not change under the integrated plan but may have to change under the subsidy. Employee communications can be extensive under the integrated plan but may be limited under the subsidy. Administration may be more complex under the integrated plan but may not need to be changed under the subsidy.

On the other hand, recordkeeping may be simple for the integrated plan but potentially extensive because CMS may require extensive recordkeeping for the subsidy. From the retirees' perspective, retirees may need to pay Part D premiums and will have potentially reduced benefits under the integrated plan, but there may be no change under the subsidy plan. The financial impact to the employer may be

significant under the integrated plan but may be lowest savings (ignoring the tax impact) under the subsidy.

Under the Financial Accounting Standards Board (FASB) staff position, FAS 106-1, the guidance is for interim or annual financial statements of fiscal years ending after December 7, 2003. Proper treatment under FAS 106 is for employers to reflect the act in the measurement of the accumulated post-retirement benefit obligation (APBO) and expense on or after the enactment date, which is December 8, 2003.

Employers can elect to defer recognition of the act until the earlier of the following two days: the date of a significant event that occurs after January 31, 2004, which would ordinarily require a remeasurement, such as plan amendment, settlement or curtailment, or the date that FASB issues final guidance on accounting for the 28 percent federal subsidy. The employers' election to defer must be made before reporting financial information, including the FAS 106 expense for the period that includes December 8, 2003.

A subsequent proposed FASB staff position, FAS 106-b, gave more guidance. The effective date is for the first interim or annual period beginning after June 15, 2004, for all public entities and nonpublic entities with more than 100 participants. Guidance relates to accounting for the subsidy, whether or not actuarial equivalents can be determined. If the plan is actuarially equivalent to Part D, then treat the subsidy as a gain. If an amendment is required to make the plan actuarially equivalent to Part D, then combine the effect of the amendment and subsidy and treat it as a plan amendment if the net effect is an increase in liability and as a gain if the net effect is a decrease in liability. Employers need to recognize this at the date that the plan amendment is adopted.

After initial recognition of the subsidy, future changes in the estimated amount of the subsidy should be treated as a gain or a loss. If the actuarially equivalent plan is amended to reduce the coverage and is no longer equivalent, combine the effect of the amendment and loss of subsidy and treat it as a plan amendment as of the date the amendment is adopted. If actuarial equivalence cannot be determined, then the employer needs to disclose the existence of the act and the fact that measures of APBO and expense do not reflect the subsidy. If actuarial equivalence can be determined, then the employer needs to disclose the reduction in APBO due to the subsidy, the effect of the subsidy on expense (including amortization of gain, service cost and interest cost) and an explanation of any significant changes in the APBO.

If the employer determines that the plan is not equivalent or is unable to conclude that the benefits are equivalent, then the employer needs to recognize any effects of the act other than the subsidy at the next measurement date if the impact is not significant. The impact would include changes in participant rates and healthcare costs. If subsequent information leads to determination of actuarial equivalence, absent a plan amendment, and if the impact is significant, employers need to

remeasure assets and liabilities at the date that actuarial equivalence is determined, and then the impact needs to be reflected in the subsequent periods. No retroactive or cumulative adjustments need to be recognized.

Employers that elected to defer need to remeasure assets and liabilities, recognizing the effects of subsidy and other effects of the act as of the earlier of the plan's measurement date after December 8, 2003, or the end of the interim or annual period that includes December 8, 2003. Remeasurement must be based on plan provisions on the remeasurement date and will affect expense for periods subsequent to the remeasurement date. The cumulative effect of remeasurement is disclosed in the first interim period after change is adopted, which is the first interim period after June 15, 2004, for public employees.

Based on the proposed FASB staff position FAS 106-b, employers that did not elect to defer need to see if previous accounting differs from the final FASB guidance. If they are different, then the adoption of guidance becomes a cumulative effect of the change in accounting principles in the next fiscal year or should be reflected in the financial statements in the same fiscal year by restating the prechange interim periods.

There are some uncertainties or concerns regarding the Medicare Reform Act. There is the possibility of legislative or regulatory changes. More FASB guidance on accounting treatment will come. Financial estimates done now may have to be revised or reversed. There is no guidance on the definition of actuarial equivalence. We do not know if the employer will get the full 28 percent subsidy in a contributory plan or if the subsidy will be shared with retirees. We also do not know if actuarial equivalence will be based on the employer's subsidized value of the plan, which is net cost, or on gross cost. Also, we do not know what designs will be offered through private plans.

These are the steps to estimate financial impact. For a subsidy approach, employers need to determine if benefits are actuarially equivalent to Medicare Part D and if an amendment is needed to make it actuarially equivalent. For the integrated approach, employers need to determine if the amendment is needed to integrate with Medicare. Then employers need to select options to consider. Employers will need to determine how much cost and obligation is associated with Medicare-eligible prescription drugs when considering these options. Actuaries can model the effect on per capita claims costs of the options under the consideration and use actuarial projections to estimate the effect on future cash costs and benefit obligations. Actuaries also can apply current and potential accounting rules to estimate the effect on FAS 106 expense.

There are some actions for employers to take now. Employers need to review long-term strategies, such as business, human resource and retirement goals, plan design, new opportunities like Medicare Advantage and financial accounting issues. Employers also need to communicate with the retirees to explain the changes to

Medicare, how they will impact employees and to help employees understand changes, if any, to their current program made as a result of the changes to Medicare. Also, employers need to move carefully because interpretations of the law and perhaps law itself may change over time.

I heard that the FASB was going to come out with their final guidance sometime this week. I was checking the Internet every hour and hoping that it was going to come out before the session, and then found out that 30 minutes before this session it actually came out.

MR. PARK: I heard the biggest change is actually under FAS 106-b. It requires employers to go back to December 31, 2003, remeasure, and then reflect that change from December 31, 2003. Under the final guidance, it actually gives employers an option to go back or just apply prospectively.

FROM THE FLOOR: Under the one that just came out they can apply it prospectively.

MR. PARK: Right.

MR. DALE H. YAMAMOTO: There is also a nice flow chart at the end of the FASB 106-2 that should help you understand what kinds of things you really have to think about when looking at the different pieces that you have to do from the combination transition. After that, you decide what you are going to do. How do you implement it? I think they did a better job at explaining some of the things that were in 106-b that I thought were confusing. They did a good job in the last couple months after they released 106-b.

Now that you have heard what Jin had to describe about basically what is changing with Medicare going forward, I want to talk about what the implications are in 106 valuations and any kind of other retiree medical valuation that we do that will have to reflect the new Part D benefits going forward. I think the key things that we need to focus on are how the claim costs might affect the trend rates going forward and the Part D participation.

This is something new that we may have to consider when we do the valuations, whether or not we want to make any kinds of assumptions that there will be more people in the Medicare Advantage plans. I remember 10 years ago, or whenever the risk plans started getting popular, we had a lot of our clients saying they would get all of their people into those Medicare Choice plans. They were the best thing since sliced bread. When you look at what the Medicare Reform Act did to the Medicare Advantage programs or the risk programs, it looks like a pretty attractive program, but we will see. I suspect most people will take a wait-and-see attitude toward that. Then they will just think about any other changes that we might have to consider going forward in the valuations.

With the direct subsidy, there are several things that we have to think about. If you have a client that says it will take that direct subsidy, how does that change the whole valuation process? Number one is, what is the value of that direct subsidy? That is the first thing you have to figure out. It is 28 percent of the charges between $250 and $5,000? What does that mean? I have found it generally ends up somewhere around $600 or $650. It depends on what the utilization of the program is. Even though there is a lot of mumbo jumbo in the act about looking at actuarial equivalence and reflecting behavioral changes, when you start making these comparisons, keep in mind that when you accept a direct subsidy you have not changed the program. You will not change the overall utilization because of the existence of another payer in the system.

Whatever experience you have right now for your current client, or if you are using a general model because the client does not have enough data to base these estimates on, it probably will not change that much. Even though I made the statement that you need to adjust for behavioral change, I do not think there will be any when you start looking at the direct subsidy. There will be a need to figure out and actually isolate that direct subsidy piece that is being paid by the government and have it separate in the valuation, so that it is another number that you have to have as a valuation output. What is the value of that direct subsidy? How does it get into the accrued cost, because you have to have an offset under FAS 109 for a deferred tax asset? If you remember, Jin said that the subsidy that you get from the government is not taxed, and you can take the full deduction for the payment that you make under your regular plan.

If your current payments are now $1,500, and all of the sudden you are getting $600 as a direct subsidy, you can still deduct that full $1,500. That is still in your calculations, and that $600 direct subsidy is a deferred tax asset, even though when you look at the bottom-line FAS 106 result, it is $1,500 minus $600. We have some extra calculations we have to do if someone decides to elect the direct subsidy, and you might also consider what kind of extra administrative charges should be loaded into the valuation now that we have to comply with all of the government regulations that they will come out with when our clients accept the direct subsidy.

After the last conversation I had with CMS, I am personally scared. Why would a company accept this direct subsidy with all the hoops that the government will ask them to jump through? The only thing I come back to is if it will cost me $1 million to comply with this, and it will save me $10 million, I will go ahead and jump through the hoops. I think that even though it will be onerous on the part of all their clients to accept the direct subsidy, they will still take it. It will be worth it financially.

Remember that the Medicare design is indexed. All of those different pieces in there that we talked about, the deductible and the $3,600 out-of-pocket maximum are indexed. Most of our clients do not have indexed programs. Unless you have a

history of that going forward, you should take that into account when considering what the healthcare trends underlying the program will be in the future. I mentioned that the value of the direct subsidy turns out to be usually about $600 for the clients I've run.

I am giving you some general guidelines here, and they are broad guidelines. I do not think I am giving you anything out of this because I am saying it is somewhere between 15 and 25 percent for a high-utilization group, and I just took 150 percent of our standard distribution that we have run against some of our clients who have claims that are 150 percent of what we considered standard. For our low-utilization group, it is somewhere between 20 and 30 percent, and I used an 80 percent standard. It varies depending on what the utilization pattern is for the company, along with the richness of their plan design. I could not come up with a really good, solid guideline about what the value of that direct subsidy is because it varies a lot.

If we decided to coordinate with Medicare in some fashion, if you guys can figure out how to do this, I think that will be interesting in itself, given that all of the prescription drug plans out there are private plans. They are all independently going to come up with their own premiums, even though that $35 is a nice average. In fact, I backed into it with some different data and different projections and compared them with CMS, and somehow they are pretty close. I do not understand how we got there because I understand what they did. I understand what I did. In two completely ways, we ended up with the same number. Sometimes we are very lucky. That is $35 a month for the plan in 2006.

That is the beneficiary's premium, which is really 24.5 percent of the cost of the Medicare plan. Now we must consider the type of coordination we will do. Think about what we are doing on the medical side. A few of our clients still have the standard coordination of benefits. You can do the same thing with the prescription drugs if you wanted to. Most of the ones I have talked to that have considered coordinating with the program will just do a carve-out type of thing. Figure out what your benefit is. Carve out what Medicare pays. It is interesting thing, in some of our designs, when you think about it, that with a relatively high co-payment like $10 on a generic, the average price of a generic today is $18. That is a little bit more than that 25 percent coinsurance in the Medicare program right now.

There will be a lot of situations where the Medicare plan actually pays more than the current employer plan. They are better off with the new program. You really have to go through and look at every different piece, and there are some strange results when you take a look at standard plans today. It will be a complicated effort to try to coordinate with the program, but I think we can do that. Also, make sure you adjust the Medicare offset for the fact that you have that true out-of-pocket maximum. If you have an overlaying plan you are coordinating with Medicare, that $3,600 applies to everything that is out-of-pocket. Remember, the employer payment does not apply to them.

I found that for most of my clients, retirees will never reach that 95 percent. I have some examples where they reach it, but not until someone has had claims over $10,000 or $15,000, and very few retirees are going to have claims above that. However, thinking out into the future, when you look at all the drugs coming onto the market right now, there are a ton of biologicals that I think will be out there that will be expensive. We have very few people hitting those catastrophic kinds of numbers today, but I think at the very high dollar numbers, especially since Medicare will pay 95 percent of that, there will be more on the market 10 years from now than there are today. That is something you really have to think about in the back of your mind, too, when setting these assumptions.

You might have to have some kind of provisions to pay for the Part D premium, because if you want to keep a retiree whole, one way to do that is to pay for the Part D premium like some companies pay for the Part B program premiums today. The easiest way to get this in the back door is that maybe you do not directly pay the premium. You reduce the retiree's contribution to reflect the fact now you have gone into a different world where they are about to pay something to Medicare for them to get the Medicare coverage, because it is still a voluntary plan. Think about whether or not that means you have to pay regional premiums around the country, because all the plans are private plans. Even though the price charged by pharmaceutical companies or charged by your local drug store may not change that much going from community to community, the utilization does. There are some significant differences in prescription drug costs from location to location.

Assuming that we have a carve-out plan, and the employer does not pay for the Part D premium, I found that the savings were usually somewhere around 25 to 40 percent and 35 to 50 percent for the low-utilization group. If the employer pays for the Part D premium, and you carve out that, or you add another $600 into their cost, magically it ends up being pretty close to what the direct subsidy reductions are. From a pretax analysis perspective, if you are paying for the Part D premium, it is pretty close to the same whether or not you accept the direct subsidy or you coordinate with Medicare and pay the Part D premium. You generally end up with the same numbers. If you have a client that is a tax-paying entity and expects to pay taxes some time in the future, I have found after-tax calculations usually end up in this range. It is kind of interesting that, depending on what you do with the program, there are only two sets of numbers you have to worry about. It is either this set of numbers or the prior set, depending on whether or not you have a taxpaying entity.

Another choice that Jin had mentioned is, of course, you could contract with a Medicare prescription drug plan or the Medicare Advantage plan like a lot of clients may have done or still do with the Medicare+Choice plan today. I think you base the estimate on current cost, where you think they will be, consider any kind of supplemental benefits that may be provided, and, of course, maybe they are at a 5 percent penetration right now in the managed care programs. I think it will grow, given the fact that Medicare has really changed the reimbursement rates going

forward to the Medicare Advantage plan. There will be some other opportunities, too. I can see more private fee-for-service plans in some of the more rural areas than there have been in the past. That may be an attractive alternative to get retirees into that type of program, and that is solely because in the rural areas I think they are being paid a lot more than they have in the past. Also consider what kind of changes in administrative expenses that may entail if you are trying to get people into the program that resembles the programs that are being offered today.

When you start looking at the healthcare trend rate assumption, I think things are going to change. You now have a different payer in the whole scheme of things. You have the Medicare program in there. A lot of different things are going on with the post-65 claims, which generally are somewhere around one-half or two-thirds of your post-65 total medical claims, and you have just reduced them by 20 or 30 percent. That means the relationship of pharmacy versus other medical expenses has changed, and these are generally the reasons that are driving different healthcare trends between pre-65 and post-65 retirees. That needs to be reviewed. Maybe now is a good time to consider separate trends for pharmacy versus medical benefits, especially if you have a client that accepts a direct subsidy, because now you have to do a valuation on medical and pharmacy together, and you have to have a separate number out there for the direct subsidy. That subsidy is going to move based on pharmaceutical trends, not your blended medical and pharmacy trends anymore.

I want to show this illustration in Chart 3 to make sure people understand the leveraging going on when you take a look at pharmacy benefits. A typical plan right now is that, for a brand-name program, you start out with the 2004 cost right here and the $20 co-payment. A $20 co-payment is pretty common today, and if we have approximately 13 or 18 percent trends, what does that mean to the bottom-line plan? Remember that a high co-payment means that you have some significant leveraging impact. Assume that costs go up 15 percent, and that is the cost of the average retail drug, a combination of price inflation on the drugs that people will take in 2004 and 2005. It also reflects the fact that maybe this year you will take Prilosec, and next year Nexium, a higher-cost drug, so you have changed the mix. That goes up 15 percent, from $80 to $92. We kept the dollar co-payment at $20.

If you do the math, subtract the two pieces out, I hope it will give you that. The price of that plan has gone from $60 to $72. Magically, instead of a 15 percent trend, you have a 20 percent trend. You have some pretty significant leveraging that you have to account for, and keep in mind that all of the Medicare numbers are indexed to pharmacy cost increases. That is something else to keep in mind. You have some underlying leveraging going on when you start looking at the client's plan and the employer plan and subtracting out the Medicare plan that has indexed co-payments or really indexed plan features.

On the subject of cost trends, I already talked about the pre-65 and post-65 mix. If you have an underlying employer plan that is not indexed or that may not say it is

indexed in the plan, they might have a history of increase in the deductibles and out-of-pocket maximums and things like that. That is part of the substantive plan, if you remember what FAS 106 said. Getting rid of the leveraging is built into the program, but you have to remember to keep all the little things in mind when you start picking out what that healthcare trend rate is.

I mentioned that Part D may be a new assumption if you decide to coordinate with the Medicare Part D plan. I suspect that almost everyone is going to change some provisions, if they coordinate with the Part D program. You will make a plan amendment in the program that is very similar to what is in most healthcare plans today with Medicare Part B, because Part B is voluntary, too. You are going to say you have to take the Part B benefits or, if you do not take them, we will presume that you have the Part B benefits. We will coordinate our plan in accordance with that. You may have someone who does not elect to go into the prescription drug plan. They are under your plan. Whoever is administering your program is going to have to be prepared to figure out what that Part D benefit would have been if they stayed in there and then do the adjustments from there.

As for Medicare Advantage plans, the payment rates were revised, really effective back in March. Going forward in March, they have some higher reimbursements. These are numbers from CMS, and I went back and duplicated them, so I understand the rationale behind it. I think going forward inherent in there is probably a bigger increase than that 10.6 percent. That 10.6 percent increase hit the newspapers. The CMS had projected a 3.2 percent increase on average going from 2003 to 2004, December to January, and then because of the act that was passed, there was another increase that bumped the reimbursements up starting in March, another 7.2 percent on average, and those are all based on the Medical+Choice enrollments as of March 2004.

Really, this is an overall increase for the participants that are in the Medicare+Choice plans that are out there right now, but if you take a look on a county-by-county basis of how the increases went, there is a low of 3.6 percent from the February to March increase. There was a low of 3.6 percent, and the average was 7.2, but there was a high of 49.7 percent. There are some counties that got huge increases. Dollar increases range from $11 to $310 a month. Don't just look at the averages when you start figuring out all these things. There are opportunities out there for a lot of health plans to enter the market because of the increase in the payment rates right now.

I think that does have an impact on current Medicare+Choice offerings, and I think there are going to be more plans entering the market in the future, when all of the health plans finish looking at the increases that Medicare is providing. I guess you could step back and say that they gave us some pretty good hits 10 years ago, too, and we dropped out because it slowed down. I think most of our clients are probably going to proceed with a little bit of caution going into this, and we

probably will not make assumptions that 70 or 100 percent of the retirees will be in Medicare Advantage plans five years from now.

Let me discuss future coordination changes. For any employers that are accepting the direct subsidy, that test of actuarial equivalence, we do not know how it will be certified, but CMS has tried to discuss with employers what they have to do to accept the direct subsidy. There may be an annual certification, but on the part of an actuary to say, based on the plan design, we think the plan is actuarially equivalent this year or next year, maybe in some future time frame. Depending on what the plan design is, a plan that is actuarially equivalent today may not be actuarially equivalent 10 years from now. You will need to think about that when you do the valuation. We may end up saying that we have a client that will accept the direct subsidy in 2006, but by 2010 we do not think they will be actuarially equivalent. We will value that direct subsidy for a four-year period, and that is it. Maybe by 2010, they will change the coordination and that kind of thing, with the same reduction in the FAS 106 expense, but that offsetting deferred tax asset will be smaller because they are no longer accepting the direct subsidy.

One of the other things that you might think about—I mentioned this already—is the result of the change, going from accepting the direct subsidy to coordinating with Medicare, might be in the valuation. The valuation will be a little bit more dynamic maybe than in the past, and—I already mentioned this—you have that indirect effect on FAS 109 because of the deferred tax asset calculations that our clients are going to have to do after they get our valuation results, and we give them what the value of that direct subsidy is, too.

MR. KENDALL: My presentation is entitled "The Proposed GASB Statements." One of the final GASB statements came out about last week, and I assumed I would get a lot of sympathy for the fact that it happened just before the meeting. Of course theirs came out 2 hours ago, so, I have been one-upped again. Some of you at this point may not be working directly with governmental entities or people subject to GASB, so you may not be as interested as you might otherwise be in the subject.

I was going to talk about the background of GASB, compare it with FASB and then talk about some of the implications. I would like to start off with a case study. This is an actual governmental entity. As I said before, you may not work with these types of plans, but you may well live in a state, city, county, school district or some other entity that provides retiree medical benefits. If you pay taxes, you may be interested in what the outcome of some of these things will be.

The particular client that I have been involved with is a large one that has 75,000 people. These are all rounded numbers. I do not have them written down, but they will be easy to remember. There are 75,000 actives and 25,000 retirees. They currently pay about $500 million a year just for the active coverage and about $250 million a year for retiree coverage. I think Dale said something about the Medicare world going in a different world. When we get into the governmental sector, in

some cases we will go into a different universe in terms of the amount of benefits and the amount that the employer is liable for those benefits.

In any event, we did a study for them. We determined that for these folks, the expected post-retirement benefit obligation (EPBO) was about $6 billion; the APBO was about $4 billion; and the annual required contribution was going to be about $400 million a year. Right now they said they pay $500 million for actives and $250 million for retirees. That basically means they have to come up with another $150 million under the new accounting guidelines over and above what they had been paying for retirees. Of course, $150 million in cash has to come from someplace.

How did we get to where we are with GASB? If we go back into the pension world, in the 1980s FAS 87 was the first accounting requirement for pension plans to use basically a single measured accrual accounting, standardized accounting for pension benefits. Shortly after FAS came out, GASB came out with its own statements regarding pension plans, which were relatively similar to the FAS statements. In 1990, FAS 106 became effective. We saw the impact on the private sector, those that are subject to FAS accounting, when those standards came out. Then GASB 12 said basically you are not required to use accrual accounting. If you want to, you can. Most plans did not. In the 1990s, GASB came out with a series of statements for their pension and retiree medical benefits. For some public plans, the retiree medical plans are actually the same as the pension plans or paid out of the same plans. These were some guidelines that affected them.

One of the watershed events in 1999 was when GASB came out with Statement 34, and that is actually a very general statement. It applies to the total financial statement for these governmental entities and said, in general, everything that you do should be done on an accrual basis. To the extent that you are providing future benefits, but you are generating the expense now, you should be recognizing that expense now. As a result of that, there have been a couple of other ones that have impacted specific areas. In 2003, GASB came out with the original proposals on how to deal with these other post-employment benefits (OPEBs).

There are actually two of them that came out. One was regarding the employer's accounting for these benefits, and the other was regarding the plan's accounting for the benefits. Earlier this year, in March I think, they revised the exposure draft for the employer's accounting. There was one significant change from the original draft, a number of smaller changes that were not as significant, and, as I said earlier, we had the final statement. One of the statements, Statement 43, was issued last week, and that is the one on the plan's accounting. It does not take into account all the employer's rules but talks about the plan's accounting for its liabilities.

As I said, the original drafts that came out last year were basically similar in terms of how to account for the cost of a plan. The one for the employers talked about how you measure the obligation and how you come up with the net periodic cost.

As for the one for the plans themselves, you are pension actuaries here. You are familiar with what we do for the value of accrued benefits under FAS 35 versus FAS 87 for pension-ongoing expense. That is the model. The effective dates in the exposure drafts that have not changed were a three-year phase-in. Again, this relates back to our governmental entities.

There are a number of changes in coordination with GASB 34. They have identified entities based on the size of the organization, based on revenue. Those with more than $100 million in revenue are considered Phase 1 or Tier 1 organizations. They will be subject to these rules for their first fiscal year after June 15, 2006. Many of them are on July 1 or October 1 fiscal years, so it would be their 2007 fiscal year. The smaller ones, between $10 million and $100 million, Phase 2, will be the following year, and then the ones that are smaller than $10 million in revenue will take it, in fact, the year after that.

As I said, the revised exposure draft that was released in January of this year had one significant change. I will talk about it a little bit later, but the original draft talked about implicit rate subsidies in which you have a case where an employer may be charging the same rates for perhaps mixing together actives and retirees. If you have a plan, and, for example, if you say that the retirees are paying the full cost, but what they are paying is this blended rate, then there is some subsidy. Implied in that is that the actives are, in fact, subsidizing the retirees. Initially GASB said you could ignore that. That was not something that they were going to be concerned about. However, in the revised draft for employers' accounting, they said that they would have to do those calculations. You will have to basically determine if there is an implied subsidy, and you will have to measure that. The revised draft did have new phased-in effective dates. These are now the fiscal years after December 15, 2006 and 2007. That means that for some of those plans that have July 1 and October 1 years, it has now been pushed actually another fiscal year into the future.

The scope of the proposed statements includes all retiree health benefits, and, as I said before, some governmental pension plans actually include healthcare benefits. It also includes other benefits, typical ones such as dental, vision, pharmacy, and life insurance, but it only includes life insurance in a healthcare plan. If the life insurance is in a pension plan, then it is not included in the scope of these statements. Also not included are things such as temporary "window" benefits. If somebody does a temporary enhancement or things such as accumulated sick leave and it gets paid out, that is not covered under these statements either.

In general, the way that we account for OPEBs under GASB is really going to be similar to the way that GASB accounts for pensions, and that is different from FASB. As you know or you may be aware, there are some differences between FAS 106 and FAS 87 in terms of the terminology, the methodology and the different types of valuations between retiree medical and pension plans on the private sector, those that are subject to FAS accounting. In the GASB accounting, I had

assumed that when the final regulations and rules came out, they would be more similar to FAS 106; in fact, they are more similar to the GASB pension requirements.

The statements require valuations at least every two years. We would anticipate that for large plans, just as they are for private plans, they will probably be doing annual valuations because of the nature of the plans and the changes that are going to occur from year to year in terms of costs and demographics. In fact, if they are a small plan, less than 200 people, then they will not be required to do it more often than every three years.

The statement allows us to use any one of six different actuarial cost methods. These are all cost methods that are fairly familiar to pension actuaries. There is entry age, normal cost. We have a frozen entry age. It depends on how we treat gains and losses and where the starting point is, but we can use entry age or attained age, normal cost plans. They specifically say in the draft to use the unprojected unit credit. We generally think of it as being a projected unit credit because we generally project benefits to retirement. The distinction that they make is that unless it is a benefit, such as a life insurance benefit that is based on pay, there should not be any future increases in the benefit due to pay.

Therefore, what we consider to be the benefit at age 65 is the benefit at age 65. They say that there is not a projection in there because there is not a pay projection out to retirement age. Essentially it is the same thing for most benefits, as it projects unit credit. Finally, you can use the aggregate method, which would generally produce the highest costs immediately, particularly to the extent that most of these plans are not funded.

Let me go through the differences. Under FAS 106, to come up with the benefits, we project the cash flows based on our economic demographic assumptions, some of which you have heard about. Once we do that, we determine the EPBO. Again some of these differences are more the terminology than they are significant differences, but we determine an EPBO. We use some attribution method. Typically it is what we would call the unit credit or projected unit credit method to determine the service cost and the APBO. For people who are fully eligible for benefits, APBO and EPBO are going to be the same thing. Once we have those pieces, we determine under FAS the net periodic benefit costs, which include a service cost, separately an interest cost, an offset for return on assets if it is a funded plan, and then typical amortization items, transition and obligation.

Again, for FAS 106, when that became effective, employers had an opportunity to immediately recognize any transition obligations, and many did so. There are not any of those around, or there never were any of those, but, if there were, they amortized the transition, past service cost, and then gains or losses, and that is how we determined the cost. From a balance-sheet perspective, the net periodic cost each year is the increase in the accrued post-retirement benefit (APB) cost. To

the extent that contributions are made or benefits are paid, that reduces the APB cost in that year, and the total accumulative differences of the net periodic cost and the contributions from year to year will add up to the current year's APB cost or if by some chance the contributions have exceeded the cost, then there could be a credit.

The GASB starts out pretty much the same way. We figure out what the benefits are going to be. We project the cash flows using assumptions, and I will talk a little bit about how some of the assumptions may be a little bit different. We determine an actuarial present value that we call an APB of all benefits using the appropriate discount rate. We then use one of the six methods that are available to determine a normal cost to separate the APB into past service and future service, and the amount that we consider to be past service is called the actuarial accrued liability.

The next step is, if we have a funded plan, we determine an actuarial value of assets, which could be something other than the market value of assets. We are allowed to use smoothing methods and those kinds of things to determine the cost. We determine the unfunded actuarial liability, the difference between the actuarial liability and the actuarial value of assets. We determine how we're going to amortize that unfunded accrued liability. In the first year we are allowed to amortize pieces of unfunded accrued liability in any method that is reasonable and consistent. However, the total period is not to exceed 30 years, and this is a true amortization with interest. For FAS 106, we use a $1/20^{th}$ for a 20-year amortization and then built the interest into the interest cost. This is actually the amortization with interest. Then we could amortize them as a level dollar amount or as a level percentage of pay over that period. Then we have the normal cost. The sum of the normal cost plus the amortization payments is called the annual required contribution (ARC).

The annual OPEB cost then is equal to the ARC plus any adjustments. Adjustments will be made if the actual contributions in the prior year differ from the ARC. In other words, if they do not contribute the full ARC, then they will build up a liability, and basically interest on that liability will be the adjustment that gets added into the current year's ARC to come up with the total OPEB cost. As of the transition date, we will not have recognized any costs. Some entities may have set aside some kind of a liability for retiree medical. They may start off with a non-zero number, but for the majority they have not yet recognized any such cost. So they will start off with zero, and then basically it will simply be the difference of the contributions, and the future OPEB costs will build up those liabilities.

I talked a little bit before about the implicit rate subsidies. That is one of the issues in GASB. They initially said not to worry about it, and then with the final one, we ought to take a look at that. Again, we blend together rates for actives and retirees. When we look at what the true cost is, we cannot use those rates for the premium costs and say that that represents the actual cost. We have to determine to what extent that does or does not reflect the total cost of retirees, presuming the retiree

costs are higher than they are for the actives. When we look at post-Medicare, then we are in a different situation, and it can be quite an exercise to decide how we should charge. If we are doing something to simplify the administration of the plan, we have to go back and pull the pieces out to decide what is really going on there and report that to GASB.

There are other things in there. There are specific provisions for small plans. These are single-employer plans with fewer than 100 total members, actives and retirees. They are allowed to estimate their costs. They are not obligated to follow specifically all the rules in GASB, but they have to say what they do. They can use simplified assumptions. They can use their actual experience. They can take into account their actual experience, but they are supposed to take into account future trends. More so, they are still required to use individually reasonable assumptions. Theoretically GASB says you do not need an actuary to do this. You can have a sponsor sign off on it. I would assume that most auditors would be happier to see an actuary put their signature on this than a small-plan employer, but we will see what happens.

Here are some of the other differences or some of the other issues. Certainly on the pension side, discount rate assumption is a major topic of discussion. On the retiree medical side, it is somewhat less so. As you know, we are supposed to choose a discount rate that basically reflects one at which we are able to settle liabilities. Since we cannot settle liabilities for a retiree health plan, I am not sure exactly what we should do, but typically we use something like the FAS discount rate for pension plans. For FASB, we are supposed to look at each year the current rate. We are supposed to decide what rate we might settle at this year. Next year, we will decide what rate we might settle at that year and reflect that.

For GASB, they tell us to use a long-term rate based on the assumed return on assets. That is more for a typical pension valuation or the expected return on assets for a FAS 87 valuation. That is what they are asking for here. You have to actually look at the assets that are going to generate the contributions and determine the long-term rate of return on those assets. As I said before, currently, since these requirements are not yet in place in particular, most of these plans are not yet funded, so there are no trusts set aside. We may start to see some of these in response to these rules. Some of them will continue to be unfunded. That means that basically the contributions are coming from general revenue. When we ask ourselves what rate of return we are getting on general revenue, that is the rate of return we are supposed to use for the discount rate for GASB.

That is really saying that you should probably use a pretty low rate to determine your liabilities, and that can have a very significant impact on the size of these liabilities. The case study that I talked about where we came up with a $6 billion EPBO and the $4 billion APBO is one where we used a 6.5 percent discount rate, which is pretty close to what we use for pension plans. If you took this literally, 6.5 percent may be too high, and the liabilities may, therefore, be too low. The

disclosure requirements, basically what you have to provide, are similar to what you have to show for GASB. On the pension side, it is pretty straightforward: the numbers, the cost, the balance sheet items, the funded status and then funding progress. You have to have a little history of how you got to where you are today in there.

The last part is, now that we have this, what is going to happen? I don't know. Most plans, as I said, have not really looked at these things before. They may have had some idea that by providing full medical benefits they know what it costs them to provide it to their actives. They know it costs them a lot now to provide it to their retirees, but they have not really looked at how much it will cost to provide it to those actives in the future. They are just getting these numbers now, and the magnitude, as I said before, is staggering. Are plans going to prefund? Some will. Where will the money come from? I don't know. Many governmental entities, California and other places, are under budget restrictions.

It will be very difficult. If you are a taxable entity, basically the governmental accountants are saying that historically we have charged these expenses off as we have done pay-as-you-go. When people retired, that was when they took the hit. We are saying that from an expense standpoint, now you have to take that hit during the working lifetime. They are shifting the cost from basically one generation to another. To come up with the cash to pay for these things, our entity is going to do some intergenerational shifting on taxes. Are we going to start raising our tax levels to pay currently for retirement benefits down the future?

As many of you I am sure are aware, probably the overwhelming response we had to FAS 106 back in 1990 among the private corporations was to reduce benefits. You would think that that would be a reasonable response in the face of this change as well, but I am not sure. It is very difficult to implement the kind of benefit changes on this group of employees, more so than it was 25 years ago, on the private side. We are talking about groups that are not only heavily unionized, but also about unions that tend to be very politically active, and it would be very difficult to do things that are going to upset these people. Obviously reducing their benefits will upset them. I am not sure what the answer is. Those of us that are dealing with these things are in the position of being the messenger and saying here is what this is going to do, but we do not have any real solutions as to how to fix the problem.

MR. CHARLES W. EDWARDS: I have a question for Jin on the issue of the ambiguities on determination of actuarial equivalence. You spoke a little bit about taking into consideration the ambiguity. One of the significant ones is about whether or not retirees' contributions toward benefits should be taken into consideration in determining whether it is actuarially equivalent to the Medicare prescription drug benefit. It seems to me that that is an unresolved issue, and yet we are all faced with moving forward in valuing these plans in the upcoming

quarter. We need an assumption, barring a plan amendment, as to whether or not the plan will qualify for the subsidy.

A number of folks at Mercer have taken the conservative approach and are advocating a conservative approach, which would look at the net benefit after contributions and which would tend to make some plans ineligible for the subsidy that might be eligible in a situation where you are not considering the retirees' contributions. That seems to me to be potentially an unreasonably conservative position, because I think that a lot of employers and particularly some of the sponsors that I work with are waiting before they amend their plan to see whether or not final guidance on the actuarial equivalence issue will necessitate that. If it does not necessitate that, they get that subsidy without a plan amendment. I think that it would seem unreasonable to think that anyone will leave this type of money on the table. I am asking if anybody has given any thought to this and whether or not it would seem to be unreasonably conservative to look at the actuarial equivalence question only on a net basis.

MR. PARK: I think that was a really good question. It is my understanding that CMS is going to come out with the regulations concerning the actuarial equivalence some time this year. They originally said around summer of this year. I do not know what other companies do. What we do is, whether you develop actuarial equivalence or not, we just look at plan design. If you just look at plan design, it is somewhat easier to determine whether your plan is actually equivalent or not, because it provides deductibles and everything. Then you try to come up with some kind of percentage of reduction in claims cost for prescription drugs, but when you apply those we try to be conservative and apply those savings percentages to net benefits. I know that it is kind of conservative, but personally I think it is more reasonable.

It has been a really long time since I brought any good news to employers regarding FAS 106. This was one piece of the good news, but I did not want to overestimate it. We can say that your savings is going to be only 20 percent, and then can come back later with, well, it happens to be 25 or 30 percent. This is better than telling our employers that the savings is 30 percent and then come back and say it will be only 10 percent. I think a conservative approach is a better approach. In my experience, the biggest issue I have with my clients is actually communication between human resources and finance, because all of these benefit design and administration issues are actually human resources issues, and they want to postpone the decision until 2006.

They want to evaluate all the options and consider retiree communication issues, but from finance this is cost savings. They are saying, "What do we want to wait for? Let's choose the option that saves us most money, and do it right now." I do not know about your clients, but most of my clients, human resources people, do not really talk to finance people and vice versa. It has been a real nightmare for us to communicate that and bring all of those related parties to the table.

MR. YAMAMOTO: I am glad I am not the only one who experiences that. I think one of the biggest issues I wrestle with among our clients is, we can take a look at their programs, and depending on a lot of interpretations, we can apply to what the actuarial equivalence definition might be. We can prove or disprove that your plan is equivalent. It generally comes down to the issue that we think regulations are going to come out some time in June, maybe final regulations later this year. That is the plan right now with CMS. The more I have talked with the staff people who are putting the regulations together, the more I have become confident that it will probably be here at the end of the year. They do not have a lot of time to get the regulations out in June, and I suspect what will come out is still their initial thinking about how things work. They still have a relatively simple mind-set of how plans work, and maybe they will learn a lot in the next month or so, but one simple example is that they are just saying that they will define actuarial equivalence based on ERISA plans. They will just take a look at an ERISA plan and figure out whether or not it is actuarially equivalent.

I said, "Did you realize that one plan could have several different groups of people in there with potentially different plan designs and different retiree contributions?" He said, "Oh, no." I hope they learn something from that, and I think maybe in the next month, while they are writing it, it will get reflected, but I suspect there will be a lot of holes in what they come out with. Even when you look at the proposed regulations in June, if they really come out in June, I am not fully confident that will be the final answer. Then you get to the finance side and say, "We can say it is actuarially equivalent now. Take the reduction and your FAS 106 hit, but you have the chance sometime in the next six months to a year that something might change, that we get final regulations, then your position changes, and we might have to bounce it back up again."

What are you willing to undergo in your financial statements for the price of potential volatility going down a lot and then coming back up or what that might be? That has helped some of the discussion going on between finance and human resources. If they start thinking about what the ramifications are in their quarterly statements, some of them may want it this year because they expect things to improve over the next year. They do not mind having maybe a lower expense hit now with a trade-off for something higher next year, because maybe there will be an offset, and they will definitely know something that you do not. I think you have to give them every opportunity and understanding of how things are going to lay out going into the future if things change. That is why I think next year is probably going to be pretty exciting.

MR. EDWARDS: Isn't there an Academy committee trying to help determine actuarial equivalence?

MR. YAMAMOTO: There is an Academy work group. Although CMS has actually shut us off from discussion at the moment, I think as soon as regulations come through, they would like to hear from the Academy.

MR. MARTIN E. STAEHLIN: My question is different. I am looking for some free consulting. I have a client that I had not worked with before, and they kept saying they were GASB, so quit talking to them as if they were FASB. They are different. It is in selection of the discount rate, and they do not have any assets. They tell me, it is a long-term rate of return of the corporate assets that is used for this benefit. When we were talking about that and I was giving them some advice, they said they invest in three-month CDs. I do not know what size their liability will be. Anyway, my problem is that whatever the answer comes out to be, should there be some discussion of, if you have three-month CDs, how will that be the right rate for funding liabilities that have a year-15 duration? Can you help me with determining discount rates for GASB?

MR. KENDALL: The answer is no. Literally the wording in it is, "use the expected long-term rate on the assets that are used to generate the contribution to the benefit payments to the fund." If they are being paid out of general assets, the best you can do is go back and look at what over some long term their rates of return have been. Literally that is what it tells you to do. If it is not being prefunded, you have problems.

It would seem to me that one potential solution would be to start prefunding at some small level, invest it in equities, and then you can expect the rate of return on your equities to be pretty good.

MR. PARK: Maybe you should just advise that they get a new investment advisor. Then it will be their problem, not yours.

MR. STAEHLIN: Dale, you were talking about the tax treatment on the subsidy, and I guess I had not fully understood before what I think you said, but it seems like a real double-dip from the IRS. I have not read the Medicare reform legislation in its entirety, but I'm hoping you have and that you are aware of some Treasury guidance. It would seem like there is a lot more value to that subsidy than the subsidy itself, because they get a tax-free payment as well as a tax deduction on an expense that they really did not have.

MR. YAMAMOTO: Right.

MR. STAEHLIN: Is that from the congressional legislation itself?

MR. YAMAMOTO: It is from the legislation itself, from the act, that the subsidy that you receive is not taxable, and that you can take the full deduction for your claim payments that are made. It is very clear.

MR. STAEHLIN: Also, you mentioned the indexing of the Medicare subsidy as well as the Medicare prescription drug benefit, and I guess at this point we do not have any detailed information on what exactly that indexing rate might ultimately be. I guess we do have some experience on Medicare reimbursement rates for medical

services. Of course, those are increased periodically in a process that is somewhat political and historically has not kept up with underlying medical inflation. You talked about leveraging, but I think there is the other issue of not just leveraging from the benefit itself but leveraging in the context of the Medicare benefit if it is a wraparound product or the subsidy if it is a full drug benefit.

MR. YAMAMOTO: Essentially when you look at the Part A hospital deductible, that is indexed based on Part A experience and cost. Going forward, the $110 and $100 Part B deductible is going to be indexed by the Part B experience. When you look at the Part D, the prescription drug cost, they will be indexed by pharmacy experience. Now you will have three different indices running through the Medicare system.

MR. PARK: Actually that tax subsidy issue is in the Medicare Reform Act. The issues are a little bit more complicated on the FAS 109. We know that on the FAS 109 with deferred tax assets or liability, we have to keep separate books, one with and one without Medicare prescription drug reform. There are guidelines, but there are certain uncertainties for us to how to deal with those issues. Does that mean with FAS 106, valuation for both scenarios under FAS 106 and FAS 109, or is it just a present value of past credit?

MR. YAMAMOTO: That is actually clarified a little bit more in the new 106-2 that just came out. There is a little paragraph in there. It is actually a simplified example. That will be helpful, but they are essentially trying to say that the deferred tax asset should not change because of the acceptance of this direct subsidy, and that is kind of the bottom line. Even though the 106 expenses now come down, the deferred tax asset should not change because of that, because the subsidy is a tax-exempt subsidy given to you.

MR. DAN LEVIN: Dale, you touched on this, but I wanted to clarify a little more the approach of coordinating an employer plan with Medicare Part D as opposed to taking the subsidy or eliminating coverage entirely. Because that $3,600 is like a moving line that employer third-party payments will not relieve a retiree's liability for Medicare, then all you could really do, it seems to me, would be to coordinate paying the first $250 and then on the next $2,000 the amount that the Medicare would have made you pay, the 25 percent. After that it seems like your plan will pay everything it otherwise would have paid anyway. Is that accurate?

MR. YAMAMOTO: That is right. You get credit for that. They are estimating the premium to be somewhere around $1,600. I mean you can back into that because $35 a month is $420 a year times four gets you $1,680. That is what CMS is estimating the overall cost to be. The value of the 95 percent catastrophic coverage is probably one-third of that.

Chart 1

Prescription drug coverage: Part D
Standard Rx benefit

- Initial coverage
  - Deductible of $250, enrollee coinsurance of 25% up to $2,250
- "Doughnut hole"
  - No coverage until enrollee reaches out-of-pocket limit of $3,600
    - Amounts paid by third parties do not count towards out-of-pocket limit
- Catastrophic coverage
  - Above the out-of-pocket limit, enrollee coinsurance is the greater of 5% or a fixed copay ($2 generic or $5 brand, indexed)
- Member pays roughly one-quarter of Part D cost (estimated at $35 in 2006)
- Amounts are indexed

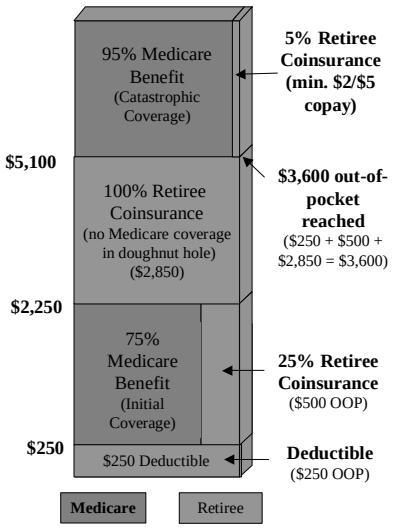

Chart 2

Opportunities and issues
Comparing the options

	Integrated Wrap-Around Plan	28% Subsidy	Benefit Reduction/ Plan Termination
Primary payer	Medicare	Plan Sponsor	Medicare
Part D premium	Yes	No (no subsidy if enrolled)	Yes
Rx design	Amendment likely and may also want to change design	Can likely remain, if equivalent (except DC and capped plans)	Need to change or terminate
Contributions	Need not change	May have to change (e.g. annual caps)	Would likely change
Communication	May be extensive	Limited (avoid Part D enrollment)	May be extensive
Administration	More complex	May be no change	Reduction – more complex Termination – none
Recordkeeping	May be no change	Potentially extensive (government reporting requirements)	May be no change
Retiree perspective	Part D premiums and potentially reduced benefit	May be no change	Part D premiums and reduced or no benefit (age discrimination issues)
Financial impact	Significant potential savings	Lowest savings (ignoring tax impact)	Greatest potential savings

Chart 3

Health Care Cost Trend Rate

- Short-term pharmacy trends still relatively high
  - Underlying trends 13% to 18%
  - High copay plans have significant leveraging impact