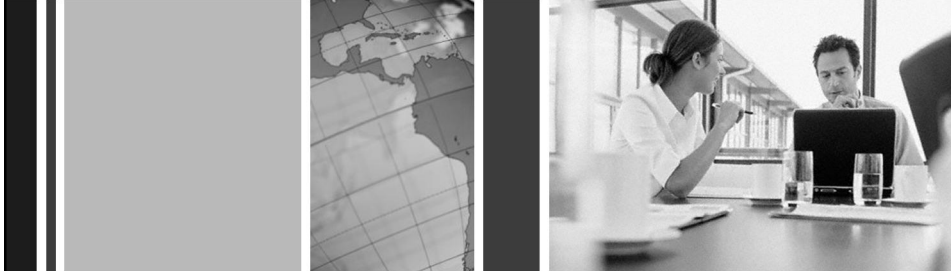


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CCA Annual Meeting Session 3:

Retiree Medical - Innovative Designs and “Cutting Edge” Accounting

Stuart H. Alden, FSA, MAAA, FCA
November 2, 2009



Background

- “Defined Dollar” designs were relatively new when FAS 106 was developed (1993)
- No precise guidance on how to account for them, in the Statement or in supplemental materials
- Need to rely on experience, an understanding of the FAS 106 concepts, and input from clients and auditors



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Discussion Outline

- Defined dollar benefits (“DDB” or “capped” plans)
- Account-based plans (notional retiree medical accounts or “RMAs”)
 - A newer variation: “Ad hoc” RMAs
- “Terminal” or “successor” VEBAs
- Access-only (“retiree-pay-all”) plans
 - Interplay with COBRA

“DDB” or “capped” plans

- Cap is a limit on employer commitment to subsidize retiree medical benefits
- Caps usually a dollar amount, generally different pre/post-65
 - Could be distinct for retiree and dependent(s)
 - Might be a multiple of average cost in a particular year (then translated to \$ amount)
 - May be related to service or points (age+service)
- When administered as true “stipend” (“here’s the money, go buy coverage”), valuation model is straightforward—like a pension
 - May be some subtleties, e.g.
 - If stipend exceeds current cost of coverage, how to handle excess?
 - Deferrals and opt-outs, if applicable

Conventional self-insured capped arrangements

- With a self-insured employer plan, caps typically “enforced” via the setting of retiree contributions
 - Critical issue: Be sure plan sponsor is administering cap correctly
 - If valuation model and actual administration are out-of-sync, one of them must change
- When developing the valuation model, first decide whether an accurate value is needed for retiree contributions
 - If not, and caps already reached, “stipend” model (“value the cap”) is simple and practical
 - If contributions must be valued, there are at least three common approaches...

Cap method 1 – “Switch Gears”

- Estimate future year when cap will hit
- Before that year, value age-related gross per-capita costs and actual (or calculated) contributions, each with trend
 - Employer amount is the balancing item
- At and after the cap year, switch to valuing just the cap for employer, balancing item is retiree contributions
- Pros:
 - Simple to explain (perhaps)
 - Estimated year that cap applies can be useful information for client, perhaps not readily obtained in the other methods
- Cons:
 - Potential “dislocation” at cap year – tends to show up in cashflow exhibits and looks unrealistic, even if overall results (APBO and SC) are reasonable

Cap method 2 – “Let it come out in the wash”

- Value gross costs as age-graded per capita
- Value employer amount as the cap (assuming it's already been reached)
- Let the balancing item be the retiree contribution
- Pros:
 - Simple and straightforward to program
 - If cap already hit, should produce reasonable aggregate cashflows
- Cons:
 - Individual results are not realistic and may look nonsensical – e.g., coverage for younger participants can look like a “profit center”
 - If cap has not yet been reached and employer amount is not permitted to go negative, may result in overall overstating of costs

Cap method 3 – “Replicate actual administration”

- Determine an average per capita cost in each future year (often needed separately pre- and post-65)
- Calculation contributions using a formula that incorporates the excess (if any) of the average cost over the cap
- Calculate the employer commitment as the age-related per capita cost minus the calculated retiree contribution
- Pros:
 - Closest to actual administration of the plan
 - Easy to explain (in most cases)
 - Individual results generally look reasonable
- Cons:
 - Need care in selecting the “vector” of future average costs
 - Average varies not only with trend but with changing average age of the inactive population
- One alternative – determine gross cashflows and headcounts and develop an average cost vector as input to the valuation

Accounting for “traditional” account-based plans

- These plans generally use a \$ amount at retirement, or an amount “earned” each year that accumulates in an “account”
 - “Account” is frequently just notional—no earmarked assets
 - Could be a single amount or separate for retiree/spouse
 - May be a true “FSA,” or usable just toward premiums, or restricted to the employer’s plan(s) only
- Natural question – can DC accounting be used (i.e., just value the “contribution”)?
 - Generally no – FAS 106’s definition of a DC plan appears to be restricted to actual funding of individual accounts.
 - So, we usually fall back to traditional “DB” accounting, even though the employer promise, strictly speaking, is the subsidy, not the benefit

Accounting for “traditional” account-based plans

- Generally most practical to treat the payout from the account as an annuity
 - Typically with aging and trend escalation
 - Account balance may or may not receive interest credits in retirement, depending on plan design
 - Account depletion can be modeled as a “lifetime maximum”
- Additional assumptions may need to be considered:
 - Draw-down rate – full amount needed for coverage each year, or something less?
 - Commencement of draw-down – at retirement or deferred?
 - Forfeiture? Depends on plan design.
 - Single-life plans versus joint & survivor payout
- After annuity is modeled, FAS 106 accounting proceeds in the usual fashion
 - May have a deferred attribution period, depending on plan design

Newer “ad hoc” account-based plans

- Rather than a strict formula (e.g., \$2500/year from age 45 through age 54), annual credit to a notional account is truly ad hoc – at employer’s discretion
 - Could employ a profit-sharing formula or other non-binding guideline
- In these situations, a conventional PUC approach may not make much sense:
 - There may be no clearly-evident substantive plan
 - Credits could cease for a number of years, with full intention to resume credits – so it’s not curtailed
- Instead, a “true” unit credit (“TUC”) approach can be used

Newer “ad hoc” account-based plans

- Under TUC, the accrued benefit is based on the notional account balance on the valuation date
 - Balance not used directly, though
 - Instead, generally project current balance forward with interest credits (if applicable) but no assumed future employer credits
 - That balance is then converted to an annuity, using the same methods as for “traditional” account-based plans
 - The annuity is present-valued at the date of decrement
 - That present value is then commuted back to valuation date with the valuation discount rate, turnover, etc.

Newer “ad hoc” account-based plans

- Some additional considerations
 - Watch out for potential back-loading situations when adopting plan design with an “opening balance” for current active participants
 - May be times where the valuation model can be simplified (e.g., skip the annuity modeling) if it can be shown that additional complexity doesn’t change results materially
 - For example, need to think about interplay between interest crediting rate and valuation discount rate

Terminal or successor VEBA arrangements

- Several industries (automotive, steel) have used or are considering using these arrangements
- Typically the employer-sponsored plan is discontinued and a trust is funded to provide future benefits
 - Trustees may be from a retiree group, a union, the employer, or some combination thereof
 - Covered group is typically closed
 - Unless there is an additional funding source, benefits will be restricted to assets available

Accounting for successor VEBAs

- In a “clean” situation, the employer makes a one-time cash payment and eliminates its plan, relieving itself of all future responsibility for funding and benefits
 - Looks and feels like a full settlement
- Unfortunately, situations are rarely this clean, e.g.
 - Payments scheduled over a number of years, possibly with interest required
 - Payments not always in cash
 - Amount/number of payment/s dependent on future financial performance
 - Employer responsibility in event of trust shortfall unclear

Accounting for successor VEBAs

- Proper accounting treatment will be specific to the situation, and is frequently subject to much discussion. Some ideas:
 - Partial settlement and conventional accounting for remaining obligations
 - APBO equal to expected value of remaining payments
 - If amount or timing of payments not known with certainty, may be able to assign probabilities
 - Other?

Handling of access-only plans

- When access-only is a small subgroup, it's easy – kick them out of the val
 - But you need to make sure no long-term employer subsidy exists, intentional or not
- As access-only approaches or reaches the entire group, then what?
 - Ignore the whole thing?
 - One (or more) year amortization of surpluses or shortfalls?
 - Other?

Access-only and COBRA

- Traditional retiree medical was generally preferable to COBRA – not the case with high retiree contribution / access-only plans
- If permitted to defer retiree medical until COBRA runs out, retirees frequently will do so
 - If employer-subsidized, retiree benefit could then be valued as deferred
- COBRA benefit can receive FAS 112 treatment in most cases, since not tied to age, service, or retirement
 - However, “hidden” subsidy is generally greater for retirees than for actives, and average duration likely longer

Comments and Questions



**RETIREE MEDICAL –
INNOVATIVE DESIGNS AND
“CUTTING EDGE”
ACCOUNTING – SESSION 3**

Gary Koscielny - Cynomys, Inc.

OVERVIEW

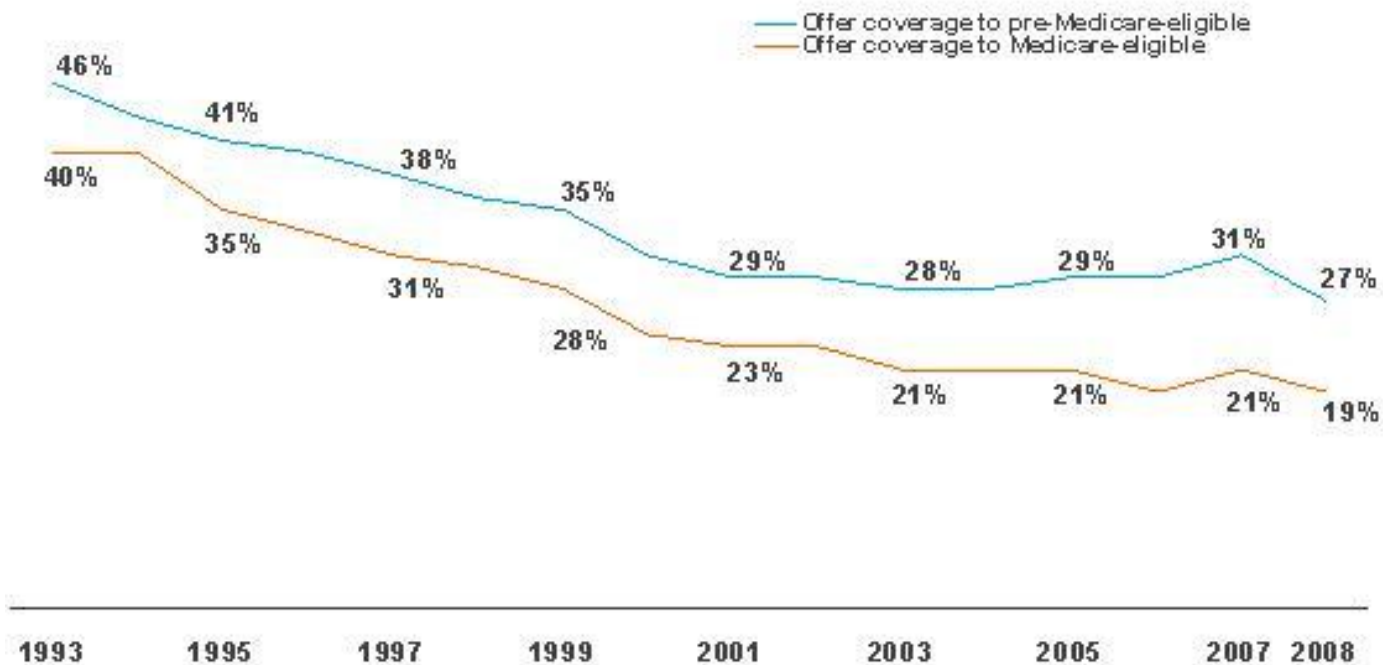
- What is happening with retiree medical plans
- What is an innovative design
- Case Studies
- Conclusions



FIGURE 7

Offerings of retiree medical plans* have fallen sharply over the past decade

Percentage of large employers



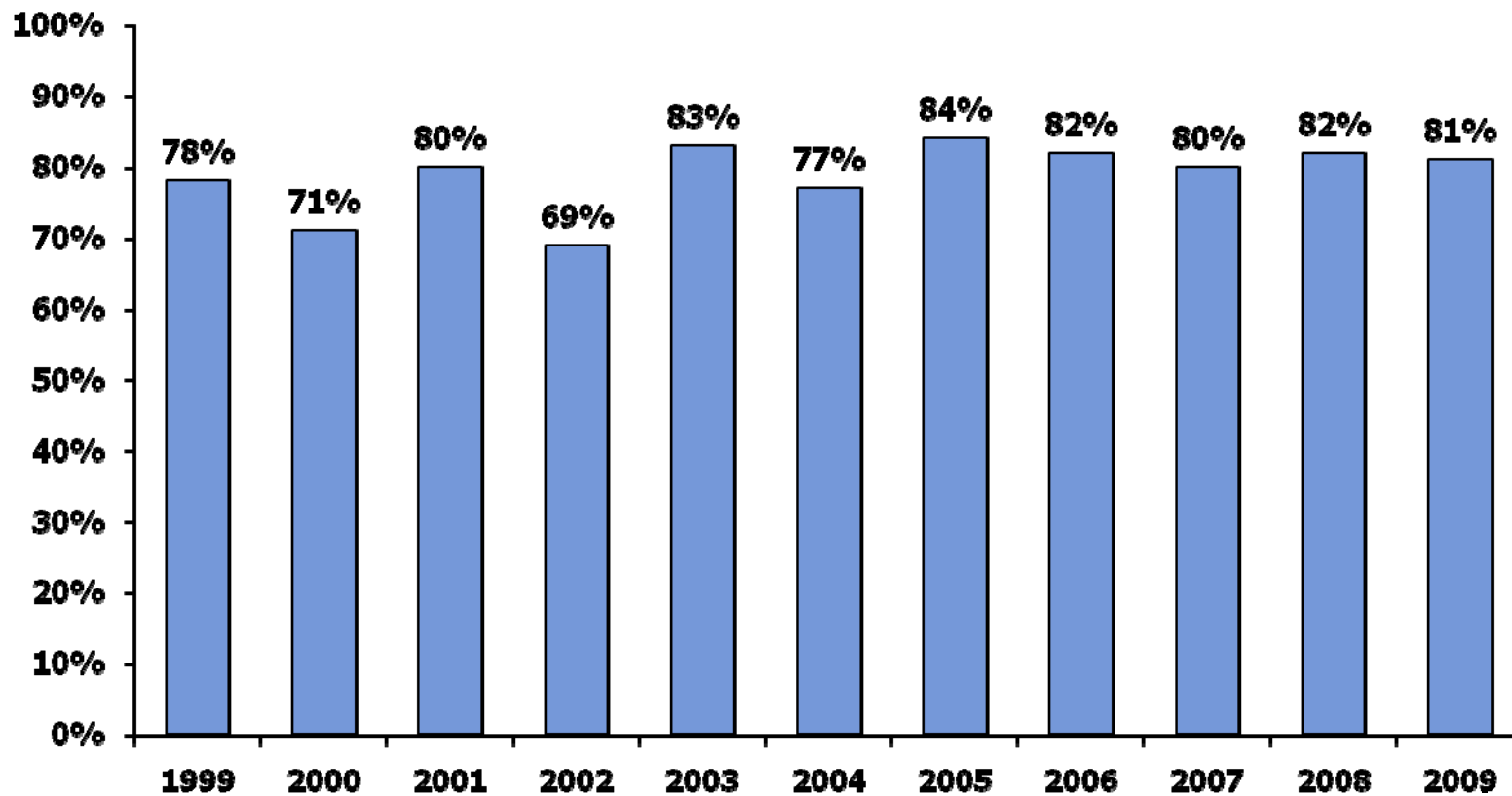
*Plan must be offered on an ongoing basis (i.e., new hires are eligible).

Source: Mercer's National Survey of Employer-Sponsored Health Plans



AMONG ALL LARGE GOVT FIRMS (200 OR MORE WORKERS) OFFERING HEALTH BENEFITS TO ACTIVE WORKERS, PERCENTAGE OF FIRMS OFFERING RETIREE HEALTH BENEFITS, 1999-2009

SOURCE: KAISER/HRET SURVEY OF EMPLOYER-SPONSORED HEALTH BENEFITS, 1999-2009



WHAT DO WE MEAN BY “INNOVATIVE”

- Cost to sponsor is “controlled”
- Provides a meaningful benefit



WHY ARE COSTS OUT OF CONTROL

- Typical plan design
 - Pre 65 Benefit Plan– continuation of active plan including employee contribution amounts
 - Post 65 Benefit Plan – supplement to Medicare
- How is a typical Benefit Plan defined?
 - Deductibles
 - Coinsurance
 - Out of pocket maximums



WHAT IS WRONG WITH THIS TYPE OF BENEFIT PLAN?

- The Benefit Plan is defined in terms of the Services to be provided to the retiree without respect to cost to the plan sponsor
 - No effective limit on number of services
 - No effective limit on new services
 - No effective limit on cost of services
- Overtreated by Shannon Brownlee



WHAT IS AN INNOVATIVE DESIGN?

- Define plan in terms of the cost the sponsor is willing to pay
- Don't define plan in terms of services to be provided



CASE STUDY 1 – THE COUNTRY SCHOOL

- Current plan
 - Pre 65 - continuation of active plan
 - Post 65 - Medicare supplement plan
 - Retiree contribution – 20% of the premium
 - Eligibility - 85 points, minimum of 20 years of service
- New Plan
 - Specific dollar subsidy for all retirees adjusted annually
 - Retiree contribution – balance of premium cost
 - Eligibility – no change – applies to post 7/1/08 hires



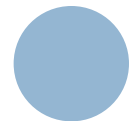
CASE STUDY 1 – THE COUNTRY SCHOOL

- Issues
 - Changes will not come into effect for 20 years or more.
 - Need to establish a mechanism to specify what the reimbursement level will be.
 - Need to communicate new plan
- Chose to start reimbursement amount at current level. Future increases at half trend.
- Pre 65 premium to be “true cost”



CASE STUDY 1 – THE COUNTRY SCHOOL

Year	Trend	Old Plan Subsidy	New Plan Subsidy
2009	N/A	\$300	\$300
2010	9%	\$327	\$314
2011	8%	\$353	\$326
2012	7%	\$378	\$337
2013	6%	\$401	\$348
2014	5%	\$421	\$356



CASE STUDY 1 – THE COUNTRY SCHOOL

- No FAS 106 savings initially because it only applies to new hires.
- Intention is to offer Company plans but at specified retiree contribution rates.
- Could also expand number of plans offered or reimburse for retiree purchase of outside plan – including Part B premium or Part D plan.
- What will marketplace be like in 20 years?



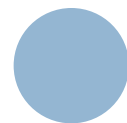
CASE STUDY 2 – THE ASSOCIATION

○ Current plan

- Pre 65 - continuation of active plan
- Post 65 - Medicare supplement plan
- Retiree contribution – None
- Eligibility – 55 with 10 years of service

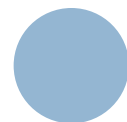
○ New Plan

- Plan provides maximum amounts to reimburse retirees for the purchase of an insurance policy
- Pre 65 – may buy COBRA for 18 months
- Post 65 – target is the sum of the Part B Premium (basic), national average premium for a Part D plan and Medicare supplement Plan C.



CASE STUDY 2 – THE ASSOCIATION

<u>Component</u>	<u>2008 Allowance</u>
Pre 65 maximum	\$ 12,750
Medicare Part B Premium	\$ 1,157
Part D National Avg Plan C	336 <u>3,057</u>
Total Post 65	\$ 4,550
Post 65 maximum	\$ 7,000



CASE STUDY 2 – THE ASSOCIATION

- Company generally reimburses actual retiree expenses. Some retirees get higher reimbursement than others – but always below the maximum
- Pre 65 coverage is generally COBRA from the Company or a spouse's plan. No one has tried to buy a commercial pre 65 plan yet.
- Small group allows great flexibility and personalization.



CASE STUDY 2 – THE ASSOCIATION

- Company no longer sponsors retiree plans
- Company retains the right to reduce its trend but so far has never done so
- Retirees can take advantage of local circumstances.



CASE STUDY 3 – CAR PARTS CO.

○ Current plan

- Pre 65 - continuation of active plan
- Post 65 - Medicare supplement plan
- Retiree contribution – 25% of cost
- Eligibility – 55 with 10 years of service

○ New Plan

- eliminated benefits for employees with less than 45 & 5
- future employer contributions capped at the current amount plus 3% per year increases



CASE STUDY 3 – CAR PARTS CO.

- New plan eliminates a significant number of current actives and reduces trend to 3%.
- The company eventually eliminated all non union benefits due to business conditions.



CASE STUDY 4 – THE PUBLISHING CO.

- Current plan
 - Pre 65 - continuation of active plan
 - Post 65 - Medicare supplement plan
 - Retiree contribution – 20% of cost
 - Eligibility – 62 with 15 years of service
- New Plan
 - future employer contributions capped at the current amount plus 4% per year increases



CASE STUDY 4 – THE PUBLISHING CO.

- Substantial FAS 106 savings due to reduction in trend.
- Continue to offer only employer plans
- New CEO guaranteed himself continuation of the prior plan in his employment agreement.



CASE STUDY 5 – THE MINING CO.

- New company formed through the purchase of several different mining operations
- Some of these operations had union contracts (200 ees) with traditional retiree medical benefits. Others were non union with no retiree medical (2,600 ees)



CASE STUDY 5 – THE MINING CO.

- New plan
 - Pre 65 - \$20/mo/yr srv subsidy
 - Post 65 - \$9/mo/yr srv
 - Retiree contribution – Balance of premium
 - Eligibility – 55 with 10 years of service
- Company to sponsor plans and allow outside purchase of coverage



CASE STUDY 5 – THE MINING CO.

- Reimbursement levels were set so that someone with 25 years of service would get 100% reimbursement for a catastrophic plan pre 65 and 80% reimbursement for a Med Supp plan.
- Co has not increased rates since plan was implemented.



CASE STUDY 5 – THE MINING CO.

- Co. plan cost substantially less than the union plans.
- Co. was able to convert 2 of 3 union groups
- The savings from the union plan conversions offset about 15% of the cost of the plan to the non union groups
- Wanted to establish an “all for one” company culture and convert the union plans to the Co. plan
- Was able to forestall unionization so far



BONUS CASE STUDY – THE BANK

- Original plan had contributions of 15% of “premium”
- Amended plan to age related percentage of “premium”
- Current plan – defined cost
 - Pre 65 - \$45/mo per year of service after age 45
 - Post 65 - \$25/mo per year of service after age 45
 - Eligibility is 10 years of service after age 45



BONUS CASE STUDY – THE BANK

- Separate subsidy paid to spouse (same amount as retiree)
- Subsidy increases 3% per annum
- Designed to pay full cost at 20 years
- No change to current retirees or actives age 60 and 5.



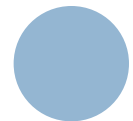
BONUS CASE STUDY – THE BANK

- Change cut active costs in half
- Due to administrative mishaps – old plan “Premiums” were seldom updated.



COMMON ELEMENTS OF “DEFINED COST” PLANS

- Costs are under employer control
- Can take advantage of local markets
 - Medicare Advantage plans (subsidized)
 - Part B premium subsidy
- Allows retiree choice
- Allows for positive outcomes for union negotiation
- Incentivizes people to use spousal plan
- Don't require participation in active medical plan
- Substitute reimbursement of Part B and D premiums for Med Supp plan



CHALLENGES FOR DEFINED COST PLAN

- Availability of pre 65 coverage
- Transition from old plan
 - Target existing plan
 - Target theoretical plan
- Difficulty converting older retirees
- Administration of premium reimbursement
- Affordability to retirees
- Communication

