BEFORE THE FLORIDA PUBLIC SERVICE COMMISSION

In Re: Application for rate increase in Brevard, Charlotte/Lee, Citrus, Clay, Duval, Highlands, Lake, Marion, Martin, Nassau, Orange, Osceola, Pasco, Putnam, Seminole, Volusia, and Washington Counties by SOUTHERN STATES UTILITIES, INC.; Collier County by MARCO SHORES UTILITIES (Deltona); Hernando County by SPRING HILL UTILITIES (Deltona); and Volusia County by DELTONA LAKES UTILITIES (Deltona)	) Docket No. 920199-WS) Filed: October 5, 1992

DIRECT TESTIMONY

OF

VICTORIA A. MONTANARO

On Behalf of the Citizens of The State of Florida

Jack Shreve
Public Counsel

Office of Public Counsel
c/o The Florida Legislature
111 West Madison Street
Room 812
Tallahassee, FL 32399-1400

(904) 488-9330

Attorney for the Citizens
of the State of Florida

BEFORE THE FLORIDA PUBLIC SERVICE COMMISSION

DIRECT TESTIMONY

OF

VICTORIA A. MONTANARO

DOCKET NO. 920199-WS

Q. Please state your name and business address.

A. My name is Victoria A. Montanaro. My business address is 111 West Madison Street, Room 812, Tallahassee, Florida, 32399-1400.

Q. What is your present occupation?

A. I am employed by the Office of the Public Counsel, Florida Legislature as a legislative analyst. My responsibilities are primarily related to special assignments in the area of telecommunication.

Q. Will you summarize your educational background and your professional experience in the field of utility regulation?

A. I earned my Masters in Accounting from Florida State University in 1983. I hold a CPA certificate in the state of Florida and am a member of the American Institute of Certified Public Accountants. From 1983 - 1987 I served as regulatory utility analyst with the Staff of the Florida Public Service Commission. While employed by the Florida Commission, I participated in

rate case examinations involving the water and sewer and the telecommunications utilities operating in Florida. In 1987, I accepted employment with the Office of Public Counsel. I have presented testimony to this Commission and participated in depositions and hearings as a class B practitioner.

Q. What is the purpose of your testimony?

A. The purpose of my testimony is to address the issue of whether using Statement of Financial Accounting Standard (SFAS) 106 to calculate postretirement benefit costs is appropriate for ratemaking.

Q. Does the Office of Public Counsel (OPC), support the adoption of SFAS 106 for ratemaking?

A. No.

Q. Why is Public Counsel opposed to Southern States Utilities, Inc. (Southern States) recovering the postretirement related costs as calculated using SFAS 106 in rates at this time?

A. There are several reasons why the rates set in this case should not include the estimate of SFAS 106 as identified by the company.

Q. Ms. Montanaro, before we get to the details of SFAS 106, will you provide its historical perspective.

A. Yes. Until the early part of this century, businesses in this country were primarily sole proprietorships and

partnerships which did not look to the public for investment. Capital was acquired against the personal credibility and integrity of the principal(s) of the firm with which lenders were personally acquainted.

As our economy became more complex, ownership of firms became more diversified; common stock was offered to members of the public who could look only to the principals of the firm (and to the principals' appointees) for accurate information concerning the income and financial health of the firm. Banking firms and other lenders were less likely to be personally familiar with principals of the firm; lenders, like investors, could look only to representations of persons they did not know.

Needless to say, there is an ever present incentive for firms to optimistically represent their financial condition to those from whom they wish to attract investment and from whom they hope to borrow money. Moreover, even in the absence of such an incentive, there was no system of uniform accounting in place to insure that financial statements rendered by firms were reliable and presented in a uniform and consistent manner. The

Great Depression proved this notion in a tangible--and in some respects--terrible way.

After a false start, or two, and with the threat of pervasive governmental regulation of the accounting profession, the Financial Accounting Standards Board (FASB, Board) was established as a private, independent board. Statements of this board are considered Generally Accepted Accounting Principles (GAAP). SFAS 106 (Statement of Financial Accounting Standard) is a statement of that board.

In my view it is extremely important to understand the purpose of FASB in its historical and present perspective. FASB requires firms (and specifically, the accountants retained by them) to accurately represent the financial condition of the firm primarily by ensuring that each firm utilizes similar accounting procedures which are generally accepted by the accounting profession.

The beneficiaries of FASB are those who were historically at risk in its absence; namely, those from whom firms seek investment and those from whom firms wish to borrow money.

Q. Ms Montanaro, your treatise on the history of FASB is interesting: please tell why you believe it relevant.

A. Because there is sometimes a notion advanced by regulated utilities that the Commission, must recognize expenses the utility incurs under SFAS 106 because FASB requires the utility to calculate its potential postretirement liability for external reporting using this standard. To the contrary, SFAS 106 is devoid of any of the traditional inquires of utility regulation. With respect to obligations which the company might incur for OPEBs (other post employment benefits), SFAS 106 suggests no inquiry of whether the obligations ought to have been incurred; whether obligations might be unilaterally modified by the company during the time rates are in effect; and no inquiry as to whether company-employee negotiations, or governmental regulations yet to be adopted might affect the obligations in a material way.

SFAS 106 was designed for external financial reporting purposes. It was not designed to ascertain whether expenses associated with OPEBs were reasonably incurred in the provision of utility service to the People of the State of Florida. To put it simply, it is the wrong tool for the job: it has no place in regulatory accounting.

Q. Would you please apply your view on SFAS 106 to this case in particular?

A. Yes. First, there is significant reason to believe that the company may restructure its benefit plan to reduce costs in the future. We would applaud the company's attempt to reduce the costs that are assigned in the ratemaking environment. However, if the rates set in this case are established before those cost-saving mechanisms can be instituted, then the revenues will recover costs greater than what the company is experiencing and rates will generate more cash than the company is entitled to.

Second, there is reason to believe that the SFAS 106 calculations are inherently unreliable in a rate setting environment. SFAS 106 requires that several assumptions be made in order for the company to calculate postretirement benefits per SFAS 106. The Financial Accounting Standards Board (FASB) and the accountants within the profession recognize the calculations are tentative and not precise on a period-to-period basis. The Actuarial Standards Board has questioned the accuracy of the calculations in the long run. Throughout SFAS 106 there is mention of the need to modify traditional accounting principles to achieve a pragmatic goal. The

calculations require retroactively calculating service costs for these prior periods, which could date back as far as twenty or thirty years. The calculations, for both the current period costs and those retroactive costs, are based upon the estimated future costs of health care. The calculations do not reflect either the cost containment measures that the company may institute or governmental intervention which may very well occur in the future.

Third, the company's postretirement calculation assigns costs of prior periods (the transitions obligation) plus current costs (the service costs) to current ratepayers. The assignment of prior period costs results in an intergenerational inequity. The point made by many utility companies is that today's costs (earned benefits as defined under SFAS 106) should not be assigned to future ratepayers, as would happen under the pay-as-you-go method. It should be noted that the adjustment proposed by Southern States Utilities does just that. It assigns costs to today's ratepayers for costs that the company says relate to a prior period. The actual current period service costs represents approximately 50% of the SFAS 106 costs which Southern States is asking recovery of.

Fourth, as these cost estimates become more reliable and cost containment measures are instituted, future ratepayers would receive the benefits from those events if the company's rates are still set based on rate of return regulation.

Fifth, there are no assurances that the funds taken from the ratepayers' pockets will be used to pay for the postretirement benefits of Southern States employees. The regulatory framework is designed to provide an opportunity to recover actual costs and a return on actual investment. This change in accounting, which is not pure accrual accounting, has the potential for violating the regulatory framework by compensating a company for expenses that will not be incurred.

Continuing the current method of cost recovery (pay-as-you-go) ensures that there is a consistent methodology for all ratepayers for all periods. No set of ratepayers is funding more than the company is paying in any specific period. If the company does continue its efforts to contain costs, then the costs in the future, under the pay-as-you-go method, could be substantially less than are estimated today.

Q. Can you briefly explain the purpose of SFAS 106?

A. Yes. Financial accounting standards are premised upon certain accounting principles. The purpose of these principles is to enhance the usefulness and reliability of the external general purpose financial statements by providing information that is useful in assessing the plan's present and future ability to pay its obligations when due and report the earnings for the period.

In adopting Financial Accounting Standard 106 the Financial Accounting Standards Board wanted to alert the users of the financial statements that a company has a growing potential postretirement benefit liability. For external financial statements, the company under SFAS 106 will be required to accrue a portion of the future liability as if a portion of the benefit is earned in each accounting period.

Q. Is the Commission obligated to follow Financial Accounting Standards for setting rates?

A. No. This Commission in the past has reserved the right to review the appropriateness of adopting a particular financial accounting standard. A standard that furthers the goal of sound accounting for external, general financial statements can be inappropriate for ratemaking.

Financial Accounting Standards are not designed for rate setting. The Financial Accounting Standards Board recognized that standards designed to strengthen the usefulness of the external financial statements might not be appropriate for ratemaking. In recognition of this fact FASB adopted SFAS 71 which is an accounting standard adopted to address issues unique to a regulated company.

Q. Does SFAS 71 have the same standing as a pronouncement as any other FASB pronouncements?

A. Yes, however, paragraph 7 of SFAS 71 states:

> Authoritative accounting pronouncements that apply to enterprises in general also apply to regulated enterprises. However, enterprises subject to this Statement shall apply it instead of any conflicting provisions of standards in other authoritative pronouncements.

Q. Has the accounting profession recently recognized that there is the possibility that in some circumstances the application of an accounting standard or other principles may not be appropriate?

A. Yes. In Statement of Auditing Standard 69, The Meaning of Present Fairly in Conformity with Generally Accepted Accounting Principle in the Independent Auditor's Report, AICPA recognized that there is a possibility that the

application of an accounting standard could render misleading financial statements. Within that Statement, there is reference to Rule 203 of the AICPA Professional Standards Volume II. This rule implies that adherence to officially established accounting principles would normally result in financial statements which are not misleading. If further states however:

> in establishment of accounting principles it is difficult to anticipate all of the circumstances to which such principles might be applied. This rule therefore recognizes that upon occasion there may be unusual circumstances where the literal application of pronouncements on accounting principles would have the effect of rendering financial statements misleading. In such cases, the proper accounting treatment is that which will render the financial statement not misleading.

Q. Would you please explain what is meant by the term GAAP?

A. As stated in SAS 69:

> The phrase "generally accepted accounting principles" is a technical accounting term that encompasses the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time.

Q. Do generally accepted accounting principles change?

A. Yes. The chairman of the Financial Accounting Standards Board in his article, What's right with the FASB, stated, "we are committed in our mission statement and rules of procedure to review the effects of our decisions and interpret, amend or replace standards in a timely fashion when necessary."

Q. Would you please explain the theoretical difference in the presentation of SFAS 106 costs and the current method of pay-as-you-go?

A. The current method of pay-as-you-go is a cash receipts methodology. SFAS 106 is premised on accrual accounting.

When using the cash receipts form of accounting, the level of postretirement expense is presented in terms of the dollars that the company actually pays out within the current accounting period.

The theory behind the accrual method is premised upon an employee earning this benefit over the years that he is employed. When using SFAS 106, methodology of accounting for postretirement costs, the level of postretirement expense presented in the external financial statements is based upon a calculation of the future health care costs of an employee after he retires. A portion of this

future cost is prorated to each accounting period in which the employee works.

Q. What is the difference between accrual accounting and cash receipts accounting?

A. FASB Statement of Concepts, Concept 6, paragraph 144, states the major difference is the timing of the recognition of revenues, expenses, gains, and losses. All other things remaining equal the costs incurred and reported would be the same over time.

Q. What is the goal of accrual accounting?

A. The goal of accrual accounting is to account for the economic impacts of events on an entity within the accounting period in which they occur. Embodied within the accrual accounting concept is a presumption that the economic impact of the event or transaction is recognizable and measurable.

Q. Does SFAS 106 represent traditional accrual accounting?

A. No. It is a hybrid. It deviates from Accounting Principles Board's Opinion (APB) 20 which provides guidance on the generally accepted treatment for a change in accounting estimates.

Q. Normally, does accrual accounting require immediate recognition of any prior period impacts of an accounting change?

A. Yes. FASB indicated in paragraph 252 that "conceptually, the immediate recognition of the cumulative effect of the accounting change would be most appropriate.... However, recognizing the magnitude of the obligation and the limited availability of historical data on which to base its measurement suggests the need for a more pragmatic approach."

Q. Does the recognition of the transition obligation over the next twenty years distort the reporting of period specific results for those years?

A. Yes. In fact, several corporations including utility companies have or are considering recognizing the transitional obligation immediately for that reason.

For example, GTE in their letter dated November 9, 1989, to the Financial Accounting Standards Board stated on page 4 the following:

> ...we believe that amortization of essentially prior year costs against current earnings is not conceptually sound nor does it serve the interest of financial statement users. This "doubling up" of costs in future years distorts current earnings for a significant number of future years and does not properly reflect the current earning power of the

enterprises. In GTE's case, we estimate that postretirement costs (which are not insignificant) initially would be increased by over 60% by the inclusion of these prior period costs. [see attachment 1 p.4]

Q. Did regulated utilities advocate the treatment of the transition obligation for regulated companies be different from the treatment for non-regulated companies?

A. Yes. In another letter written by GTE dated June 28, 1990 the company wrote," the treatment of rate regulated companies must, of necessity, be different." [see attachment 2 p. 3]

Q. Was there an effort by several utility companies to address the concern of the transition obligation for the regulated companies?

A. Yes. According to a letter dated July 11, 1990, USTA, BellSouth, Bell Atlantic and GTE participated in a conference call with Diana Scott the OPEB Project Manager- FASB Staff on June 18, 1990 to discuss the industry's position on immediate recognition versus amortization of the transition obligation. The letter states that FASB's decision of June 27, 1990 to allow the option of either amortizing the obligation or immediately recognizing the expense "...is optimal from a regulated

accounting prospective". A decision to mandate immediate recognition and/or to charge the obligation to retained earnings could have provided ammunition for federal or state Commissions to deny the recovery of these expenses. [See attachment 3]

Q. Have you identified any documents from Southern States or any other utility which indicates that the FASB revised its exposure draft ruling regarding recognition of the transition obligation as an accommodation to the regulated industry?

A. Yes. In the memo attached to the joint Bell Atlantic and BellSouth letter, it states:

> ...the FASB plans to address recognition of the transition obligation at its June 27 Board meeting (and is considering modifying the existing exposure draft proposal to allow the immediate recognition option or even go so far as to mandate immediate recognition of the transition obligation). [See attachment 3 p. 3]

The memo goes on to state:

> After discussing and analyzing the issue, we agreed to communicate the following industry consensus position to the FASB, prior to the

Board's scheduled meeting on June 27, 1990, to resolve this issue:

1. If the FASB modifies the Exposure Draft to give companies the option of either immediate recognition or amortization of the transition obligation, the industry would not object to this modification.
2. If the FASB modifies the Exposure Draft to mandate immediate recognition, the industry is strongly opposed for the following reasons:... [See attachment 3, p.3-4]

Q. From your reading of the memorandum did those reasons focus on the issue of sound accounting principles or strategies for increasing the revenue requirement?

A. The telephone industry wanted the costs amortized and reflected in the income statement to advance their argument for increased revenues to support the effect of the new accounting standard. The thrust of their argument was not to advance sound accounting principles. [See attachment 3, p. 5-7]

Q. What is the effect on Southern States's ratepayers as a result of the company seeking recovery of this transitional amount?

A. The adoption of SFAS 106 for ratemaking shifts Southern States's estimates of these prior period costs (as retroactively calculated by SFAS 106) onto the current and future ratepayers for the next twenty years. In effect, the Southern States customers will be double charged for postretirement benefits. The customers will be charged for costs associated with the employee's services of the current period as well as costs associated with employee's services rendered to a prior generation of customers.

Q. Do you have some concern with the way Southern States has applied SFAS 106?

A. Yes. SFAS 106 attempts to alert the user of the financial statement that the company has incurred a liability or future cost and reports the costs associated with that liability in the proper accounting period. In addition to the improper assignment of prior period costs to current ratepayers, it is possible that the cost which the company is attempting to recover in future rates may not meet the commonly understood term of costs.

Q. Please explain.

A. An accounting cost is commonly understood to represent an occurrence of a sacrifice in financial or monetary terms. Southern States may never experience a sacrifice of its monetary resources to the extent presented in its calculation of its postretirement cost based on SFAS 106.

Q. Is SFAS 106 based upon the following assumptions: (1) the company has promised a benefit to the employee; (2) the benefit is earned over the period of employment; and (3) the plan in effect today will remain in effect in the future?

A. Yes. FASB is attempting to recognize through SFAS 106 the postretirement obligations that the company has undertaken. These costs are viewed as a form of deferred compensation which should be accrued as a liability over the period of service or employment. SFAS 106 does not address the issue of possible or potential gratuities that a company may grant to its employees after retirement. Rather, SFAS 106 addresses the issue of a promise between an employee and its employer. It reflects a promise by the company to pay an employee providing services in a particular accounting period for those services after the employee's retirement.

Q. Why do you say Southern States may not experience an economic loss at the level presented in this case?

A. There are two main reasons. One reason is Southern States is continuing to review options to modify its benefit plan; and therefore, the level of benefits which the company is presenting in this case may or may not be offered in the future. The other reason is the accuracy of the estimate of postretirement benefit costs as calculated using the SFAS 106 methodology.

Q. Would you please explain your concern with the level of benefits which the company may or may not be providing in the future?

A. Yes. A modification of the plan will impact the costs calculated by SFAS 106. If the modification is for the purpose of containing health care costs in the future, then the costs calculated under SFAS 106 in the MFRs would be overstated.

Q. Are you aware of any plans which Southern States has regarding modifying its postretirement benefit plans?

A. Yes, In the May 29, 1992 Actuarial study undertaken by McMillian and Robertson three alternatives to the current plan are evaluated. [See attachment 4, p.8 of 19]

Q. What is the calculated percent change in the net periodic cost for each of these alternatives when compared to the plan presented in this rate case?

A. Alternative 1, which would increase the retiree contribution, generates a 5% decrease in annual expense;

Alternative 2, which would cap benefits for participants 65 years of age and older at $10,000 for their lifetime, generates a 44% decrease in annual costs; and, Alterative 3, which would define the dollar benefit and match the level of benefits to the number of years of service rendered, generates a 32% decrease in annual costs compared to the costs presented in this case. [See attachment 4 p.8 of 19]

Q. Does SFAS 106 accommodate the possibility of modifications to the postretirement plans?

A. Yes, SFAS 106 speaks to the possibility that many companies, upon seeing the dollar magnitude of the liability, may well look for ways to curb this growing liability. The study, Retiree Health Benefits How to Cope with the Accounting, Actuarial, and Management Issues, written by Coopers and Lybrand, one of the larger accounting firms, states, "It is anticipated that the nature and prevalence of retiree health benefits will change over time as employers respond to increasing pressure to hold down costs as well as to changing demographics and retiree needs."

Q. Has there been a more recent report on efforts of corporations to contain their health care costs?

A. Yes. In the July 1992, Journal of Accountancy, Stanley Zarowin, senior editor of the Journal and an employee of the AICPA, wrote the following:

> An increasingly popular idea, from the employers' point of view is dollar-denominated benefits, sometimes called defined-dollar or company caps. Under such a plan, recently adopted by both AT&T and IBM, a company sets a cap on future payments for retirement health-care benefits; costs exceeding the cap shift to the retirees.

Q. Does the calculation of postretirement costs as prescribed by SFAS 106 include the possibility that the benefit levels of a plan may change?

A. No. In paragraphs 173-176 of SFAS 106, FASB discusses the rationale for basing the calculation of future health care costs on the assumption that the current level of compensation will continue in the future unless there is evidence to the contrary. Only, if a company has communicated to its employees that the company is amending its plan would the company incorporate the reduction of benefits in the calculation of postretirement benefits under SFAS 106. Further, if the company's past practices differ from the written plan, then the substantive plan is based upon the past

practices. In the event a company has deviated from the written plan or has communicated to its employees that there will be plan amendments, then the substantive plan should reflect the impact of the amendment to the extent known. In the case where the benefits have been collectively bargained, then the calculations are based upon the written plan for those employees.

Q. Is it your position a company should not try to control its costs?

A. No. The point is postretirement costs, as calculated under SFAS 106, could and probably would cause overrecovery in the rate making environment. SFAS 106 costs, as calculated by the company, are based upon today's substantive plan. By the time the employees retire, ten or twenty years from now, the company could be offering a very different plan. If SFAS 106 were adopted for rate recovery, it is very probable the ratepayer will be paying for a transitional obligation and current costs which has little resemblance to the health benefits provided under the plan at the time the employee retires.

Q. Would you agree the level of benefits that a company offers its employees is a management prerogative?

A. While it can be argued that it is management's prerogative to determine the level of compensation given

to their employees or to modify their promise of deferred compensation, it is the Commission's responsibility to evaluate the reasonableness, accuracy and certainty of costs that are to be included in rates.

If it is likely that a company will institute cost cutting measures or even terminate a plan, then the Commission should not include postretirement costs as calculated under SFAS 106 in rates. To do so could allow overrecovery of the company's actual expense level.

Q. Has there been any study of the level of benefits offered to utility employees as compared to the employee of other industries?

A. Foster and Higgins, consultants on employee benefits constructed a study of on health care benefits. In their study, utilizing 1991 survey data, they reported that the utility industry had the highest average per employee medical plan costs. [See attachment 5 p.7]

Q. Do you have concerns regarding the SFAS 106 calculation methodology for purposes of setting rates?

A. Yes. In addition to the possibility that Southern States may modify, suspend or terminate its postretirement plan and therefore never incur the costs for which they are seeking recovery of today, there are other concerns with the postretirement plan. The main concern relates to the

assumptions that are employed in the calculation of the future costs and the apportionment of those projections to the various accounting periods.

Q. Would you please describe the method for calculating the future health care costs?

A. Yes. The methodology used in computing SFAS 106 costs is multi-faceted and based upon many assumptions. The interplay between the assumptions can have a significant impact on the final calculation. The calculation (like pensions) is based upon actuarial data. But further, assumptions have to be made regarding the future health needs of Southern States's "employee/retiree" population, the marital status of the employee during retirement, the dependent status of future employees, health care costs during retirement as well as the usual retirement date and longevity assumptions.

Q. Have other accountants questioned the complexity and reliability of the calculations of future health care costs which are produced using the SFAS 106 methodology?

A. Yes. The accounting firm of Arthur Young stated in its comments on the exposure draft of SFAS 106, that the estimates "suggest that the amounts shown are precise, when in fact they are at best ballpark estimates." The firm further described the computations used in calculating SFAS 106 costs as an "approach to measuring

the postretirement benefit without basis in fact and an arbitrary exercise."

Q. Does SFAS 106 recognize the unreliable nature of the calculation of future health care costs?

A. Yes. In its discussion regarding whether to allow immediate recognition of the transition liability, SFAS 106 states the following in paragraph 256 of the appendix:

> [FASB] also note that the actuarial techniques for measuring postretirement health care benefit obligations are still developing and should become more sophisticated and reliable with time and experience. They observe that near-term measures of the accumulated postretirement benefit obligation from which the transition obligation is derived will reflect the deficiencies of insufficient data collection in the past and the evolving actuarial practice in this area....

Q. Does the SFAS 106 acknowledge there will be significant volatility in the calculation of SFAS 106 estimates over time?

A. Yes. In paragraph 293 the FASB discusses the volatility in estimating the health care costs of employees who will

retire years in the future. The Board admits the volatility,

> ... may reflect an unavoidable inability to predict accurately the future events that are anticipated in making period-to-period measurements. That may be particularly true for postretirement health care plans in light of the current inexperience in measuring the accumulated postretirement benefit obligation for those plans.

Q. Are there mechanisms within SFAS 106 to recognize the change in the actuarial assumptions, such as the level of coverage?

A. Yes. After the first year of implementation, the actuary will evaluate the actuarial gains or losses. If the plan or cost calculations have been modified, then there will be an adjustment. However, the level of the adjustment reflecting the modification will be repressed. In an attempt to deal with volatility between accounting periods, in paragraph 294, of SFAS 106, FASB concluded that the impact of changes in estimates should not be recognized in the period in which they occur. Rather, the FASB requires a delayed recognition of gains or losses. Only the portion of the gain or loss that exceeds 10% of the accumulated postretirement benefit

obligation will be reflected in the net periodic costs.

Q. Does FASB acknowledge that the smoothing mechanism is contrary to normal accrual accounting?

A. Yes. Paragraph 294 states, "Both the extent of reduction in volatility and the mechanism adopted to effect it are essentially practical decisions without conceptual basis."

Q. Why did FASB believe that it was necessary to have a mechanism that reduced volatility in the calculation of the SFAS 106 obligation?

A. FASB states in paragraph 293:

> In the case of the accumulated postretirement benefit obligation, reported volatility may not be entirely a faithful representation of changes in the status of the obligation (phenomenon represented). It also may reflect an unavoidable inability to predict accurately the future events that are anticipated in making period-to-period measurements. That may be particularly true for postretirement health care plans in light of the current inexperience in measuring the accumulated postretirement benefit obligation of those plans. The difference in periodic measures of

the accumulated benefit obligation for a postretirement health care plan, and therefore the funded status of the plan, results partly from the inability to predict accurately for a period, or over several periods, annual expected claims costs, future trends in the cost of health care, turn over rates, retirement dates, dependency status, life expectancy, and other pertinent events. As a result, actual experience often differs significantly from what was estimated, which leads to changes in the estimates for future measurements. Recognizing the effect of revisions in estimates in full in the period in which they occur may produce financial statements that portray more volatility than is inherent in the employer's obligation.

Q. In your opinion is the concern regarding the volatility heightened because of the magnitude of postretirement expense that the company is presenting on their financial statements?

A. Yes. It is my belief that, if the current service costs were the only expense at issue, it is probable that the smoothing mechanism would not have been adopted by FASB. For example, the current service costs represent only 50%

of the cost which Southern States is seeking to recover. However, because the calculation includes recognition of a portion of the transition or prior period obligation, a change in an assumption could have a significant impact on the cost presented for the financial statements.

Q. What impact does this smoothing mechanism have on the ratepayer?

A. If the Commission adopts SFAS 106, then there is little hope the current ratepayer will see any benefit from cost containment provisions or improvement in estimates made by Southern States. If the company were to reduce its costs, the expense recovery would remain the same unless the effect of the cost containment provisions exceed 10% of the accumulated postretirement benefit obligation and rates were reset. It should be noted that an overcharge can only be corrected prospectively, and then only if the rates are adjusted.

Q. Does the company have a great deal of flexibility regarding the assumptions that are used in the actuarial valuation?

A. Yes. Coopers and Lybrand illustrated the flexibility in its study. The firm stated in reference to that illustration, "Employers should be aware that the use of different plan terms and actuarial assumptions would have

resulted in significantly different estimates of obligations and expense."

Further, Coopers and Lybrand in the study referenced above, stated:

> The measurement of the obligations and expense related to retiree health benefits is in an evolutionary stage. Employers, their actuaries, and accountants are continuing to improve their understanding of the complex issues surrounding the measurement of these benefits.

Q. Does the actuarial firm select the assumptions for the calculation of SFAS 106?

A. No. According to SFAS 106, the actuarial assumptions represent the company's best estimate of what will occur in the future.

Q. Is there variation in the discount rate used by companies?

A. Yes. Attached is late filed deposition exhibits 1 and 6 filed by Hewitt and Associates in the Florida Power Corporation rate case which depicts the variability in the discount rate selected by companies using this actuarial firm. [See attachment 6]

The second attachment is a survey conducted by Towers Perrin Company. The discount rates used varied from a range of 5.1% to 10.0%. [See attachment 7]

Q. What is the significance of a low versus high discount rate?

A. The lower the discount rate the higher the present value calculation. This high present value calculation translates into a higher expense for the accounting period. The decrease in the discount rate would increase the period costs because the transition obligation portion would increase, the interest component would decrease, and the service costs would increase.

Q. Is it true that over time the cost would be the same?

A. This is only true if you assume that the discount rate used for the calculation will not change over time.

Q. Does this variation in discount rates effect the integrity of the calculation?

A. Yes.

Q. What is the discount rate that Southern States used in calculating the SFAS 106 costs?

A. Southern States used a discount rate of 8.00%.

Q. Is the use of the rates of return on long term fixed investments an appropriate discount amount for ratemaking?

A. No. For the unfunded plan using the company's cost of capital as the discount rate would better reflect the economic effect of the passage of time.

Q. Are there any utilities who would agree with you?

A. Yes. GTE's filed the following comments in their August 7, 1989 letter to Timothy S. Lucas regarding the appropriate basis for calculating the present value of the potential post retirement obligation: ...

> It is probable that benefits for unfunded plans will be paid with funds generated from operations or raised through debt or equity financing. Accordingly, we believe that the company's cost of capital would more appropriately reflect the rate at which obligations of unfunded plans will be settled and should be used as the discount rate for these plans.
>
> We understand that the Board disagrees with this approach. The Board believes that it would reduce comparability since the cost of capital differs among companies. However, we believe that if the cost of capital is the cost of paying these benefits, using it as the discount rate will better reflect these

economics in the financial statements. Comparability should provide assurance the differences can be seen, not hidden. The latter would occur if a similar discount rate is used for all companies with unfunded plan. [See attachment 8 p. 5]

Q. Would you recommend that this Commission use the company's cost of capital as the discount rate for ratemaking purposes for Southern States?

A. Yes. While FASB rejected the use of the cost of capital as the discount rate in determining the calculation for external, general purpose financial statement purposes, it should be considered in the calculation of postretirement costs for ratemaking purposes.

Q. You mention an actuarial study earlier in your testimony, in order to implement this standard, is there a need for an actuary to assist in the calculations?

A. Yes.

Q. Were there any actuaries who commented on the FASB exposure draft on postretirement benefits?

A. Yes. David J. D. Mecleish, Chairman and Chief Executive Officer of Godwins International Holdings Inc. commented that, "...traditional thinking which underpins the accounting treatment of employee retirement benefits is

fundamentally flawed. More simply, that is wrong." [See attachment 9, p.1]

The comments go on to state that the methodology used to calculate the postretirement obligation creates a false liability and violates the intent of the accounting profession which emphasizes the representational faithfulness of the balance sheet. He further states:

> Presumably the liability is an "accounting liability" and just as with the actuarial liability I referred to earlier, I would observe that it would not represent a true liability in any legal sense nor indeed in any other sense that normally would be attached to that word. [see attachment 9 p.4]

Q. Does the actuarial profession have standards which would provide guidance on the development of the actuarial calculations required by SFAS 106?

A. Yes. In addition to the standards the Actuarial Standards Board had previously issued to meet the needs of their profession, the Board has issued an exposure draft of guidelines to be used in the calculation of SFAS 106 costs. The proposed Actuarial Compliance Guidelines, entitled Compliance with Statement of Financial Accounting Standards No. 106 Employer's Accounting for

Postretirement Benefits other than Pensions was released in October 1991. The guidelines are in the comment phase. The comment deadline was March 15, 1992. The Board is currently reviewing those comments and the Board will decide whether to adopt these guidelines at their October 1992 meeting. According to the Board staff the Board may decide to continue to revise the proposed guidelines.

Q. Do the guidelines deviate from other procedures which are required for generally accepted actuarial purposes?

A. Yes. In the transmittal letter of the exposure draft the Board indicated:

> Enclosed in this booklet is an exposure draft of a proposed actuarial compliance guideline of actuarial calculation required under SFAS 106, promulgated by the Financial Accounting Standards Board(FASB). The purpose of the guideline is to set forth generally accepted actuarial principles for such calculations. Because this document is a standard for compliance with an outside requirement (i.e., an accounting standard), certain procedures may or may not be generally accepted for other actuarial purposes. [See attachment 10 p. ix-x]

Q. Does the Actuarial Board comment on the level of reliability that can be expected from the actuarial calculations?

A. Yes. In the background section, it is stated:

> The committee recognized the SFAS 106 implies more precision and accuracy than exists in this area of actuarial practice. The relatively long-term nature of the obligations, the significant year-to-year variations in the trend rates, and the underlying political and economic nature of the benefits almost assure substantial variations between the actual results and expected results. [See attachment 10 p. ix-x]

Q. Does the exposure draft make a reference to a scope limitation?

A. Yes. The guideline reads, "This guideline is believed to accurately represent current understanding of SFAS 106 as it pertains to actuarial calculations; the guideline is not an actuarial standard of practice." [See attachment 10 p. 1]

Q. Are there disclosure requirements?

A. Yes. The actuarial communication for purposes of SFAS 106 should be identified as such, and should disclose that the results of calculations performed for other

purposes (e.g., plan reporting, government requirements, etc.) may differ significantly from the results for purposes of SFAS 106. [See attachment 10 p. 33]

Q. Would you please review the components that are involved in calculating SFAS 106 costs for external, general purpose financial statements?

A. There are six possible components involved in the calculation of SFAS 106 costs. Not every company will include each of these costs. The cost components included will depend upon a company's particular circumstances. The possible cost components are:

(1) service costs

(2) interest costs

(3) returns on plan assets

(4) prior service costs

(5) gains and losses

(6) amortization of the unrecognized transition obligation or asset.

Q. Is Southern States requesting cost recovery of postretirement costs that relate only to the current period for ratemaking purposes?

A. No. Southern States has included service costs, amortization of its prior period costs (unrecognized transitional liability) and interest costs in its test period costs.

Q. Do the components included in Southern States's calculation for ratemaking match the components which would be included in their calculation for external, general purpose financial statements?

A. It can not be determined. We do not know how the company will treat the transition obligation for external financial statements.

Q. Would you please explain service costs?

A. Yes. Service costs represent the increase in the accumulated post retirement obligation that relates to the present period. It is that portion of the postretirement benefits that is earned by the employee during the current period. The cost is stated in terms of present value.

Q. What is the unrecognized transitional obligation cost?

A. It is defined in SFAS 106 paragraph 46 as "the amortization of the unrecognized obligation or asset existing at the date of initial application of this statement...." Under SFAS 106 definition of period costs, these costs would represent the benefits earned in prior periods.

Q. Does the company have the option of either recognizing the obligation immediately or delaying the recognition of the costs and amortizing it over future periods.

A. Yes.

Q. Please explain the accounting entries for immediate recognition of the accumulative effect of implementing SFAS 106.

A. Immediate recognition of the accumulative effect of SFAS 106 is reflected as a charge or debit to the income statement and a credit to the liability account for the period in which it was recognized. It would be treated as the effect of an accounting change as outlined in APB 20.

Q. Were companies prohibited from recognizing postretirement costs on an accrual basis in the past?

A. No. The issue of postretirement liability and its growing impact on the financial statements has been discussed by the accounting standards-setting body since 1979.

Q. Is it true that the generally accepted accounting principles in existence prior to the issuance of SFAS 106 would have allowed for the accrual of postretirement benefits.

A. Yes. If the company has a liability, that is a company will experience an economic sacrifice in financial or monetary terms as defined in FASB Statement of Financial Accounting Concept 6, then the company could and should accrued for the expense. This basis of accrual accounting has been in practice for years and would have

provided the authority to recognize the postretirement cost in the past.

Q. If this is true, then why weren't corporations accruing for this postretirement costs are calculated under SFAS 106 in the past?

A. The main reason is the postretirement costs recognized by SFAS 106 do not represent a legal liability or a liability as previously defined by the accounting literature. However, for purposes of SFAS 106 the definition of a liability has been broadened.

Q. Does the broaden definition of liability as it relates to postretirement benefit reflect the normal definition of costs to be included in the ratemaking process?

A. No. It has been the Commission's prior practice and the interpretation of statutory language as referenced in the Water and Sewer DORP under the Operation and Maintenance Expense that the "... regulated utilities are entitled to recover through their rates prudently and reasonably - incurred expenses, necessary to the provision of adequate, sufficient and efficient service. The law provides that entitlement, but no more."

Q. It is your testimony that the SFAS 106 is an inadequate and inappropriate measure of postretirement benefits costs for ratemaking?

A. Yes. The current method of pay-as-you-go for recognizing and compensating the company for the postretirement costs which it has or will incur is adequate to meet any the statutory requirements placed upon this Commission. Further, it is my testimony that SFAS 106 will over compensate the company for these expenses and therefore is in conflict with the intent of the statute and the Commission's own policy as outlined in the DORP.

Q. Are postretirement benefits characterized as deferred compensation in SFAS 106?

A. Yes.

Q. If this is in fact a form of deferred compensation, is there reason to believe that in a projected test year the costs of wages and compensation should be limited to the inflation rate?

A. Yes. The Water and Sewer DORP, under the topic of Employee Compensation, states that projected expenses should be adjusted to reflect the current projection of inflation. Further there is a reference to wages increases being limited for non-union employees. The wage increase is to be limited to the inflation rate. Since the Commission is not bound by union negotiated contracts and Southern States does not bargain postretirement benefits, the issue of treating union personnel differently is mute.

Q. Is it fair to assume a company will adjust its total compensation package if one component of that package is increased disproportionately?

A. Yes. A rationale company would evaluate its compensation package as a whole if one portion of that package were to increase disproportionately. There is no basis to believe that the company will allow a portion of the compensation package to increase without some compensating decrease elsewhere.

Q. Have you reviewed any documents which would indicate that a Florida regulated utility has in fact adjusted benefits as you have suggested?

A. Yes. Two electric companies have done just that. Florida Power Corporation in the last union contract reduced postretirement benefits and increased pension benefits. TECO has a stated policy of maintaining the benefit to salary ratio. TECO has adjusted its benefits to maintain the relationship of no more than 42 cents toward benefits for each dollar of compensation. [See attachment 11]

Q. Is there an interest component included in the postretirement costs as calculated using SFAS 106?

A. Yes.

Q. Please define the interest costs in the SFAS 106 calculation of costs for postretirement benefits.

A. The interest costs in the SFAS 106 calculation represents the passage of time costs associated with calculation. The costs are initially presented in terms of present value. Because the Board did not require funding, there was a need to recognize the increase in the liability as time passed. For those companies who do fund, the interest costs are offset by the earnings on the fund. If the company recovers service cost in rates and invests those funds, then there is no need to assign interest to the current or future ratepayer.

Q. Should the ratepayer be assessed for interest costs associated with the transitional obligation?

A. No. As characterized the Financial Accounting Standards Board these are prior period costs. If one accepts the premise that the postretirement benefits are earned ratably over the attribution period (length of employment until eligible to retire), then it is not appropriate to assign the current ratepayer the passage of time costs associated with services provided in prior periods to prior generation of customers.

Q. In Southern States's calculation of its postretirement costs, does the company include any expected earnings?

A. No. Although the company states on schedule B-3 page 2-2 that the company intend to fully fund its postretirement

benefits liability, there is no indication that the company has recognize interest earnings on those funds.

Q. Why do you recommend that the interest associated with the service costs, interest costs and transition costs which have been recognized be recorded as a below the line expense?

A. If the company funds the plan the cash would be earning a return to offset the interest associated with the recognized service costs, recognized interest costs and recognized transition costs. Additionally, the regulatory ratemaking process should eliminated costs which relate to prior periods.

Q. Should the ratepayer pay a return on the cash flow the company experiences from collecting the expense prior to paying the associated costs?

A. No. Just as the Commission does not allow the company to earn a return on the deferred taxes, the Commission should not allow the company to earn on return on the cash flow generated by the adoption of SFAS 106. Any expense recovered in excess of the pay-as-you-go amount, should be recognized as a zero-cost source of capital.

Q. Is it your testimony that the company should reflect the full liability as zero source of capital even if the company funds their plan as indicated on schedule B-3 page 2 of 2?

A. Yes. Unless the company establishes a non-revocable external trust, then the company could still have control over the funds. If the company still has control of those funds then the cash flow from the adoption of SFAS 106 is in fact an other source of funds to the company.

Q. Why is there a need to recognize any special adjustment to the capital structure?

A. When an accrued expense is greater than the current cash outlay for that expense, then there is a concern that the customer will be paying a return to the company on those funds through the working capital adjustment. This possibility arises because the cash in isolation will increase the working capital balance. For regulatory purposes the balance of cash working capital is viewed as a component of the ratebase.

Q. Should the company be recording a liability for the recognized portion of their postretirement costs?

A. Yes. Unless the company has established a non-revocable external trust for these benefits, then a liability should be recorded.

Q. Would you please review the journal entries involved in recognizing postretirement benefit costs.

A. Yes. The debits are to the expense and cash accounts with a corresponding credit to the long term liability account and revenue accounts.

The following illustrates the entries. It should be noted that pay-as-you-go amount is included within the postretirement expense recorded for the period.

1.	Postretirement Exp.	$110	
	OPEB liability		$110
2.	Cash/Accts Rec/d (dr.)	$110	
	Revenue		$110
3.	OPEB Liab (paygo portion)	$10	
	Cash		$10
4.	OPEB Liab. (to fund Trust)	$100	
	Cash		$100

The entries above would be the same, in isolation, for a regulated or non-regulated corporation assuming each increased the price of its product to cover its increased costs as calculated under SFAS 106.

Q. Does the application of SFAS 106 create a tax timing difference?

A. Yes. Unless a corporation funds its postretirement plan using a taxed advantaged fund, the revenues generated from the price increase will be taxable. The postretirement expense is tax deductible only to the extent that there is an actual cash outlay for the tax period (pay-as-you-go). For book purposes the cost is tax

deductible. Whether it is permanent or temporary is dependent upon the actual occurrence of a tax deductible expense in the future.

Q. What effect does the tax timing difference have in the regulatory process?

A. For ratemaking, the deferred taxes are treated as a zero-cost source of funds for the utility in the capital structure. If SFAS 106 is adopted for ratemaking, the booked tax expense is less than the tax payable amount. The difference is recorded as a debit to deferred taxes. The effect is to increase the cost of capital in the regulatory revenue requirement calculation. For example (in isolation):

Tax expense (dr.deducted for books.)	$0	
Deferred taxes (dr.)	$34	
Tax Payable (cr.)		$34

When the tax is paid the following entry would be made:

Tax payable (dr.reverse the liab.)	$34	
Cash (Cr. remit the tax)		$34

Q. Has the Commission ruled in any prior case that the revenue requirement should be reduced to reflect a reduction in the ratebase for the unfunded amount of the accrued postretirement liability?

A. Yes. In the Order NO. PSC-92-0708-FOF-TL, it states on page 40, the following:

> We believe that treating the liability as a reduction to working capital fully recognizes the effect of the liability in reducing the revenue requirement. Accordingly, we find it appropriate to treat the liability as a reduction to working capital.

Q. Is there any other reference made regarding the Commission's intent to reduce ratebase by the accrued liability?

A Yes. The order referenced above further states on page 40, "We believe that there are two positive aspects to not funding. By not funding, the company can reduce its external financing needs. Additionally, the accrued liability serves to reduce rate base".

Q. Does the recognition of the revenues associated with postretirement expenses as a zero-cost source of capital, in isolation, lower the revenue requirement that a company experiences?

A. No. The recognition of the expenses recovered as a zero-cost source of capital prevents the company from charging the customer a return on these funds. If it is the Commission's intent to reduce the revenue requirement by the amount of the liability, as stated in order PSC-92-

0708-FOF-TL, then the final order for Southern States should reflect that intent.

Q. How could this be accomplished?

A. If the commission were to order that the company reduce equity by the amount of the postretirement benefits this would prevent the company from having excess cash and would reduce the revenue requirement of the company.

Q. In Southern States's MFRs did the company record a liability equal to the debit in the expense account?

A. No. Mr. Gangnan stated at the time of his deposition that the company would fund this plan. It should be noted, however, that he stated to the best of his knowledge the company had not determine what vehicle that the company would use to fund the plan. In response to staff's question, he stated the company wanted to fund "primarily because we don't want to have that liability shown on the balance sheet."

Q. You mentioned that several problems associated with SFAS 106 would be solved if the company were to fund the plan. Would the customer be better off with funding versus not funding?

A. If the company does establish an external trust, then the incentive to inflate the costs is curbed since the company's control of those funds would be irrevocably relinquished. Further, if the plan were funded, the

revenues associated with recovery of the postretirement costs would be placed in a postretirement fund and all earnings would remain in the trust. There would be no need to charge the customer for interest costs on the funds the company had already collected. Nor, there would be any need to track the rate base or capital structure impact.

Funding the plan through a tax deductible plan would prevent the reduction of deferred taxes (a zero-cost source of capital). Additionally, funding the plan could reduce the costs assigned to the ratepayer in the future through earnings much like the earnings on pension funds has done.

Q. Since Southern States is planning to fund its plan, if the Commission accepts the company's adjustment for postretirement benefits as calculated under SFAS 106, should an adjustment be made to normalize the cost of postretirement benefits?

A. Yes. There should be an adjustment to recognize the benefit of funding.

Q. Have any of the accounting firms analyzed the impact of funding, not funding and continuing a pay-as-you-go method?

A. Yes. Coopers & Lybrand's Joint Study with the National Association of Accountants Retiree Health Benefits How to cope with the Accounting, Actuarial, and Management Issues, illustrated a hypothetical case which depicts the long run impact of prefunding. The assumption in the prefunding case was that the contributions and earnings were each tax deductible. In this illustration, pay-as-you-go is the least costly. However, if SFAS 106 is adopted, this illustration indicates a funded, tax deductible plan is less costly than an unfunded plan.

Q. Is it true that the attribution period for SFAS 106 is less than the service life of the employee?

A. SFAS 106 requires that the cost of postretirement benefits be accrued by the time the employee is eligible for full benefits. This may and probably will be prior to the time an employee will retire. This has the effect of "front loading" the costs onto the current ratepayers.

Q. Does the adoption of SFAS 106 by Southern States "front load" cost on to current ratepayers?

A. Yes. According to the company's current plan any employee with 5 years of service and 55 years of age is eligible for benefits. Under SFAS 106, the full benefit obligations for that employee must be accrued on the books by the time the employee is eligible for benefits. However, according to the McMillian and Robertson's

actuarial valuation report only 2% of the employees will retire by 55 years of age. [See attachment 4 p.19 of 19]

Q. If the Commission does not adopt SFAS 106 for rate making does this create an accounting problem for the company?

A. No. The company can recognize the costs under an accrual method of accounting for their external, general purpose financial statements and recover in rates on a pay-as-you-go basis.

Q. Does a Commission have a choice of whether it uses SFAS 106 or some other method for ratemaking purposes?

A. Yes. The Financial Accounting Standards Board cannot dictate to this Commission or any commission what costs are to be included in rates or how those costs are to be calculated. The Financial Accounting Standards Board recognized this when it adopted SFAS 71.

Q. Does SFAS 71 envision the situation where rates are set based upon accounting estimates that may not come to pass?

A. Yes, paragraph 11 gives three examples where the rate-setting action of a regulator can impose a liability on a regulated enterprise. The second example addresses the question of how to account for a commission's actions which are designed to protect the customer when rates are set based upon an estimate or anticipated cost. Item b in paragraph 11 states:

A regulator can provide current rates intended to recover costs that are expected to be incurred in the future with the understanding that if those costs are not incurred future rates will be reduced by corresponding amounts. If current rates are intended to recover such costs and the regulator requires the enterprise to remain accountable for any amounts charged pursuant to such rates and not yet expended for the intended purpose, the enterprise shall not recognize as revenues amounts charged pursuant to such rates. Those amounts shall be recognized as liabilities and taken to income only when the associated costs are incurred.

Q. Do you believe there is a need for the Commission to address the issue of recapturing changes in estimates if they do include the cost of postretirement benefits as calculated using SFAS 106?

A. Yes, the order should require that the company recalculate the SFAS 106 costs and record a credit to the postretirement expense account to reflect any changes in estimates. A change in the estimate could significantly affect the costs that should be charged to the ratepayer.

Q. Is the company harmed if the Commission does not adopt SFAS 106?

A. No. Whether the Commission continues the current pay-as-you-go method or adopts SFAS 106, the company recovers its costs. It is a matter of timing. Under the pay-as-you-go method the company recovers its costs in the year it pays the expense. Under the SFAS 106 method, the company recovers its estimate of costs years prior to expending those funds on the associated postretirement liability.

Q. Does the pay-as-you-go method prevent overrecovery of costs from the ratepayer?

A. Yes, under the pay-as-you-go method all cost containment adjustments are reflected in the costs that are assigned to the customer.

Q. Why is Public Counsel opposed to Southern States recovering its estimate of postretirement related costs in rates at this time?

A. As indicated above postretirement costs as calculated under SFAS 106:

1. Do not represent a legal liability,
2. Can not be calculated with any accuracy, and
3. Represents the most costly recovery of post-retirement costs for the next twenty years.

Continuing the current method of cost recovery (pay-as-you-go) ensures that there is a consistent methodology for all ratepayers for all periods. No set of ratepayers is funding more than the company is paying in any specific period. If the company does continue its efforts to contain costs, then the costs in the future, under the pay-as-you-go method, could be substantially less than are estimated today.

Q. Does this conclude your testimony on postretirement benefits?

A. Yes.

Docket No. 911188-WS
V. Montanaro Exhibit No ___
Attachment 1
GTE's November 9,1989
Letter to FASB

OPEB - HEARINGS

714-246-6358
T. HIGGINS

Thomas J. Devine
Vice President-Corporate Accounting

GTE Service Corporation
One Stamford Forum
Stamford, CT 06904 USA
203 965-2000

November 9, 1989

Mr. Timothy S. Lucas
Director of Research and Technical Activities
File Reference No. 078
Financial Accounting Standards Board
401 Merritt 7, P.O. Box 5116
Norwalk, CT 06856-5116

Dear Mr. Lucas:

At GTE's presentation to the Board on October 11, 1989 at the public hearing on Other Postretirement Benefits (OPEB), GTE was asked to respond to the following issues raised by Board members:

1. Rate-regulated companies - Further discussion was requested on why GTE recommended that regulated companies treat the transition obligation in a different manner than nonregulated companies.

2. Offset of OPEB transition obligation against pension transition asset - The Board requested our views on permitting companies the option of offsetting the OPEB transition obligation against any remaining transition asset related to the company's pension plan.

3. Medical inflation rate - The Board requested that we provide them with an explanation of how we would propose to account for differences between the estimated medical inflation rate and actual experience arising from technological changes and utilization patterns.

4. Effect of changes in assumptions - During our presentation we recommended that a wider corridor was needed for unrecognized net gains and losses. We noted that even a 20% corridor would be barely sufficient to absorb the effect of a 1% change in GTE's assumed discount rate or health care trend rates. The Board requested that we provide them with additional detail on this evaluation so they can better understand the relationship between GTE's assumptions and the accumulated benefit obligation.

540038

A discussion of each of these issues follows.

1. Rate-regulated companies - In GTE's response to the Exposure Draft and in our presentation at the public hearings, we proposed that nonregulated companies be permitted the option of restatement or amortizing the transition obligation over the remaining service lives of active plan participations to equity, rather than to income as proposed by the Board. However, we recommended that companies subject to rate regulation be permitted to amortize this transition obligation to income as collected in rates in accordance with existing procedures.

   As indicated in GTE's response to the ED and in its presentation at the public hearings, we believe that the change from pay-as-you-go to accrual accounting is essentially the correction of an error for nonregulated companies. As the Board has characterized it, the change is a result of the failure to accrue a liability in the past. Further it represents a change from an accounting principle that is not generally accepted (cash basis accounting) to one that is generally accepted (accrual basis accounting). Paragraph 13 of APB No. 20 classifies such a change as a correction of an error. Since restatement is the appropriate accounting for the correction of an error, we believe that it should be permitted as an option. Alternatively, for practical reasons, a company should also be permitted to amortize the transition obligation to equity, as we believe that under no circumstances should a correction of an error related to prior periods be charged to current or future earnings.

   With respect to rate regulated companies, however, the change from pay-as-you-go accounting does not represent the correction of an error. For these companies, pay-as-you-go accounting reflects the amounts that are being recovered through the actions of regulators. Consequently, under FAS No. 71, these are the amounts that should be recorded as OPEB expense. Therefore, pay-as-you-go accounting cannot be considered an error in the same sense as for nonregulated enterprises. When the new accounting is adopted, the transition obligation should continue to be treated in accordance with ratemaking practices, with any differences between the OPEB cost as defined in the final statement and amounts considered for ratemaking purposes recognized as an asset or liability created by the actions of the regulator, subject to the test of recoverability.

2. Offset of OPEB transition obligation against pension transition asset - The Board, in its attempts to provide a practical solution for the recognition of the transition obligation, has suggested that one approach might be to permit the offsetting of the OPEB transition obligation against any remaining unrecognized pension transition asset. We believe this proposal is inappropriate. The pension transition asset resulting from the adoption of FAS No. 87 is very different from the transition obligation that would be required under the OPEB Exposure Draft.

The pension transition asset generally reflects the accumulation of unrecognized prior service costs and unrecognized gains or losses, which under both APB No. 8 and FAS 87 require amortization to future periods. Therefore, we believe that prospective recognition of the transition asset as provided by FAS 87 is appropriate.

The OPEB transition obligation, on the other hand, represents primarily the cumulative difference between amounts recorded on the cash basis and amounts that would have been recorded on the accrual basis of accounting. This difference does not represent unrecognized prior service costs or gains and losses.

To offset what are primarily experience gains from pension plans with costs resulting from the failure to accrue prior years' obligations is not logical and has no basis in current accounting. Further to make such a change five or six years after FAS No. 87 has been adopted and generally accepted, in our opinion, would be confusing to financial statement users.

3. Medical Inflation Rate

GTE proposed that a medical inflation rate be used rather than the health care cost trend rate as proposed by the Board. The medical inflation rate would exclude estimates of health care cost increases due to changing technology and utilization patterns. A question was raised as to how costs related to these excluded factors should be recognized in the financial statements.

From one point of view, these costs do not represent the types of gains or losses that would be included in the corridor since changes in technology and utilization patterns were not included in the assumptions. On this basis, an argument could be made that increases resulting from these factors should be recognized currently since the differences arise from a failure to accrue for these costs rather than from a difference between estimates and actual experience.

We understand this argument from a theoretical standpoint, nevertheless we believe that the amounts related to these increases should be treated in the same manner as other actuarial gains and losses. There are numerous factors, including technology and utilization patterns, which result in changes in health care costs. However, we do not believe it is practical to segregate differences due to actual experience as to the source of the change and treat them differently from other changes such as mortality, per capita costs, geographic location, etc. We believe that the medical inflation rate is the most reasonable estimate that can be made without introducing components that are highly subjective and unpredictable considering the extended period (up to 70 years) for which such estimates are required. Therefore, we believe that the gain or loss resulting from the use of this estimate should be treated in its entirety as an actuarial gain or loss in accordance with the Exposure Draft.

4. Effect of changes in assumptions
GTE recommended in its comments that the Board consider increasing the corridor to at least 20%. We reached this conclusion because GTE's actuaries have determined that a 1% change in either the health care trend rate or the discount rate would increase or decrease GTE's accumulated postretirement benefit obligation by approximately 20%, thereby greatly exceeding the 10% corridor proposed by the Board.

In response to your request for additional information on this evaluation, we have attached as Exhibit A a simplified analysis provided by our actuaries. The analysis calculates the accumulated postretirement benefit obligation for a typical GTE employee, using a 7 1/2% health care trend rate and discount rate. Examples, are then provided for the same employee changing either the healthcare trend rate or the discount rate by one percentage point in either direction. Although, it is a fairly simplistic analysis, it does illustrate the significance of the effect of a change in either assumption.

We hope that these observations will be helpful to the Board in its deliberations. We would also like to reemphasize that, while the theoretical aspects of this problem cannot be ignored, it is more important that a practical solution be found to the accounting for the transition obligation. After participating in the hearings, listening to other views and reviewing many of the comments received by the Board, we continue to believe that the "amortization to equity" approach described in our comments is the most practical approach to this problem for nonregulated companies and could help the final standard gain the acceptance necessary for a change of this magnitude.

Other alternatives such as "cumulative effect" or restatement would not be practical alternatives for many companies. Indeed, we can envision retained earnings of many companies being reduced by such charges to a point where regular dividends to shareholders would have to be discontinued, causing serious disruption to stock prices and investors. This argues for the gradual transition approach proposed by the Board. However, we believe that amortization of essentially prior year costs against current earnings is not conceptually sound nor does it serve the interests of financial statement users. This "doubling up" of costs in future years merely distorts current earnings for a significant number of future years and does not properly reflect the current earning power of the enterprises. In GTE's case, we estimate that postretirement costs (which are not insignificant) initially would be increased by over 60% by the inclusion of these prior period costs.

We recognize that few companies have recommended an "amortization to equity" approach (we are aware of only Deloitte Haskins & Sells voicing similar comments), but we believe this may be because it was just not considered. We agree with Deloitte Haskins & Sells that charging current earnings with these prior costs, as proposed by the Exposure Draft, would make earnings for those periods inconsistent with the definition of that element in Paragraph 79 of SFAC No. 5 which notes the "widely acknowledged importance of earnings and its components as a primary measure of performance for a period".

Therefore, we believe that our proposal would be preferable from both a practical and a conceptual standpoint. We hope that the Board will seriously consider it and test its merits with other companies and public accounting firms.

We would be happy to meet with you to further discuss this issue or any others in which you have an interest.

T. J. Devine

Financial Capital Group
695 East Main Street
Stamford, CT 06901-2138
203 326-5400
Facsimile: 203 326-5499

EXHIBIT A

TPF&C

a Towers Perrin company

November 9, 1989

Mr. Thomas J. Devine
Vice President -- Corporate Accounting
GTE Corporation
One Stamford Forum
Stamford, CT 06904

Dear Tom:

We've prepared the attached illustrations for the FASB staff to demonstrate the volatility of the Retiree Medical APBO which will occur as interest discount or medical trend assumptions are changed.

By necessity, these illustrations use a somewhat simplistic approach to demonstrate the inherent volatility of the Retiree Medical APBO. But the logic is sound and the volatility illustrated faithfully represents the true economic and actuarial realities.

Very truly yours,

Kenneth L. Pitzer, F.S.A.
Principal

KLP:gh

EXHIBIT A

EFFECT OF A ONE PERCENT CHANGE IN ASSUMED RATES

The following attachments calculate the Accumulated Postretirement Benefit Obligation (APBO), which would result from a 1% change in the Health Care Trend Rate or Discount Rate, under the five scenarios shown below for an average GTE employee.

It is assumed that the average employee is 43 years old, with 13 years of service, is married, will be eligible for benefits at age 55 and will retire at age 62, with a life expectancy to age 80. His spouse is three years younger with a life expectancy to age 83. Since the employee's total service life through the eligibility date will be 25 years, the APBO at the current date is 52% (13/25 years) of the expected postretirement benefit obligation.

SUMMARY

	Discount Rate	Health Care Rate	APBO	Incr. (Decr.) From Base Case APBO	Attachment Number
Base Case	7.5%	7.5%	26,847		1
1% Change in Health Care Rate					
	7.5%	8.5%	34,516	28.6%	2
	7.5%	6.5%	20,907	(22.1%)	3
1% Change in Discount Rate					
	8.5%	7.5%	20,713	(22.8%)	4
	6.5%	7.5%	35,016	30.4%	5

DEMOGRAPHICS:

AGE	43
RETIREMENT	62
DEATH	79
HIRE AGE	30
EUGIBILITY	55

HEALTH CARE RATE	7.5%
DISCOUNT RATE	7.5%
CLAIMS COST - 1989:	
PRE - 64	2500
POST - 64	1000

		PER CAPITA COSTS		EMPLOYEE	SPOUSE	
	AGE	PRE - 64	POST - 64	PAYMENTS	AGE	PAYMENTS
1989	43	$2,500	$1,000	$0	40	$0
1990	44	2,688	1,075	0	41	0
1991	45	2,889	1,156	0	42	0
1992	46	3,106	1,242	0	43	0
1993	47	3,339	1,335	0	44	0
1994	48	3,589	1,436	0	45	0
1995	49	3,858	1,543	0	46	0
1996	50	4,148	1,659	0	47	0
1997	51	4,459	1,783	0	48	0
1998	52	4,793	1,917	0	49	0
1999	53	5,153	2,061	0	50	0
2000	54	5,539	2,216	0	51	0
2001	55	5,954	2,382	0	52	0
2002	56	6,401	2,560	0	53	0
2003	57	6,881	2,752	0	54	0
2004	58	7,397	2,959	0	55	0
2005	59	7,952	3,181	0	56	0
2006	60	8,548	3,419	0	57	0
2007	61	9,190	3,676	0	58	0
2008	62	9,879	3,951	9,879	59	9,879
2009	63	10,620	4,248	10,620	60	10,620
2010	64	11,416	4,566	11,416	61	11,416
2011	65	12,272	4,909	4,909	62	12,272
2012	66	13,193	5,277	5,277	63	13,193
2013	67	14,182	5,673	5,673	64	14,182
2014	68	15,246	6,098	6,098	65	6,098
2015	69	16,389	6,556	6,556	66	6,556
2016	70	17,618	7,047	7,047	67	7,047
2017	71	18,940	7,576	7,576	68	7,576
2018	72	20,360	8,144	8,144	69	8,144
2019	73	21,887	8,755	8,755	70	8,755
2020	74	23,529	9,412	9,412	71	9,412
2021	75	25,294	10,117	10,117	72	10,117
2022	76	27,191	10,876	10,876	73	10,876
2023	77	29,230	11,692	11,692	74	11,692
2024	78	31,422	12,569	12,569	75	12,569
2025	79	33,779	13,512	13,512	76	13,512
2026	80	36,312	14,525	0	77	14,525
2027	81	39,036	15,614	0	78	15,614
2028	82	41,963	16,785	0	79	16,785
2029	83	45,111	18,044	0	80	18,044
2030	84	48,494	19,398	0	81	19,398
2031	85	52,131	20,852	0	82	20,852

PRESENT VALUE	51,625
APBO FACTOR	0.52
APBO	26,847

540045

DEMOGRAPHICS:

AGE	43
RETIREMENT	62
DEATH	79
HIRE AGE	30
ELIGIBILITY	55

HEALTH CARE RATE	8.5%
DISCOUNT RATE	7.5%
CLAIMS COST - 1989:	
PRE - 64	2500
POST - 64	1000

		PER CAPITA COSTS		EMPLOYEE	SPOUSE	
	AGE	PRE - 64	POST - 64	PAYMENTS	AGE	PAYMENTS
1988	43	$2,500	$1,000	$0	40	$0
1990	44	2,713	1,086	0	41	0
1991	45	2,943	1,177	0	42	0
1992	46	3,193	1,277	0	43	0
1993	47	3,465	1,386	0	44	0
1994	48	3,759	1,504	0	45	0
1995	49	4,079	1,631	0	46	0
1996	50	4,425	1,770	0	47	0
1997	51	4,802	1,921	0	48	0
1998	52	5,210	2,084	0	49	0
1999	53	5,652	2,261	0	50	0
2000	54	6,133	2,453	0	51	0
2001	55	6,654	2,662	0	52	0
2002	56	7,220	2,888	0	53	0
2003	57	7,834	3,133	0	54	0
2004	58	8,499	3,400	0	55	0
2005	59	9,222	3,689	0	56	0
2006	60	10,006	4,002	0	57	0
2007	61	10,856	4,342	0	58	0
2008	62	11,779	4,712	11,779	59	11,779
2009	63	12,780	5,112	12,780	60	12,780
2010	64	13,868	5,547	13,868	61	13,868
2011	65	15,045	6,018	6,018	62	15,045
2012	66	16,324	6,530	6,530	63	16,324
2013	67	17,711	7,085	7,085	64	17,711
2014	68	19,217	7,687	7,687	65	7,687
2015	69	20,850	8,340	8,340	66	8,340
2016	70	22,623	9,049	9,049	67	9,049
2017	71	24,546	9,818	9,818	68	9,818
2018	72	26,632	10,653	10,653	69	10,653
2019	73	28,896	11,558	11,558	70	11,558
2020	74	31,352	12,541	12,541	71	12,541
2021	75	34,017	13,607	13,481	72	13,607
2022	76	36,908	14,763	14,492	73	14,763
2023	77	40,045	16,018	15,579	74	16,018
2024	78	43,449	17,380	16,748	75	17,380
2025	79	47,142	18,857	18,004	76	18,857
2026	80	51,149	20,460	0	77	20,460
2027	81	55,497	22,199	0	78	22,199
2028	82	60,214	24,086	0	79	24,086
2029	83	65,333	26,133	0	80	26,133
2030	84	70,896	28,354	0	81	28,354
2031	85	76,911	30,764	0	82	30,764

PRESENT VALUE	68,377
APBO FACTOR	0.52
APBO	34,516

CALCULATED	34,516
BASELINE	26,847
INCREASE	7,669
PERCENTAGE	28.6%

540046

DEMOGRAPHICS:

AGE	43
RETIREMENT	62
DEATH	79
HIRE AGE	30
ELIGIBILITY	55

HEALTH CARE RATE	6.5%
DISCOUNT RATE	7.5%
CLAIMS COST - 1989:	
PRE - 64	2500
POST - 64	1000

		PER CAPITA COSTS		EMPLOYEE	SPOUSE	
	AGE	PRE - 64	POST - 64	PAYMENTS	AGE	PAYMENTS
1989	43	$2,500	$1,000	$0	40	$0
1990	44	2,563	1,065	0	41	0
1991	45	2,836	1,134	0	42	0
1992	46	3,020	1,208	0	43	0
1993	47	3,216	1,286	0	44	0
1994	48	3,425	1,370	0	45	0
1995	49	3,648	1,459	0	46	0
1996	50	3,885	1,554	0	47	0
1997	51	4,137	1,655	0	48	0
1998	52	4,406	1,763	0	49	0
1999	53	4,693	1,877	0	50	0
2000	54	4,998	1,999	0	51	0
2001	55	5,323	2,129	0	52	0
2002	56	5,669	2,267	0	53	0
2003	57	6,037	2,415	0	54	0
2004	58	6,430	2,572	0	55	0
2005	59	6,848	2,739	0	56	0
2006	60	7,293	2,917	0	57	0
2007	61	7,767	3,107	0	58	0
2008	62	8,271	3,309	8,271	59	8,271
2009	63	8,809	3,524	8,809	60	8,809
2010	64	9,382	3,753	9,382	61	9,382
2011	65	9,992	3,997	3,997	62	9,992
2012	66	10,641	4,256	4,256	63	10,641
2013	67	11,333	4,533	4,533	64	11,333
2014	68	12,069	4,828	4,828	65	4,828
2015	69	12,854	5,141	5,141	66	5,141
2016	70	13,689	5,476	5,476	67	5,476
2017	71	14,579	5,832	5,832	68	5,832
2018	72	15,527	6,211	6,211	69	6,211
2019	73	16,536	6,614	6,614	70	6,614
2020	74	17,611	7,044	7,044	71	7,044
2021	75	18,755	7,502	7,573	72	7,502
2022	76	19,975	7,990	8,141	73	7,990
2023	77	21,273	8,509	8,751	74	8,509
2024	78	22,656	9,062	9,407	75	9,062
2025	79	24,128	9,651	10,113	76	9,651
2026	80	25,697	10,279	0	77	10,279
2027	81	27,367	10,947	0	78	10,947
2028	82	29,146	11,658	0	79	11,658
2029	83	31,040	12,416	0	80	12,416
2030	84	33,058	13,223	0	81	13,223
2031	85	35,207	14,083	0	82	14,083

PRESENT VALUE	40,205
APBO FACTOR	0.52
APBO	20,907

CALCULATED	20,907
BASELINE	26,847
DECREASE	(5,940)
PERCENTAGE	(22.1%)

DEMOGRAPHICS:

AGE	43
RETIREMENT	62
DEATH	79
HIRE AGE	30
ELIGIBILITY	55

HEALTH CARE RATE	7.5%
DISCOUNT RATE	8.5%
CLAIMS COST - 1989:	
PRE - 64	2500
POST - 64	1000

		PER CAPITA COSTS		EMPLOYEE	SPOUSE	
	AGE	PRE - 64	POST - 64	PAYMENTS	AGE	PAYMENTS
1989	43	$2,500	$1,000	$0	40	$0
1990	44	2,688	1,075	0	41	0
1991	45	2,889	1,156	0	42	0
1992	46	3,108	1,242	0	43	0
1993	47	3,339	1,335	0	44	0
1994	48	3,589	1,436	0	45	0
1995	49	3,858	1,543	0	46	0
1996	50	4,148	1,659	0	47	0
1997	51	4,459	1,783	0	48	0
1998	52	4,793	1,917	0	49	0
1999	53	5,153	2,061	0	50	0
2000	54	5,539	2,216	0	51	0
2001	55	5,954	2,382	0	52	0
2002	56	6,401	2,560	0	53	0
2003	57	6,881	2,752	0	54	0
2004	58	7,397	2,959	0	55	0
2005	59	7,952	3,181	0	56	0
2006	60	8,548	3,419	0	57	0
2007	61	9,190	3,676	0	58	0
2008	62	9,879	3,951	9,879	59	9,879
2009	63	10,620	4,248	10,620	60	10,620
2010	64	11,416	4,566	11,416	61	11,416
2011	65	12,272	4,909	4,909	62	12,272
2012	66	13,193	5,277	5,277	63	13,193
2013	67	14,182	5,673	5,673	64	14,182
2014	68	15,246	6,098	6,098	65	6,098
2015	69	16,389	6,556	6,556	66	6,556
2016	70	17,618	7,047	7,047	67	7,047
2017	71	18,940	7,576	7,576	68	7,576
2018	72	20,360	8,144	8,144	69	8,144
2019	73	21,887	8,755	8,755	70	8,755
2020	74	23,529	9,412	9,412	71	9,412
2021	75	25,294	10,117	10,117	72	10,117
2022	76	27,191	10,876	10,876	73	10,876
2023	77	29,230	11,692	11,692	74	11,692
2024	78	31,422	12,569	12,569	75	12,569
2025	79	33,779	13,512	13,512	76	13,512
2026	80	36,312	14,525	0	77	14,525
2027	81	39,036	15,614	0	78	15,614
2028	82	41,963	16,785	0	79	16,785
2029	83	45,111	18,044	0	80	18,044
2030	84	48,494	19,398	0	81	19,398
2031	85	52,131	20,852	0	82	20,852

PRESENT VALUE	39,832
APBO FACTOR	0.52
APBO	20,713

CALCULATED	20,713
BASELINE	26,847
DECREASE	(6,134)
PERCENTAGE	(22.8%)

DEMOGRAPHICS:

AGE	43	HEALTH CARE RATE	7.5%
RETIREMENT	62	DISCOUNT RATE	6.5%
DEATH	79	CLAIMS COST - 1989:	
HIRE AGE	30	PRE - 64	2500
ELIGIBILITY	55	POST - 64	1000

		PER CAPITA COSTS		EMPLOYEE	SPOUSE	
	AGE	PRE - 64	POST - 64	PAYMENTS	AGE	PAYMENTS
1989	43	$2,500	$1,000	$0	40	$0
1990	44	2,688	1,075	0	41	0
1991	45	2,889	1,156	0	42	0
1992	46	3,106	1,242	0	43	0
1993	47	3,339	1,335	0	44	0
1994	48	3,589	1,436	0	45	0
1995	49	3,858	1,543	0	46	0
1996	50	4,148	1,659	0	47	0
1997	51	4,459	1,783	0	48	0
1998	52	4,793	1,917	0	49	0
1999	53	5,153	2,061	0	50	0
2000	54	5,539	2,216	0	51	0
2001	55	5,954	2,382	0	52	0
2002	56	6,401	2,560	0	53	0
2003	57	6,881	2,752	0	54	0
2004	58	7,397	2,959	0	55	0
2005	59	7,952	3,181	0	56	0
2006	60	8,548	3,419	0	57	0
2007	61	9,190	3,676	0	58	0
2008	62	9,879	3,951	9,879	59	9,879
2009	63	10,620	4,248	10,620	60	10,620
2010	64	11,416	4,566	11,416	61	11,416
2011	65	12,272	4,909	4,909	62	12,272
2012	66	13,193	5,277	5,277	63	13,193
2013	67	14,182	5,673	5,673	64	14,182
2014	68	15,246	6,098	6,098	65	6,098
2015	69	16,389	6,556	6,556	66	6,556
2016	70	17,618	7,047	7,047	67	7,047
2017	71	18,940	7,576	7,576	68	7,576
2018	72	20,360	8,144	8,144	69	8,144
2019	73	21,887	8,755	8,755	70	8,755
2020	74	23,529	9,412	9,412	71	9,412
2021	75	25,294	10,117	10,117	72	10,117
2022	76	27,191	10,876	10,876	73	10,876
2023	77	29,230	11,692	11,692	74	11,692
2024	78	31,422	12,569	12,569	75	12,569
2025	79	33,779	13,512	13,512	76	13,512
2026	80	36,312	14,525	0	77	14,525
2027	81	39,036	15,614	0	78	15,614
2028	82	41,963	16,785	0	79	16,785
2029	83	45,111	18,044	0	80	18,044
2030	84	48,494	19,398	0	81	19,398
2031	85	52,131	20,852	0	82	20,852

PRESENT VALUE	87,338
APBO FACTOR	0.62
APBO	35,016

CALCULATED	35,016
BASELINE	26,847
INCREASE	8,169
PERCENTAGE	30.4%

Docket No. 911188-TL
V. Montanaro Exhibit No ___
Attachment 2
GTE's June 28, 1990
Letter to FASB

GTE Telephone Operations

Williams Square - West Tower
5205 N. O'Connor Boulevard
P.O. Box 152092
Irving, TX 75015-2092
214 718-4963

WILLIAM F. TORMAN
Assistant Vice President
Regulatory Accounting

June 28, 1990

Ms. Diana Scott
Project Manager
File Reference No. 078
Financial Accounting Standards Board
401 Merritt, P.O. Box 5116
Norwalk, CT 06856-5116

Dear Ms. Scott:

In reference to the letter I just sent to you, I am providing the attached letter which has been revised to correct a sentence that was inadvertently phrased in such a way as to misstate our position.

You will note that the last sentence on the first page has been revised to read:

> However, since under no circumstances should a correction of an error related to prior periods be charged to current or future earnings, we believe that amortization of this obligation to equity is the best alternative to restatement or an immediate charge to equity.

Please disregard my first letter. I apologize for any inconvenience.

Sincerely,

William F. Torman

WFT:eap
Attachment

c: T. J. Devine

0500025

GTE COPY

GTE Telephone Operations

Williams Square - West Tower
5205 N. O'Connor Boulevard
P.O. Box 152092
Irving, TX 75015-2092
214 718-4963

WILLIAM F. TORMAN
Assistant Vice President
Regulatory Accounting

June 28, 1990

Ms. Diana Scott
Project Manager
File Reference No. 078
Financial Accounting Standards Board
401 Merritt 7, P.O. Box 5116
Norwalk, CT 06856-5116

Dear Ms. Scott:

After your conference call last Monday with various USTA representatives, Dane Beck, who participated in the call, apprised me of the topics which were discussed. GTE appreciated the opportunity to address the concerns of regulated companies with respect to the Other Postretirement Employee Benefits (OPEB) transition obligation.

For regulated companies, the preferred treatment of the transition obligation is amortization to income. However, GTE believes that nonregulated companies should be permitted to amortize the transition obligation to equity. We do not feel this treatment is inconsistent for the reasons stated below.

As indicated in GTE's response to the Exposure Draft and in its presentation at the public hearings, we believe that the change from pay-as-you-go to accrual accounting is essentially the correction of an error for nonregulated companies. As the Board has characterized it, the change is a result of the failure to accrue a liability in the past. Further it represents a change from an accounting principle that is not generally accepted (cash basis accounting) to one that is generally accepted (accrual basis accounting). Paragraph 13 of APB No. 20 classifies such a change as a correction of an error. Although restatement is the appropriate accounting for the correction of an error, for practical reasons, we believe a nonregulated company should also be permitted to amortize the transition obligation. However, since under no circumstances should a correction of an error related to prior periods be charged to current or future earnings, we believe that amortization of this obligation to equity is the best alternative to restatement or an immediate charge to equity.

2

0500026

While we recognize that at first, this may seem to be an unusual approach, the unprecedented magnitude and nature of this change warrants it. Amortization to equity would also enhance comparability of future income statements with companies that chose or will choose immediate recognition under Technical Bulletin 87-1.

The treatment of rate regulated companies must, of necessity, be different. For these companies, pay-as-you-go accounting reflects the amounts that are being recovered through the actions of the regulators. Consequently, under FAS No. 71, these are the amounts that should be recorded as OPEB expense. Therefore, pay-as-you-go accounting cannot be considered an error in the same sense as for nonregulated enterprises. When the new accounting is adopted, the transition obligation should continue to be treated in accordance with ratemaking practices, with any differences between the OPEB cost as defined in the final statement and amounts considered for ratemaking purposes recognized as an asset or liability created by the actions of the regulator, subject to the test of recoverability.

Tom Devine, our Vice President-Accounting at GTE's Corporate Headquarters in Stamford or myself would be pleased to discuss this matter further or assist you in addressing any accounting issues related to the amortization of equity approach, if you so desire.

Thank you for the opportunity to express our opinion on this very important issue.

Sincerely,

William F. Torman

WFT:eap

c: T. J. Devine

Docket No.911188-WS
V. Montanaro Exhibit No ___
Attachment 3
Joint Letter July 11, 1990
To USTA re FASB conference call

Bell Atlantic Corporation
1310 N. Court House Road
Arlington, VA 22201

BellSouth Corporation
1155 Peachtree Street, N.E.
Atlanta, GA 30367

copy to Jim

July 11, 1990

Mr. Porter E. Childers
USTA
900 19th Street, N.W.
Suite 800
Washington, DC 20006-2102

Dear Porter:

Re: **Employers' Accounting for Post-retirement Benefits Other than Pensions (OPEB) - Transition Obligation**

Attached please find an analysis prepared by Bell Atlantic and BellSouth regarding the recent Financial Accounting Standards Board (FASB) action with respect to the transition obligation component of the Employers' Accounting for Post-retirement Benefits Other than Pensions (OPEB). Please arrange to send this paper to the USTA FASB and Regulatory Accounting committees.

Last month, members of the industry's financial community heard that the FASB was considering immediate recognition of the transition benefit obligation (TBO) rather than amortizing it over 15 years. We wanted to stress to the FASB the possible negative effects this could have on any regulated company, especially if the recognition were required to be taken directly to retained earnings, as opposed to flowing it through to expense on the income statement.

On Monday, June 18, 1990, Bell Atlantic, BellSouth, GTE and USTA participated in a conference call with Diana Scott, OPEB Project Manager - FASB Staff. On this call, we conveyed our industry's position on immediate recognition vs. amortization of the transition obligation. First, we reinforced our support of an OPTION to either immediately recognize the obligation or amortize it, but emphasized that if the Board was to choose one alternative over the other, we supported the amortization approach.

Second, we stated that from a regulatory perspective we were emphatically opposed to directly charging the transition obligation to retained earnings, since bypassing the income statement could jeopardize our chances for recovery of these expenses through the rate-making process. In addition, it would have the effect of artificially increasing our earned return on equity, which could also threaten recovery of costs.

The FASB officially met on June 27, 1990, and tentatively agreed to revise its exposure draft ruling regarding recognition of the transition obligation by ALLOWING THE OPTION to either amortize or immediately recognize the expense.

With respect to immediate recognition of the transition obligation, the Board ruled that companies may NOT charge this expense directly to retained earnings. However, companies that elect the immediate recognition alternative must account for the obligation as an extraordinary item on the income statement, which would mean it would be excluded from rate-making. Those choosing the amortization approach must treat it as a "net periodic cost" on the income statement, which means it would be afforded rate-making treatment.

In addition, the TBO is to be amortized over a period of twenty years or the average remaining service life, whichever is longer (the exposure draft specified fifteen years or average remaining service life). Finally, the FASB postponed the new standard's effective date by one year, from 1/1/92 to 1/1/93 (actually, the accounting standard will be effective for fiscal year beginning after 12/15/92).

The FASB's decisions concerning recognition of the transition obligation are optimal from a regulated accounting perspective. A decision to mandate immediate recognition and/or to charge the obligation to retained earnings could have provided ammunition for federal or state commissions to deny the recovery of these expenses.

Should you or any members of the committees have any questions or comments, please do not hesitate to call us directly, or call Christine Latsey (703) 974-3477 or Tom Bausch (703) 974-1201 of Bell Atlantic, or Pat Major (404) 249-2477 of BellSouth.

Matt McGarvey
Director,
Regulatory Accounting Standards
Bell Atlantic

Frances Dennis
Operations Manager,
Corporate Accounting Matters
BellSouth

Attachment

cc: Mr. D. Beck - GTE

July 2, 1990

MEMO TO FILE - REVISED

RE: STATUS OF TRANSITION OBLIGATION ISSUE, OPEB

****

There was a conference call on Friday, June 15 which was initiated by USTA to discuss the telephone industry's position on immediate recognition vs. amortization of the transition obligation. The need to address this issue is prompted by the fact that the FASB plans to address recognition of the transition obligation at its June 27 Board meeting (and is considering modifying the existing exposure draft proposal to allow the immediate recognition option or even go so far as to mandate immediate recognition of the transition obligation). Kim Petrone, who works for the FASB project manager on OPEB, requested our industry's views concerning these potential modifications. Ms. Petrone informed Denise Wirth of USTA that an informal communication of our views was what she was looking for (vs. a comment letter).

Participating in the conference call were representatives from USTA (Denise Wirth), Bell Atlantic (Matt McGarvey, Christine Latsey and Tom Bausch), BellSouth (Frances Dennis, Pat Major and Greg Griffin) and GTE (Jim Megan).

After discussing and analyzing the issue, we agreed to communicate the following industry consensus position to the FASB, prior to the Board's scheduled meeting on June 27, 1990, to resolve this issue:

1. If the FASB modifies the Exposure Draft to give companies the option of either immediate recognition or amortization of the transition obligation, the industry would not object to this modification.

2. If the FASB modifies the Exposure Draft to mandate immediate recognition, the industry is strongly opposed for the following reasons:

Regulated Telecommunications - Industry Specific

- The industry will ask the FCC for exogenous treatment of OPEB if price caps take effect. Our fear is that if immediate recognition is mandated as GAAP, the FCC might be inclined not to allow us to amortize the transition obligation for interstate ratemaking in light of Part 32 accounting and recent FCC actions (e.g., GAAP requires that gains or losses resulting from extinguishment of debt be recognized in the year of extinguishment. However, the FCC denied BellSouth's request to amend Part 32 to amortize such gains or losses, stating that the prescribed GAAP accounting produces equitable results; also, the FCC's decision vis a vis use of SFAS 87 for ratemaking).

- If the FCC denies exogenous treatment, states are certainly unlikely to permit recovery. Even if the FCC permits the use of amortization for interstate ratemaking, state commissions may not allow recovery of the transition obligation. Accordingly, **writing off the transition obligation in one year might severely limit the percentage that we are able to recover at the state as well as the federal level.**

General Industry

- The FASB has stated that amortization is a practical matter. The magnitude of the transition obligation and the limited availability of historical data on which to base measurement require a pragmatic way to reflect the transition obligation. Amortization must be allowed to give companies the ability to smooth the impact of this accounting change and avoid the result of significantly distorting earnings by a change in accounting which was previously perfectly acceptable as GAAP.

- The FASB Exposure Draft provides that immediate recognition of the transition obligation would result in immediate recognition of unrecognized prior service costs, gains and losses, and that such accounting treatment would be inconsistent with the Board's decisions in this proposed statement to delay recognition of the effects of plan improvements and the delayed recognition alternative for recognizing gains and losses.

- Only 2.6% of the 467 comment letters received by the FASB rejected the amortization approach.

- Amortization will not reduce the integrity of financial statements because the amount of the unamortized transition obligation would be disclosed with the statements. The FASB has stated that the initial emphasis of the proposed statement is on disclosure of that obligation with recognition being phased in over future periods.

- Insofar as the Board is concerned with improving understandability and comparability of financial reporting, the Exposure Draft provides that this objective would be furthered by phasing in recognition of the transition obligation for all employers given that the actuarial techniques for measuring the OPEB obligation are still developing.

- The Exposure Draft states that provisions of this proposed statement are similar in many respects to those in SFAS 87 and that different accounting treatment would be prescribed only when the FASB has concluded that there is a compelling reason for different treatment. The above arguments show that there is no such compelling argument. Amortization of the transition obligation is consistent with SFAS 87 in which the transition is required to be amortized on a straight line basis.

- For companies choosing to adopt accrual accounting prior to action by the FASB, Technical Bulletin (TB) 87-1 gives companies the option of writing the entire transition obligation off in the year of adoption or amortizing the obligation. As such, the Board's argument that consistency needs to be achieved as the reason for mandating one method of recognizing the transition obligation is hampered by the fact that some companies have already adopted accrual accounting, pursuant to FASB TB 87-1, and by the fact that those adopting early had an option.

3. If the FASB informs us that the Board is considering changing the length of the amortization period, the industry consensus is that the amortization period should be lengthened.

4. If the FASB ultimately determines to mandate immediate recognition of the transition obligation, then it should not require companies to take it to retained earnings. This would be the worst of all possible scenarios for regulated industries as the amount would never show up on the income statement (as a cost of service), and would artificially drive up our rates of return.

Conference Call - Monday, June 18, 1990 with FASB Staff

On Monday, June 18, Bell Atlantic participated in a conference call with Diana Scott (OPEB Project Manager) and Kim Petrone of the FASB to communicate the above positions to the FASB. Also participating were Terry Betts, Pat Major and Greg Griffin from BellSouth; Dane Beck from GTE; Denise Wirth from the USTA; and Matt McGarvey, Christine Latsey and Tom Bausch from Bell Atlantic.

Ms. Scott related the Board's plans to address the issue of modifying the existing proposal to recognize the transition obligation through amortization, given the fact that an overwhelming number of comments asked that immediate recognition be permitted as well. In addition, Ms. Scott related that the Board was considering how to charge the obligation, as some comments recommended that the obligation be charged to retained earnings, rather than net income.

Because of concern about the potential ramifications of these proposals on regulated industries, Ms. Scott wanted input from our industry prior to the June 27, 1990 Board meeting.

Specifically, she requested input on the industry's position should the Board approve the OPTION to either immediately recognize or amortize the transition obligation. (Ms. Scott stated that we should not be concerned with the Board authorizing immediate recognition as the only methodology.)

In addition, she requested the industry position regarding charging this obligation to retained earnings vs. net income.

Mr. McGarvey acted as spokesman on this conference call and provided the following comments:

Re: Option of Immediate Recognition or Amortization

- The industry does not have any objection to this scenario;
- Industry consensus is that if the Board provides an option, a regulatory body would not mandate immediate recognition without corresponding rate recovery;
    - Should a regulatory body attempt this, it could be considered confiscation, and we would have a very strong legal case against such action.

Re: Charging to Net Income or Directly to Retained Earnings

Apparently the FASB is considering a proposal to require that the effect of recognition of the transition obligation be captured in retained earnings (RE), rather than charged to net income. If this change were made by the FASB, the charge to RE would apply to companies which choose to amortize the obligation as well as for companies choosing the immediate recognition option.

Industry position on this issue is very emphatic: Board direction to charge directly to retained earnings, whether amortized or written off immediately, would prove extremely damaging on several counts to regulated telecommunications companies:

- A charge to retained earnings (RE) means that the obligation would never appear on the income statement, and therefore would not be part of a regulated company's cost of service for the purposes of revenue requirements determination;
    - Bypass of the revenue requirements formula would provide fuel to the regulators' desire to NOT allow rate recovery of the obligation expenses;
    - Since implementation of our new Chart of Accounts (Part 32) the FCC has employed a "pro-GAAP" stance that would, if the Board elects to charge the obligation to RE, provide impetus to the FCC as well as the state commissions, to follow this recommendation. Such action would prevent these costs from flowing into our revenue requirements, and would therefore make rate recovery difficult;

- The feeling of several companies (especially BellSouth) is that their commissions would not allow recovery of rates should GAAP mandate charging the transition obligation to retained earnings; at best it would be an uphill battle;

- A charge to RE would also have the effect of artificially increasing our earned return.

By charging to retained earnings, equity will decrease. However, by bypassing the income statement, earnings will remain constant. The effect is an increase in return on equity (ROE), even though earnings have not changed:

Example: ROE = Earnings/Equity

Pre-Obligation Expense
Earnings = 10
Equity = 100 ROE = 10%

Post Obligation Expense
Earnings = 10
Equity = 90 ROE = 11.11%

ROE increases even though earnings are constant

Ms. Scott appeared sincerely appreciative of our comments, as she was not thoroughly aware of all of the implications that the Board's action would have upon the regulated telecommunications industry, especially with respect to a direct charge to retained earnings.

Mr. McGarvey concluded the call by thanking Ms. Scott for entertaining our industry's concerns prior to the Board's meeting to resolve this issue on June 27, 1990. Ms. Scott then urged us to call her following this meeting to learn the outcome of the Board's decision.

FASB Meeting - June 27, 1990

On Wednesday, June 27, 1990, the Financial Accounting Standards Board met to discuss its outstanding proposal on Employers' Accounting for Post-retirement Benefits Other than Pensions (OPEB).

At this meeting, the Board tentatively agreed to change its exposure draft (ED) regarding the transition obligation, to provide the **OPTION** to either amortize over 20 years (or the average remaining service life of the employees, whichever is longer) or immediately recognize the cost of the transition obligation. This is a change from its previous posture in the ED of **REQUIRING** amortization over 15 years (or average remaining service life).

In addition, the FASB postponed the effective date of compliance to the new accounting standard from 1/1/92 to 1/1/93 (actually, it must be adopted by all companies starting with the fiscal year beginning subsequent to 12/15/92).

Per Ms. Scott's invitation, Mr. McGarvey telephoned the FASB staff (specifically, Kim Petrone, OPEB Project Team) following the Board meeting, to clarify the proceedings of this meeting.

She confirmed that the Board did elect to preclude companies from directly charging retained earnings for the transition obligation, whether choosing amortization or immediate recognition. However, Mr. McGarvey was informed that companies choosing the option of one-time recognition must account for the transition obligation as an extraordinary item on the income statement. For regulated companies, this would mean 'below-the-line' accounting treatment.

Those companies that amortize this expense must account for it as a 'net periodic cost' on the income statement, which, assuming state and Federal commissions' approval, would equate to 'above-the-line' accounting treatment (and therefore would be included in revenue requirements) for regulated companies.

Prepared by:

BELL ATLANTIC
Christine Latsey
(703) 974-3477
Tom Bausch
(703) 974-1201

Docket No. 911188-TL
V. Montanaro Exhibit No ___
Attachment 4
Actuarial Valuation of Current
and Alternative Benefits

Actuarial Valuation of Current and Alternative Retiree Health Benefits Provided by the SSU Services, Inc.

May 29, 1992

MILLIMAN & ROBERTSON, INC.

DR 39-L
2 18

Actuarial Valuation of Current and Alternative Retiree Health Benefits Provided by the SSU Services, Inc.

Table of Contents

MILLIMAN & ROBERTSON, INC.
Actuaries and Consultants

Suite 400
15700 Bluemound Road
Brookfield, Wisconsin 53005
Telephone: 414/784-2250
Fax: 414/784-6388

Wendell Milliman, F.S.A. (1976)
Stuart A. Robertson, F.S.A.
Chairman Emeritus

Gerald R. Bernstein, A.S.A.
Stephen D. Brink, F.S.A.
Brian Z. Brown, F.C.A.S.
Mark J. Cain, A.C.A.S.
Susan J. Comstock, F.S.A., F.C.A.S.
Thomas K. Custis, F.S.A.
Patrick J. Dunks, A.S.A.
Pamela J. Evans, A.S.A.
Daniel J. Flaherty, F.C.A.S.
Steven G. Hanson, A.S.A.
Richard H. Hauboldt, F.S.A.
Peggy L. Hauser, F.S.A.
Gregory N. Herrie, F.S.A.
William V. Hogan, F.S.A.
Gary R. Josephson, F.C.A.S.
David J. Kershner, A.S.A.
Frank Kopenski, Jr., A.S.A.
Kenneth E. Leinbach, F.S.A.
Mark E. Litow, F.S.A.
Elaine Magrady, A.S.A.
Sandra A. Mertes, F.S.A.
James C. Modaff, F.S.A.
Kenneth W. Newhouse, A.S.A.
David F. Ogden, F.S.A.
William M. Pollock, F.S.A.
Kevin B. Robbins, F.C.A.S.
Robert L. Sanders, F.C.A.S.
Steven J. Sherman, F.S.A.
John B. Snyder, F.S.A.
Lee H. Straate, F.S.A.
Peter G. Wick, A.C.A.S.
Roger A. Yard, A.C.A.S.

May 29, 1992

SSU Services, Inc.
1000 Color Place
Apopka, FL 32703

Attention: Ms. Roxan R. Haggerty

RE: Actuarial Study of Alternative
Retiree Health Benefits

Ladies & Gentlemen:

We have completed an actuarial valuation of the current and proposed retiree health benefits for SSU Services, Inc. The results of our calculations are set forth in the following report, as are the actuarial assumptions on which our calculations have been made. We have relied on the basic employee data as submitted by your office.

As the results, discussions, conclusions and recommendations of this report are considered, it is important to remember that these results are based on projections of future claims experience. These projections are particularly sensitive to changes in certain assumptions. While we have included numbers which demonstrate the impact of a change in the medical cost trend assumption, the scope of this study does not permit analysis of the potential variability associated with other assumptions (such as retirement decrements), nor does it deal with possible external changes (such as Medicare Catastrophic Coverage or National Health Insurance). The results, therefore are intended as a guide, not as a prediction. They should give management a sense of the magnitude of the financial obligation.

DR 39-L
4 of 18

On the basis of the foregoing, we hereby certify that, to the best of our knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices which are consistent with the applicable Guides to Professional Conduct, amplifying Opinions and supporting Recommendations of the American Academy of Actuaries.

In our opinion, the individual assumptions used are reasonably related to the experience of the plan and to reasonable expectations, and represent our best estimate of anticipated experience under the Plan.

Sincerely,

Thomas K. Custis, F.S.A.
Consulting Actuary

Paul W. Withington
Actuarial Assistant

TKC/PWW/bh

Actuarial Valuation of Current and
Alternative Retiree Health Benefits
Provided by the
SSU Services, Inc.

I. INTRODUCTION AND SUMMARY OF RESULTS

This report presents the results of an actuarial valuation of the current and proposed health plans covering the retirees of SSU Services, Inc. This valuation was based on census data as of July of 1991 for the active employees and as of November 1991 for the retired employees. Our calculations include employees not covered by the pension plan but eligible for the health and death benefits. See Appendix B for our treatment of these employees. The liabilities are all expressed as of January 1, 1992 and the expense and cost figures reflect amounts applicable to 1992.

A. Valuation Method

In December of 1990, the Financial Accounting Standards Board (FASB 106) issued its long-awaited final rules regarding "Employers' Accounting for Post-Retirement Benefits Other Than Pensions". These rules require private employers to accrue the costs of post-retirement benefits over the periods when service is provided by employees rather than on a pay-as-you-go basis after the employee retires.

FASB 106 has introduced some new terminology which is summarized below:

- The Expected Post-Retirement Benefit Obligation (EPBO) is defined as the actuarial present value of benefits expected to be paid to or on behalf of employees. The EPBO is relevant only as the basis for determination of APBO (see below).

- The Accumulated Post-Retirement Benefit Obligation (APBO) is defined as the portion of EPBO allocated to service rendered prior to the measurement date, based on the accrual period defined by the accounting standards. The APBO is the basic obligation for determination of costs and liabilities.

- The Net Periodic Post-Retirement Benefit Cost (NPPBC) is defined as the amount recognized in an employer's financial statements as the cost of a post-retirement benefit plan for a period. Components of the NPPBC include service cost, interest cost, actual return on plan assets, gain or loss, amortization of unrecognized prior service cost, and amortization of the unrecognized transition obligation or asset.

B. Summary of Results

Following are the results based on our assumptions as to future trend rates. The presentation is modeled after the standard disclosure requirements set forth in FASB 106. The report compares the current retiree medical plan liabilities to the liabilities for the three proposed plans. We have shown the results net of the employee contributions expected to be received in the future. The current and proposed plan provisions are described in Section II, and they are all assumed to be in effect as of January 1, 1992. Since there are no proposed changes to the death benefit, those numbers are not included in this report. However, the death benefit liabilities would need to be disclosed in a FASB 106 statement.

The table sets forth the funded status which would be reported at January 1, 1992:

	Current Plan	Proposed Plan 1	Proposed Plan 2	Proposed Plan 3
Expected Post-Retirement Benefit Obligation	$11,678,973	$11,678,973	$6,676,579	$11,678,973
Accumulated Post-Retirement Benefit Obligation (APBO)	6,034,055	6,034,055	4,111,310	6,034,055
Present Value of Future Employee Contributions Toward APBO	967,450	1,174,106	667,015	1,748,254
Employer APBO Net of Employee Contributions	5,066,605	4,859,949	3,444,295	4,285,801
Plan Assets at Fair Value	0	0	0	0
Employer APBO in Excess of Plan Assets	5,066,605	4,859,949	3,444,295	4,285,801
Unrecognized Net Gain From Past Experience Different From That Assumed and From Changes in Assumptions	0	0	0	0
Prior Service Cost Not Yet Recognized in Net Periodic Post-Retirement Benefit Cost	0	0	0	0
Unamortized Transition Obligation	5,066,605	4,859,949	3,444,295	4,285,801
Accrued Post-Retirement Benefit Cost	0	0	0	0

Upon adoption of FASB 106, the employer has the option of immediately recognizing the total liability rather than posting an unrecognized transition obligations.

DR 39-c

8.04 18

Net periodic post-retirement benefit cost projected for 1992 ~~would include the~~ following components:

	Current Plan	Proposed Plan 1	Proposed Plan 2	Proposed Plan 3
Service Cost - Benefits Attributed to Service During the Period	$ 648,900	$608,210	$284,192	$334,924
Interest Cost on Accumulated Post-Retirement Benefit Obligation	404,171	387,639	274,386	341,707
Actual Return on Plan Assets	0	0	0	0
Amortization of Transition Obligation Over 20 Years	253,330	242,997	172,215	214,290
Net Amortization and Deferral	0	0	0	0
Net Periodic Post-Retirement Benefit Cost	1,306,401	1,238,846	730,793	890,921

The weighted-average health care cost trend rate used in determining the accumulated post-retirement benefit obligation was 8.8%. This trend rate was applied to the total annual claim costs for medical coverage. For the Current Plan and Proposed Plan 1, the Employee contributions are assumed to increase at the trend rate. For Proposed Plan 2, the lifetime benefit is assumed to be capped at $10,000 for those participants over age 65. For Proposed Plan 3, the employer contributions are assumed to remain fixed based on the employee's years of service at retirement if less than 20. The employer pays for the full benefit if the retiree has at least 20 years of service at retirement.

II. CURRENT AND ALTERNATIVE MEDICAL COVERAGES

A. Current Plan

COVERAGE FOR RETIREES

Eligibility: Employees who are at least fifty-five (55) years of age or older who are retiring from the Company with at least five (5) years of service with the Company.

Medical Benefits:

- 90% coinsurance for Great West Hospital/Physician
- Generally 80% coinsurance for other provider
- Deductible = $0 for Great West care
  = $100/$300 for other
- Out-of-Pocket Maximum = $5,000/$10,000
- Health care review service
- Medicare carve-out of benefits

Medical Contributions:

° Employee Only	$15
° Employee Plus One Dependent	$50
° Employee Plus Two Dependents	$70
° Employee Plus Three or More Dependents	$90

Death Benefits:

- $10,000 Life Insurance Benefit

B. Proposed Plan 1

COVERAGE FOR RETIREES

Eligibility: Same as current plan.

Medical Benefits: Same as current plan.

Medical Contributions:

- No contributions for employee coverage.
- Dependent coverage is optional. The retiree contribution amount would be 50% of the cost of the dependent coverage. As an example, based on estimated claim costs for 1992, dependent coverage would be provided for employee contributions of roughly:
  $150 per month for pre-65 coverage,
  $ 50 per month for post-65 coverage,
  These amounts would increase at the assumed trend rate.

Death Benefits: Same as current plan.

* This proposed plan would affect only those active employees not currently eligible for retiree medical benefits. (i.e. Those employees who currently are less than age 55 or have less than 5 years of service.)

C. Proposed Plan 2

COVERAGE FOR RETIREES

Eligibility: Same as current plan.*

Medical Benefits: Same as current plan except that for between ages 55 and 65 there would be a benefits maximum of $1,000,000 per covered individual. After age 65 there would be a lifetime maximum of $10,000 worth of benefits per covered individual.

Medical Contributions: Same as current plan.

Death Benefits: Same as current plan.

* This proposed plan would affect only those active employees not currently eligible for retiree medical benefits. (i.e. Those employees who currently are less than age 55 or have less than 5 years of service.)

D. Proposed Plan 3

COVERAGE FOR RETIREES

Eligibility: Same as current plan.

Medical Benefits: Same as current plan.*

Medical Contributions: Retirees will receive the following employer payment toward the purchase of retiree medical insurance:

Years of Service	Benefit Per Month
5	$ 50
6	75
7	100
8	125
9	150
10	175
11	200
12	225
13	250
14	275
15	300
16	325
17	350
18	375
19	400
20*	Full cost of individual and dependent coverage.

Death Benefits: Same as current plan.

* This proposed plan would affect only those active employees not currently eligible for retiree medical benefits currently eligible for retiree medical benefits. (i.e. Those employees who currently are less than age 55 or have less than 5 years of service.)

III. FUTURE MEDICAL COST INCREASE

The present value of future retiree medical benefits depends on the relationship between the assumed annual trend in health care cost increases and the discount rate. Because expenses are based on present value calculations, the expense calculations are affected by both of these assumptions. The anticipated level of benefits paid out each year also depends on the annual trend assumption.

Long-range trend assumptions were selected based on the assumed long-term relationship with the discount rate. Our estimates are based on the following assumptions:

Discount Rate	=	8.0%
Long Range Weighted Average Trend Rate	=	8.8%

Clearly, the basic relationships between these assumptions are subject to variation. Their absolute levels could also vary significantly from those assumed. However, since it is the relationship between the trend and discount rate that affects the magnitude of the obligations, varying their absolute values while keeping the same spread would not produce dramatic changes in the general patterns produced by the assumptions shown in this report.

For purposes of determining the trend increase on the health plan cost to the employer, we applied a trend factor starting at 12% and grading down to 8% after a period of 8 years.

NET PERIODIC COST TERMINOLOGY

The terminology utilized in calculating the net periodic post-employment benefit cost is described below.

A. Service Cost

This represents the cost of the portion of an employee's benefit deemed to be earned in the current year. In pension plans where a benefit is earned during each year of service, it is relatively easy to visualize the Service Cost as being the cost for each participant of the benefit earned in the current year. In a program such as a post-retirement life or health insurance plan, this cost cannot be easily related to the benefit formula. Instead the Service Cost was calculated so that the total value of a participant's benefit would be accrued in equal units over his total service to the earlier of expected retirement or full eligibility. Thus if an employee's total projected service to retirement (or full eligibility, if earlier) was 30 years, 1/30th of the value of the expected post-retirement benefit obligation would be the Service Cost. This would be the annual cost over the long term if (1) the Service Cost attributable to the past had been full funded, and (2) interest were earned at the assumed rate on the accumulated post-retirement benefit obligation.

B. Interest Cost

This represents the amount of investment income which would be earned if the employer had previously funded the total Service Cost for past periods. This is offset by actual investment returns on the qualified pension plans, since they have been funded. On unfunded plans such as the retiree life and health insurance plans, there is no offsetting actual investment return and so this represents an additional expense. Since the SSU Services, Inc. plans were not funded, the assets to cover these liabilities remain on the corporate balance sheet and the investment income they generate is included in earnings.

C. Amortization Accruals

To the extent that actual past costs differ from the Service Costs that should have been accrued in the past, that difference as of the effective date of the new rules is to be amortized over the average future working lifetime of employees expecting to benefit under the SSU Services, Inc. plans or 20 years, if greater. Since these are unfunded plans, there is an obligation which is to be accrued.

Appendix B
(Page 1 of 1)

Actuarial Valuation of Current and Alternative Retiree Health Benefits Provided by the SSU Services, Inc.

Summary of Census Data

	7/1/91 Pension Data	1/1/92 Estimate
ACTIVE		
Number	340	460*
Average Age	-	40.6
RETIREES		
Number	9	9
Average Age	-	66.8

*Includes those employees who are eligible for health and life benefits but are not in the pension plan.

SUMMARY OF ACTUARIAL ASSUMPTIONS

Investment Return: 8.0% compounded annually.

Mortality Rates: 1971 Group Annuity Mortality Male Table for males and 1971 Group Annuity Mortality Male Table set back six years for females.

Termination Rates: Special rates based on the Company's recent past experience.

Retirement Rates:

Age	Probability of Retirement
Less than 55	0%
55-59	2
60-61	10
62	30
63-64	20
65 and Over	100

Percentage Married: 85% with the spouse three years younger.

1992 Annual Claim Costs: The annual claim costs of benefits utilized in the projections are summarized below:

Annual Claim Costs as of January 1, 1992	
Age 65 - Single	$ 970
Age 65 - Family	$1,930

Increase in Benefits Costs by Year ("Trend"): Annual per capita benefit costs were projected to grow each year due to increases in the cost of health care attributable to inflation, utilization and changes in the types of services provided. This is referred to as "trend" in the report. The trend rate assumed was a graded schedule as shown below:

Year	Medical Trend Rate
1992	12.0%
1993	11.5
1994	11.0
1995	10.5
1996	10.0
1997	9.5
1998	9.0
1999	8.5
After 1999	8.0

Retiree Contributions: Current retiree contribution rates were also assumed to increase at the medical trend rate.

Docket No.911188- WS
V. Montanaro Exhibit No __
Attachment 5
Foster and Higgins
Study of Health Care Benefits

Foster Higgins

CONSULTANTS ON EMPLOYEE BENEFITS

The *Foster Higgins Health Care Benefits Survey* was established in 1986 as a way to collect and share information on employer-sponsored health benefit programs and cost management initiatives. The results of the 1991 survey are being released in a series of four reports which may be purchased from Foster Higgins for $100 each:

Report 1: Indemnity Plans: Cost, Design and Funding

Report 2: Managed Care Plans

Report 3: Flexible Benefit Programs

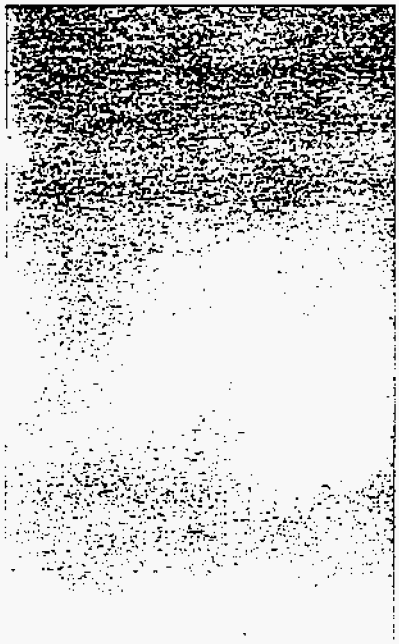
Report 4: Retiree Health Care

The survey questionnaire was distributed in the summer of 1991 with the help of employer coalitions around the country. This report reflects the input of 2,409 employers, whose plans cover a total of 13.8 million employees. Respondents include private and public organizations of all sizes and industry types, from all 50 states. Nearly half of the Fortune 500 companies participated, as well as 48 state governments.

HOW TO GET MORE INFORMATION

This report reflects only a portion of survey data. The total body of information, dating back to 1986, is stored in our survey database. If you would like more information than is presented here, please contact us to discuss whether our database can supply what you need. Foster Higgins survey specialists can also design and conduct a customized survey, by phone or by mail, if you need data on a topic that was not addressed in our survey or if you would like to target a specific group of respondents.

CALL OR WRITE:
Foster Higgins
Survey and Research Services
212 Carnegie Center
Princeton, NJ 08543-5323
609-520-2289



Indemnity Plans: Cost, Design and Funding

This report is an overview of traditional insured and self-insured medical plans in 1991. We identify specific influences on health care costs and trends in medical plan design. We also discuss the role of employee communication in managing plan design change. Tables of survey responses, in geographic, employer size, and industry categories, are given in the back of the report.

Taking the lead in health care reform

"Simply by using their purchasing power to reward efficient providers, employers can help to restructure the health care system."

Health care has risen to the top of the American political agenda. While our health care system is capable of delivering the best care in the world, problems of cost and access have raised widespread concern. These problems are closely related. We spend almost 12 percent of our gross national product on health care (more than any other nation), yet some 35 million people—most of them employed—lack health insurance. The high cost of health care prevents many small employers from offering insurance, and purchasing an individual policy is not an option for many people because of the cost.

Legislative proposals have ranged from heating up competition among private insurers by requiring each citizen to buy basic coverage, to scrapping private insurance and creating a single government-sponsored plan. Employers attempting to set long-term strategies for their own plans are understandably concerned about where this debate will lead. While it's impossible to predict what reforms, if any, actually will be enacted, as the 1992 presidential election draws closer and the candidates reveal their platforms, it seems safe to venture a guess about what will not happen.

The debate so far has focused mainly on the question of accessibility: extending coverage to the poor and homeless not covered by Medicaid and to the working uninsured. While there has been much talk about introducing a national health program along the lines of the Canadian system, it seems unlikely that such a major overhaul will happen in the near-term. The current crop of proposals is aimed at getting more people insured within the current public/private health care system, not at substantially transforming the system itself. Congress and state legislators will address the scope of Medicare and Medicaid entitlement programs, leaving employers to struggle with making affordable insurance available to working Americans. Far from displacing employer-sponsored health plans, nearly all of the latest proposals build on them, either by mandating employer coverage or by providing employers with tax incentives to offer coverage. Under the "pay-or-play" proposals, for example, employ-

ers who don't currently offer benefits may either provide a mandated level of benefits or pay into a government-sponsored plan.

Cost and quality: employers' responsibility

It's unlikely that any reform legislation will adequately address cost or quality issues. Plan sponsors will continue to shoulder the responsibility for making quality health care affordable to employees. The most important step employers can take toward this goal is to seek out and select the best available means to finance and deliver care. Simply by using their purchasing power to reward efficient providers, employers can help to restructure the health care system.

For some, the traditional indemnity approach remains the most viable option—at least for the short-term. Keeping such coverage affordable will likely mean shifting more and more cost to employees through contributions, deductibles and coinsurance, and narrowing the scope of benefits offered. At some point, the value of the indemnity plan from the employees' perspective must decline as medical costs continue to climb. Employers should continually evaluate the pros and cons of maintaining an indemnity plan in the context of the changing health care market.

Other employers will cast their lot with managed care vendors, selecting from competing HMOs and PPOs on the basis of price and quality. For employees, managed care usually entails a trade-off: restricted access to providers but a broader range of benefits. Periodic audits of vendor performance, as well as employee satisfaction with vendor procedures and services, will assure employers that they're getting the best value for their money.

Still other employers will create their own alternative delivery systems by contracting directly with hospitals and physicians in preferred provider or exclusive provider arrangements. Again, by using their purchasing power, American employers can not only win discounts but lay the groundwork for more efficient, higher quality care.

Some employers are even developing in-house medical facilities to provide primary care to employees and their families and to serve as gatekeeper to the larger medical system.

Organizations with multiple locations may use all these approaches, since managed care programs are not uniformly available around the country.

Measuring value

As employers become more involved in the health care system—using their purchasing power, negotiating with providers—they will also have to address issues of quality. The key measurement of health delivery system effectiveness is value—the quality of the program in relation to the cost of the program. Unfortunately, there are few universally agreed-upon measures of health care quality. As American employers have been forced to focus on quality improvement by tougher competition at home and abroad, so will they need to define and enforce quality measures for the providers with whom they do business. Of course, providers themselves must be willing to establish and accept norms for treatments and outcomes—something they've showed little inclination to do. Growing competition in the health care industry may be pushing providers toward quality measurement at last, and employers should do all they can to speed the process.

The debate over health care reform will likely continue long after the election. But it seems clear that employer-sponsored health care will remain the predominant means of providing health care to working Americans for the foreseeable future, and employers will remain responsible for keeping it affordable. It's a big responsibility. What's at stake is the continued existence of the greatest private social welfare system in the world—the US employer-sponsored health care benefits system.

JOHN C. ERB
PRINCIPAL

KEY FINDINGS

■ The average cost of traditional medical indemnity plan coverage rose 13.0 percent in 1991, from $3,161 per employee in 1990 to $3,573. This follows a 21.6 percent increase in 1990.

■ Against the backdrop of the recession, health benefit cost as a percent of corporate net earnings rose sharply, from 26 percent in 1989 to 45 percent in 1990.

■ Employee contributions kept pace with costs. Over half (55 percent) of employers require a contribution for employee-only coverage; the contribution amount averages $35 per month (up 13 percent from 1990). Over three-fourths of employers require a contribution for family coverage; on average, $101 per month (up 17 percent).

■ Deductible amounts continue to rise. Half of all major medical individual deductibles are set at $200 or above. In 1986 only 25 percent were at this level.

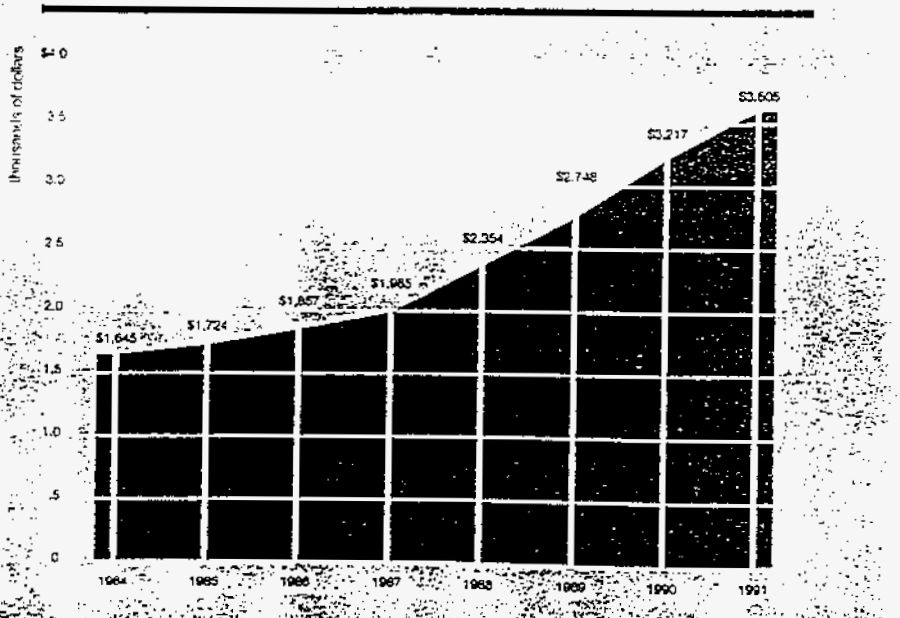
■ The number of employers self-insuring their medical plans rose from 59 to 65 percent in 1991. While self-insurance is more common among large employers (82 percent of employers with 5,000 or more employees), today nearly half of employers with fewer than 1,000 employees also self-insure.

■ Employers are showing renewed interest in wellness/fitness programs. Over a third provide either an on-site fitness facility or a financial subsidy for health club membership (up from 17 percent in 1989), and 43 percent offer some diagnostic screening tests (up from 19 percent in 1990). In addition, 65 percent of respondents have instituted a smoke-free workplace policy.

■ The total cost of providing employee health benefits in 1991 averaged $3,605 per employee, up 12.1 percent from 1990's $3,217. This figure combines employer and employee contributions for traditional medical plans; PPOs; HMOs; and dental, vision, hearing, and prescription drug plans. Included are all claims costs or premiums and claims administration expenses for active and retired employees and their dependents.

Total per employee health plan cost grows 12.1% in 1991

AVERAGE ANNUAL PER EMPLOYEE COST, 1984–1991



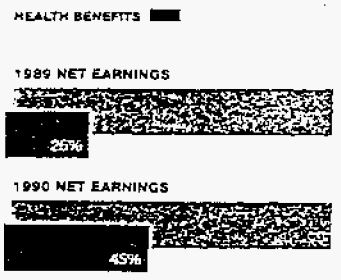
MEDICAL PLAN COST

The average cost of providing traditional medical indemnity plan coverage rose 13.0 percent in 1991, from $3,161 per employee in 1990 to $3,573 per employee in 1991. This is the slowest annual rate of growth in the average cost of medical plans since 1987 and a considerable drop from last year's record-breaking increase of 21.6 percent. However, it is still four times as high as the increase in the Consumer Price Index during the same period.

In the last three years, traditional medical indemnity plan cost has climbed more than 65 percent (from an average of $2,160 in 1988). In combination with the economic downturn, growing health benefit expense is playing havoc with corporate profits. In 1989, the total cost of corporate health benefit programs equaled, on average, 26 percent of net earnings (after-tax profit). This year's survey respondents report that total health costs jumped to 45 percent of net earnings in 1990. For a number of survey respondents, health costs exceeded net earnings.

Health benefit cost as a percent of net earnings nearly doubles

AVERAGE TOTAL COST OF HEALTH BENEFITS AS A PERCENT OF NET EARNINGS (AFTER-TAX PROFIT)

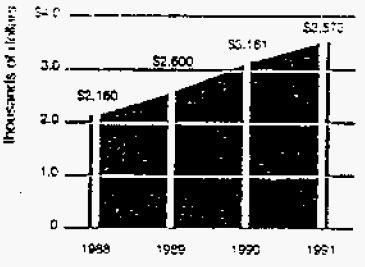


While employers were aided by a dip in medical price inflation (the annual increase in the medical component of the CPI fell from 9.6 percent in 1990 to 7.9 percent in 1991), survey findings suggest that the slowdown in the cost trend in 1991 is also attributable to aggressive cost management efforts. Employee cost-sharing requirements—in the form of premium contributions, deductibles, and copayments for medical services—were raised significantly. Comprehensive major medical plans continued to displace first-dollar hospitalization plans. And more employers moved to self-funding to reduce retention expenses and avoid mandated benefit requirements.

While these initiatives offered employers some much-needed relief from escalating premium costs during a recessionary 1991, unfortunately none are likely to influence the underlying 20 percent trend experienced since 1988. In apportioning a greater share of the cost of medical treatment to their employees and changing funding methodology, employers found a one-time cost reduction, not a long-term solution.

Traditional medical indemnity plan cost up 13.0%

AVERAGE ANNUAL PER EMPLOYEE MEDICAL PLAN COST, 1988–1991

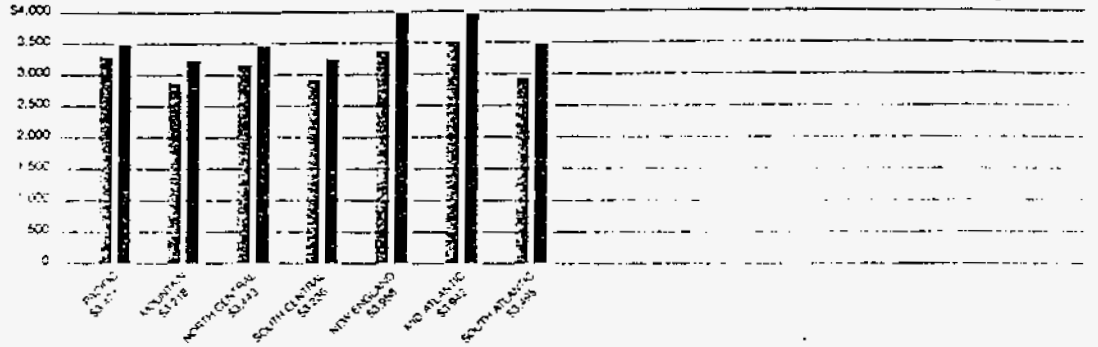


Indemnity plan cost per employee

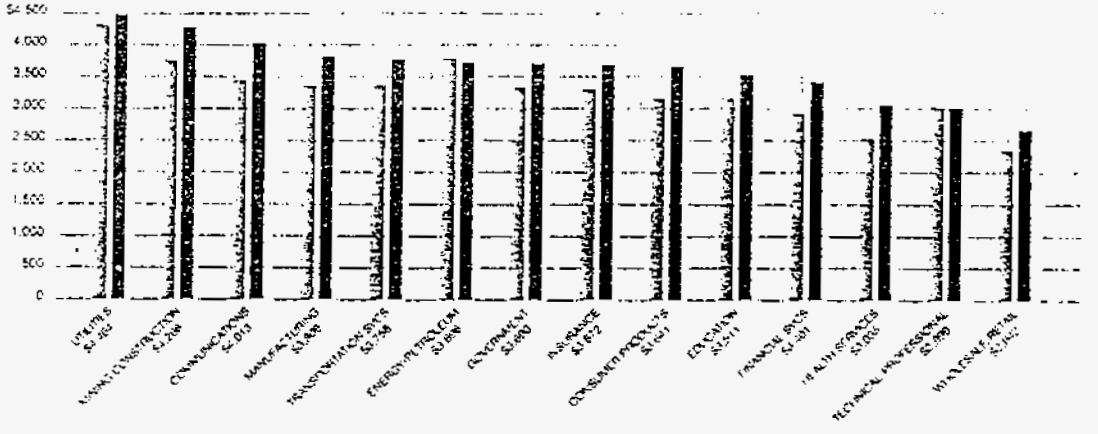
1990 1991

Average 1991 per employee cost is given under bars

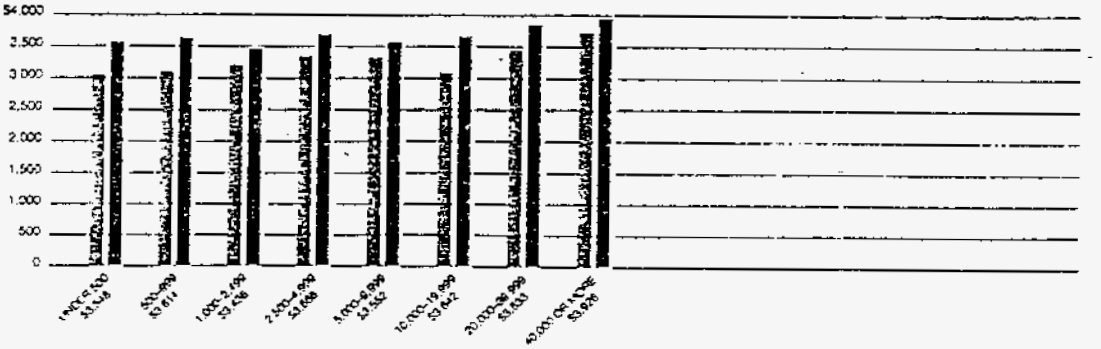
REGION



INDUSTRY



EMPLOYER SIZE (NUMBER OF EMPLOYEES)



Costs vary by funding method, region, industry

Self-funded employers experienced a slightly lower trend (12.3 percent) than insured employers (13.6 percent) in 1991. Per employee cost among self-insured plans now averages $3,469, compared to $3,736 among insured plans.

The regions hardest hit in 1991 were the South Atlantic and New England states, where average per employee medical plan cost rose 19.6 percent and 18.4 percent, respectively. However, in the Pacific region, average medical plan cost rose only 6.1 percent per employee; in the North Central region, cost rose only 9.7 percent.

The industry group with the highest rate of increase was Health Services, which experienced an average 21.1 percent rise in cost per employee. Respondents in Communications and Financial Services also reported higher-than-average increases during this period (17.6 percent and 17.2 percent, respectively).

Average medical plan cost per employee is highest in the New England ($3,958), Mid-Atlantic ($3,942) and South Atlantic ($3,495) regions, and lowest in the South Central ($3,236) and Mountain ($3,218) regions.

Utilities employers experienced the highest average cost per employee ($4,464), followed by Mining/Construction ($4,268), Communications ($4,013) and Manufacturing ($3,809). Employers with at least half of their employees in unions reported an average per employee cost of $4,255 in 1991, compared to $3,770 for employers with less than half their employees in unions. Average per employee cost drops to $3,328 among employers with no employees in unions.

Contributions

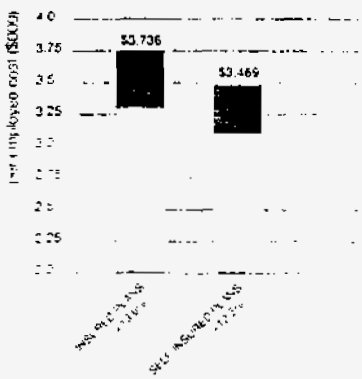
Employee contributions kept pace with medical plan cost inflation in 1991. For those respondents requiring employee contributions for employee-only coverage—55 percent of all 1991 respondents—the average contribution rose 13 percent, from $31 per month to $35 per month. Over three-fourths (76 percent) of respondents require contributions for family coverage. Here, the average contribution rose 17 percent, from $86 to $101 per month. The employee contribution for

Factors affecting plan costs

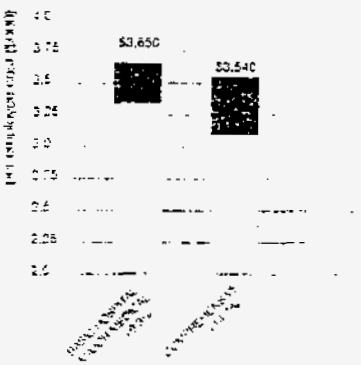
AVERAGE 1991 PER EMPLOYEE MEDICAL PLAN COST

1990 1991

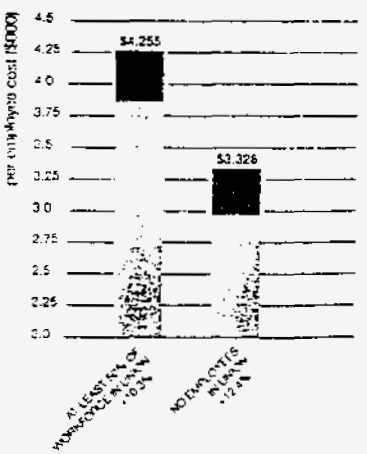
FUNDING



PLAN TYPE



UNION PRESENCE

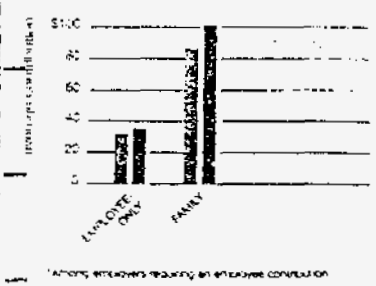


Percent increase over 1990 cost given under bars

Employee contributions keep pace with inflation

AVERAGE MONTHLY DOLLAR CONTRIBUTION REQUIRED*

1990 1991



*Among employers requiring an employee contribution

Employees' share of the premium

EMPLOYEE CONTRIBUTION AS A PERCENT OF TOTAL PREMIUM*

EMPLOYEE EMPLOYER

EMPLOYEE-ONLY

80%

FAMILY

72%

*AMONG EMPLOYERS REQUIRING AN EMPLOYEE CONTRIBUTION

employee-only coverage now represents 20 percent of the total premium; for family coverage, 28 percent of the total premium.

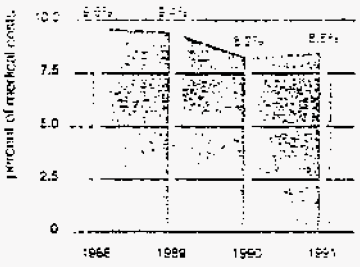
MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS

The cost of mental health/substance abuse benefits as a percent of total medical plan costs rose from 8.2 to 8.5 percent in 1991. Mental health spending was highest in the Mid-Atlantic and New England regions (9.9 and 9.6 percent of total medical cost, respectively). Costs were also higher among larger employers. For respondents with 1,000 or more employees, mental health cost averaged 8.9 percent of medical cost, compared to 7.6 percent among smaller employers.

The increase in mental health costs in 1991 is especially troubling given that so many employers have attempted to restrain cost growth in the past several years by putting special limits on mental/substance benefits. Eighty-seven percent of employers now limit inpatient benefits in one or more of the following ways: maximum dollar amount per year or lifetime, maximum number of days per year or lifetime, and/or higher coinsurance. Almost all employers (91 percent) limit outpatient mental/substance benefits: maximum dollar amount per year or lifetime, higher coinsurance, maximum number of visits per year, and/or maximum dollar amount per visit.

Mental health cost rising again

MENTAL HEALTH SUBSTANCE ABUSE COST AS A PERCENT OF TOTAL MEDICAL COST



These cost-shifting measures did help to slow cost growth—for the short-term. In 1988, mental health benefits accounted for 9.6 percent of total medical costs. This figure dropped to 9.4 percent in 1989 and to 8.2 percent in 1990 as employers tightened coverage limitations. In 1991, however, the trend reversed.

The number of employers screening employees for substance abuse continues to rise. More than a third (37 percent) now include screening in a pre-employment physical (up from 32 percent in 1990); 16 percent screen employees in selected job categories (up from 11 percent); and six percent screen all employees (unchanged from 1990).

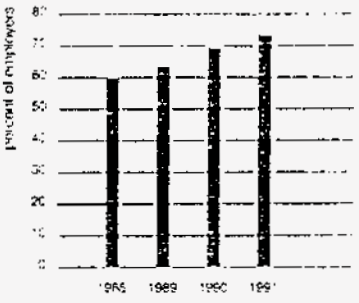
The move from basic hospitalization/major medical plans to comprehensive major medical plans continued in 1991. Seventy-three percent of survey respondents now offer a comprehensive major medical plan, up from 69 percent in 1990. In 1986, only 59 percent of respondents offered comprehensive plans.

Survey participants using Blue Cross/Blue Shield organizations to administer their medical indemnity plans offer comprehensive plans less frequently (56 percent) than those using commercial insurance carriers (80 percent) or TPAs (76 percent), or those who self-administer (77 percent).

As in past years, employers with at least half of their employees in unions are significantly less likely to offer comprehensive plans (55 percent) than employers with fewer than half of their employees in unions (77 percent) or employers with no unionized employees (76 percent).

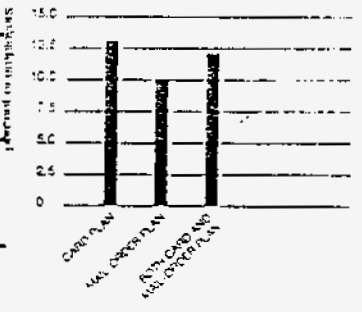
Continued move to comprehensive plans

EMPLOYERS WITH COMPREHENSIVE PLAN



More employers carve out prescription drug benefits

EMPLOYERS OFFERING SEPARATE DRUG PLAN



Scope of coverage

There was little change in the types of coverage offered in 1991. Eighty-six percent of this year's participants offer dental coverage, in most cases (68 percent) as a freestanding option.

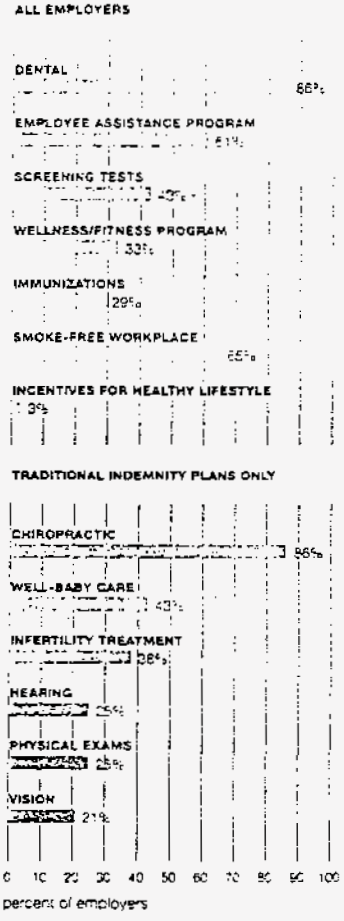
More employers are carving prescription drug coverage out of their medical plans and implementing card or mail-order plans. In 1991, 36 percent of the respondents offered a card or mail-order benefit, up from 27 percent in 1990.

Forty-three percent of all traditional indemnity plans provide well-baby care and immunizations. Although this coverage was recently mandated by a number of states, there is no difference in the incidence of coverage between insured plans, which are subject to state mandates, and self-insured plans, which are exempt.

Wellness and fitness programs grew in popularity in 1991. A third of all survey respondents provide either an on-site fitness facility or a financial subsidy for health club membership costs, up substantially from 1989 when only 17 percent offered these benefits. In addition, 43 percent of respondents now offer at least some diagnostic screening tests to employees, more than double the number providing this coverage last year (19 per-

Scope of benefits offered

EMPLOYERS OFFERING COVERAGE



cent). Employers offering Employee Assistance Programs also grew significantly in 1991, from 52 to 61 percent.

Nearly two-thirds of the 1991 survey participants report that they have instituted a smoke-free workplace policy.

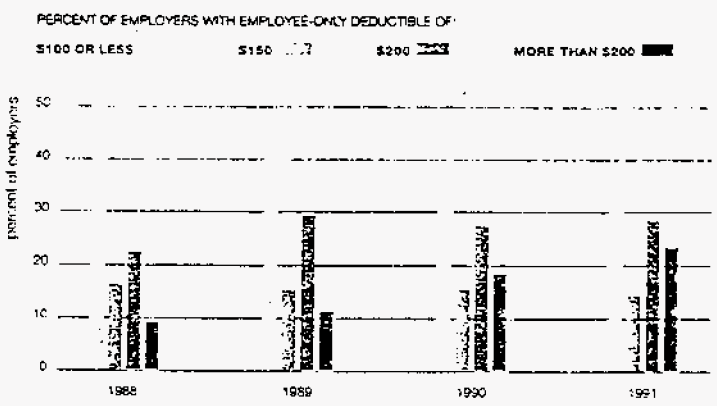
Cost sharing

Employee cost-sharing requirements—deductibles, copayments, and out-of-pocket maximums—got tougher in 1991, as employers reacted to the worsening economic slump and decline in corporate earnings. Increasing cost sharing is probably the quickest and easiest way for employers to reduce costs in a traditional medical plan. Of course, the drawback to this cost management approach is its immediate (and obvious) impact on employees and their families.

Deductibles In 1991, the median traditional medical plan deductible rose from $150 to $200. More than half of responding employers required deductibles of $200 or more in 1991, compared to only 25 percent of respondents to our 1986 survey. The median family deductible has now reached $400. In 54 percent of plans, the family deductible is $400 or more, and in 32 percent, $500 or more.

Most employers (93 percent) report that the medical plan deductible is the same for all employees. Employers show little inclination to move toward salary-based deductibles at this time. Only a small percentage—unchanged since 1989—base deductibles on salary, salary strata, or employee classification.

Majority of employers set deductible at $200 or more



For years, employers have borne the brunt of health care costs that rise at several times the rate of inflation. One cause: cost-shifting, primarily from government. Now, our health care survey shows, employers are stepping up their cost-shifting to employees. The average family contribution went up 17% last year, and the median individual deductible jumped from $150 to $200. At some companies the increases have been much more severe. One large financial services company boosted employee contributions by more than 50% in each of the past two years. An engineering and manufacturing company boosted employee contributions 10-fold—from $5 biweekly to $50—for family coverage in 1991. For employees at the low end of the pay spectrum, these increases can be overwhelming.

Employers shift costs to employees to save money, certainly, but also as a means to better cost management. Employees are more likely to take an active role in controlling health care costs if they have something at stake. Marshalling the active support of the health care consumer is a fundamental strategy in managing costs—whether you're changing indemnity plan design or introducing managed care.

Changing behavior to control cost

It's unrealistic to expect that employees will enthusiastically embrace cost shifting. More often, a communication objective is to minimize negative reaction. But silent acceptance is not enough. From the viewpoint of the employer—who still foots most of the bill—the best outcome is active support and behavior change that helps manage costs. Organizations need to mobilize employees—and family members—to be wiser health care consumers. Lacking that underlying behavior change, cost-shifting to employees is a temporary fix with significant risks to employee relations. Here are guidelines for winning employee support and commitment:

■ **Explain the problem** Surprisingly, more than half of employees we survey still grossly underestimate the cost and rate of increase of their health coverage. Without a clear understanding of the seriousness of the problem, its impact on the company, or its effect on them, employees aren't likely to accept the solution or play an active role in it.

■ **Demonstrate management's concern** Too often, the only message is the factual one: "The cost of our health plan is going up, and you're going to have to share in that increase." It fails to acknowledge the financial impact on employees and—more important—the emotional nature of the issue. When an employee's child is sick, cost be damned—the only focus is on getting the best care quickly.

■ **Create a "community of interest"** It's to the mutual advantage of the company and employees to manage health care costs. The common enemy is skyrocketing costs that do nothing to improve quality of care. What's more, whether or not employers shift costs directly by increasing employee contributions, there *is* ultimately a cost to employees. Money the company spends on health benefits can't be spent on pay increases, for instance.

■ **Share with employees the steps management has taken to address the problem** Otherwise, employees are likely to perceive that management is merely passing the problem on to them, or is incapable of dealing with the issues. They may not realize that the company is constantly looking at a range of alternatives to manage costs and maintain valuable benefits.

■ **Enlist the support of employees in finding solutions** The solution doesn't necessarily have to come from management. Some employers have surveyed employees or conducted focus groups to get their input. A few organizations, like Danbury Hospital in Connecticut, have gone so far as to form an employee task force to examine alternatives. While the outcome may be similar to what management would have come up with, the process helps employees understand the issues and "own" the solution. And an employee task force may come up with answers management might have dismissed as too extreme.

■ **Empower employees** Patients traditionally have taken a passive role in the health care system. Now it's to their advantage—and to their employers'—to become activists. That's dramatic behavior change in a society where doctors have controlled the system. Employees need to understand the dynamics of the health care system and where they fit in.

■ **Offer regular updates** If employees truly are to be partners in this battle against health care costs, they should know what's working and what isn't, and be given progress reports. Are their efforts having an impact on health care costs? How many employees are enrolled in an HMO? Is the push to make better use of home health services succeeding?

Finally, sustain the effort. If there's one thing all of us have learned over the past 10 years, it's that there is no quick fix. Hold down unit costs and utilization increases. Move employees to outpatient treatment centers, and the cost of that treatment suddenly jumps. A one-time blitz of education and communication isn't likely to have much impact, particularly as the health care environment changes. It may be months—even years—between the time an employee is given information about using health care services and the time the employee actually needs them. Americans have deeply ingrained attitudes and habits about health care, and their behavior won't change over night. On-going communication is essential if we're to have any real impact.

The runaway cost of providing coverage for mental health and substance abuse treatment in the mid-1980s prompted employers to furious cost-containment activity. Many redesigned their plans to impose special limits on the number of allowable inpatient days and to set caps on the dollar amount payable per year or per lifetime. The result was an immediate reduction in employer liability for mental health/substance abuse expense. The cost for these benefits as a percent of total medical plan costs dropped from 9.6 percent in 1988 to 8.2 percent in 1990—an impressive decline.

In 1991, however, the cost of mental health and substance abuse treatment as a percent of total medical plan costs began creeping upward. Is this new trend an anomaly, or an indication of things to come?

Clearly, egregious excesses in length-of-stay for mental health/substance abuse disorders have been checked by rigid benefit limitations. But this cost-management approach is not without pitfalls. It may be that plan participants in legitimate need of care are receiving treatment in a medical/surgical environment rather than the appropriate mental health/substance abuse facility—so that cost associated with their treatment is merely shifted from one line item to another. And, as we've had demonstrated time and again, providers are quick to adapt to plan sponsors' attempts at utilization and cost control. It's probably safe to assume that they've developed strategies to generate more revenue from the shorter stays caused by these benefit limitations.

The key to plan management: utilization analysis

If you've added or tightened mental health/substance abuse benefit limitations in the past few years, now is a good time to examine how employees are using these benefits—and how providers are delivering care. In utilization studies we've performed for our clients, we've seen the following patterns emerge:

- Average length-of-stay for inpatient care is falling, but admission rates are rising. In other words, a few large claims have become many smaller claims.
- Treatment plans more often involve the entire family, rather than just the individual patient, resulting in higher overall utilization.
- Hospital charges for mental health/substance abuse treatment are rising rapidly, so that savings from declining volume are being offset by higher unit charges. Average per diem charges for this type of care are approaching those for medical/surgical treatment.
- Readmission rates are rising. This may indicate that, in some cases, necessary care is being deferred or abbreviated by coverage limitations.

As the mental health care delivery environment changes, employers may need to reassess their approach to managing mental health benefit cost. As we discovered in the eighties—when these costs grew at two or three times the rate of overall medical plan costs—the usage and delivery patterns associated with mental health and substance abuse treatment are very different from those associated with medical/surgical treatment. While imposing additional limitations on mental health coverage has been a successful "quick fix," the impact on access to care—and the efficacy of care—is not yet clear.

New options in managed care

Even employers committed to a traditional indemnity plan for covering medical services would do well to look at their mental health/substance abuse benefits as a separate plan and explore alternative cost management approaches.

In the past few years, the health care industry has introduced a number of effective managed care vehicles specifically for mental health/substance abuse treatment. Specialized utilization review programs focus on the management of individual cases, rather than on uniform limitations, and guide patients to the most suitable type of care. Preferred provider or exclusive provider arrangements direct employees to cost-effective providers, rather than reducing coverage for all.

In the long run, the managed care approach to containing mental health and substance abuse costs will serve both the employer and the employee better than the simpler strategy of limiting coverage. And the payoff can be measured in both dollars and employee productivity.

Effect of cost sharing on plan cost

	AVERAGE 1991 PER EMPLOYEE MEDICAL PLAN COST
Basic hospitalization/major medical plans	$3,650
Comprehensive plans	3,540
No hospital coinsurance required	3,938
20% coinsurance required	3,424
Family out-of-pocket maximum under $3,000	3,558
Out-of-pocket maximum $3,000 or more	3,411

The number of employers requiring separate deductibles for hospitalization remained stable at 13 percent in 1991. However, this figure has declined slightly since 1986, when 16 percent of survey respondents required a separate hospital deductible. This likely reflects the move away from basic hospitalization/major medical plans and toward comprehensive plans.

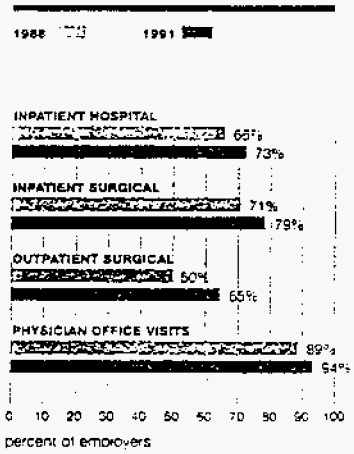
Coinsurance Traditional medical plans require employee coinsurance (or copayments) for most categories of medical service. Nearly three-fourths (73 percent) of employers require employee coinsurance for inpatient hospital expenses. In most cases (86 percent), the coinsurance level is set at 20 percent of eligible expenses.

Seventy-nine percent of survey participants require employee coinsurance for inpatient surgical care. In most cases, again, the coinsurance amount required is 20 percent of eligible charges.

In the mid-1980s, many employers instituted full coverage for outpatient surgical expense, hoping to cut down on costly hospital stays by encouraging employees to seek treatment in less expensive outpatient settings. Now, many procedures are routinely performed in outpatient settings. Unfortunately, outpatient costs have risen without attendant savings in total inpatient costs, and today fewer employers are willing to waive the coinsurance requirement for outpatient surgery. The percentage of survey participants requiring no coinsurance for these services has dropped substantially in the past few years, from 50 percent in 1988 to 35 percent in 1991.

Employee coinsurance required for most expenses

EMPLOYERS REQUIRING EMPLOYEE COINSURANCE 1988–1991*



Eighty-two percent of employers require a 20 percent copayment for physician office visits; 12 percent set lower coinsurance levels or require none. Fixed-dollar copayments for physician services are seen in only four percent of the traditional indemnity plans surveyed.

Out-of-pocket maximums Most employers (93 percent) cap employee out-of-pocket liability in the medical plan. In most of these plans (92 percent), the cap is a flat dollar amount per individual family member. Eight percent of plans base the cap on salary or employee classification.

The median out-of-pocket maximum for an individual is $1,050, up from $1,000 in 1990. Seventy-one percent of individual out-of-pocket maximums are set at $1,000 or more; 32 percent are set at $1,500 or more.

The median family out-of-pocket maximum is $2,100, up from $2,000 in 1990. Over three-fourths (79 percent) of respondents set the family maximum at $1,500 or more; 43 percent set it at $2,500 or more.

Employee out-of-pocket maximums rise

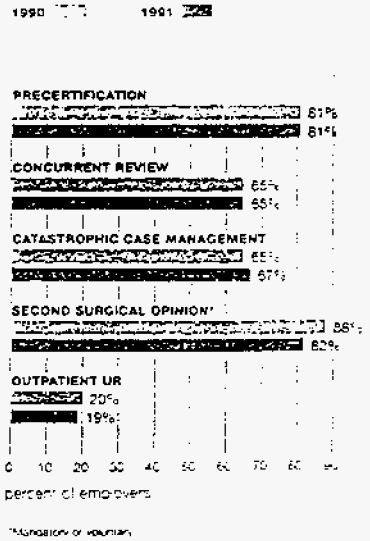
Utilization review

Nearly all employers (92 percent) use some form of utilization review in conjunction with their medical plans. The most common UR program, precertification, is found in 81 percent of plans, followed by case management (67 percent), concurrent review (65 percent), mandatory second surgical opinion (49 percent), voluntary second surgical opinion (33 percent), and outpatient UR (19 percent). These figures are essentially unchanged from 1990, ending the steady growth in UR programs recorded since 1986.

In addition, this year fewer employers believe they are seeing a savings from their UR programs. Only 21 percent say their UR programs helped decrease medical plan costs (compared to 24 percent last year). Nine percent say UR had no effect on costs, and most (70 percent) say they don't know.

Hospital admission rates and length of stay for specific illnesses have fallen since UR programs were first instituted in the early eighties. Perhaps because utilization review has been effective in changing provider behavior on the whole, individual employers no longer see dramatic savings from implementing UR. Respondents estimate that UR programs reduced their costs by four percent. This is also down from 1989, when respondents reported savings of five percent.

Growth in utilization review levels off



*Mandatory or voluntary

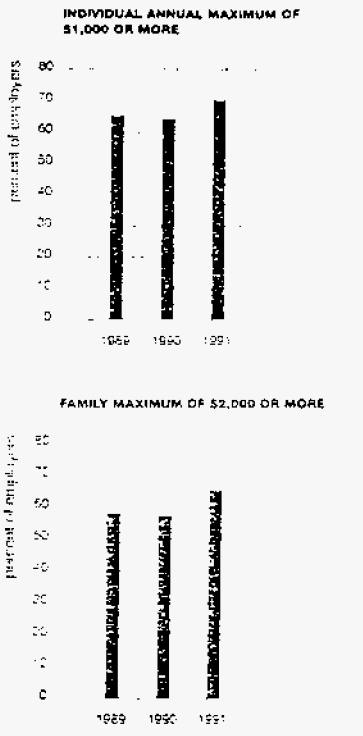
Eighty-two percent of employers require a 20 percent copayment for physician office visits; 12 percent set lower coinsurance levels or require none. Fixed-dollar copayments for physician services are seen in only four percent of the traditional indemnity plans surveyed.

Out-of-pocket maximums Most employers (93 percent) cap employee out-of-pocket liability in the medical plan. In most of these plans (92 percent), the cap is a flat dollar amount per individual family member. Eight percent of plans base the cap on salary or employee classification.

The median out-of-pocket maximum for an individual is $1,050, up from $1,000 in 1990. Seventy-one percent of individual out-of-pocket maximums are set at $1,000 or more; 32 percent are set at $1,500 or more.

The median family out-of-pocket maximum is $2,100, up from $2,000 in 1990. Over three-fourths (79 percent) of respondents set the family maximum at $1,500 or more; 43 percent set it at $2,500 or more.

Employee out-of-pocket maximums rise



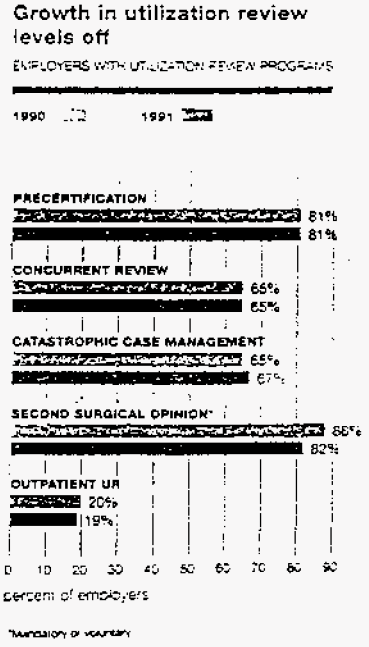
Utilization review

Nearly all employers (92 percent) use some form of utilization review in conjunction with their medical plans. The most common UR program, precertification, is found in 81 percent of plans, followed by case management (67 percent), concurrent review (65 percent), mandatory second surgical opinion (49 percent), voluntary second surgical opinion (33 percent), and outpatient UR (19 percent). These figures are essentially unchanged from 1990, ending the steady growth in UR programs recorded since 1986.

In addition, this year fewer employers believe they are seeing a savings from their UR programs. Only 21 percent say their UR programs helped decrease medical plan costs (compared to 24 percent last year). Nine percent say UR had no effect on costs, and most (70 percent) say they don't know.

Hospital admission rates and length of stay for specific illnesses have fallen since UR programs were first instituted in the early eighties. Perhaps because utilization review has been effective in changing provider behavior on the whole, individual employers no longer see dramatic savings from implementing UR. Respondents estimate that UR programs reduced their costs by four percent. This is also down from 1989, when respondents reported savings of five percent.

Growth in utilization review levels off



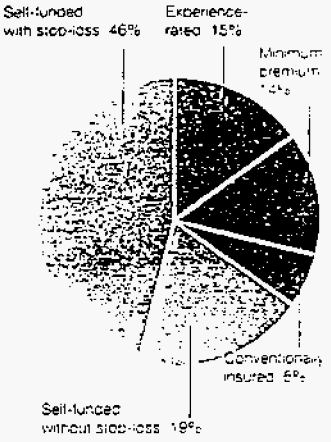
FUNDING

The number of employers self-insuring their medical plans rose from 59 percent in 1990 to 65 percent in 1991. This trend has been in evidence since 1986 (the first year the *Foster Higgins Health Care Benefits Survey* was conducted), when only 46 percent of the respondents self-insured their plans. Employers typically move to self-funding to reduce administrative expense and hold on to cash reserves, and to escape the increasingly complex (and expensive) state mandates for coverages. In a period of recession, these objectives become all the more pressing.

While large employers are still the most likely to self-fund, employers of all sizes moved to self-insurance in 1991. Among smaller employers (under 1,000 employees), self-funded plans grew from 44 percent in 1990 to 48 percent in 1991. The largest increase was seen among midsize employers (1,000 to 2,499 employees), where self-funding rose from 69 to 74 percent. Self-insurance is already the norm for large employers (5,000 or more employees); among this group, self-funded plans rose from 79 to 82 percent.

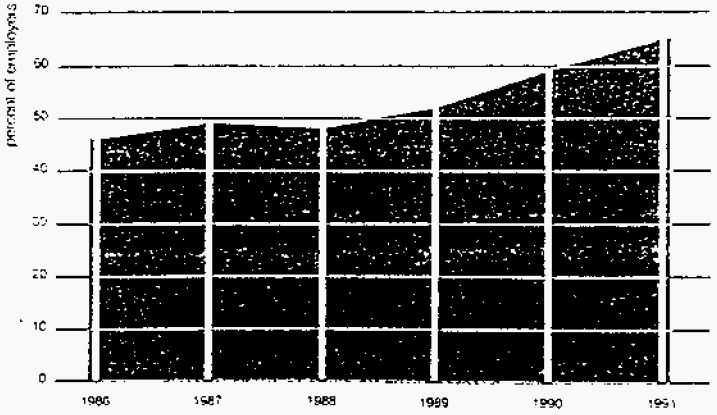
The trend toward self-funding is seen among plans with all types of administrative arrangements. Because most employers using independent third-party administrators are already self-funded (91 percent in 1990, 92 percent in 1991), most of the growth in self-funding occurred among employers using commercial insurance carriers (46 percent in 1990, 53 per-

Method of funding



Growth in self-insurance continues

EMPLOYERS WITH SELF-INSURED PLANS



cent in 1991). Slower growth in self-funding occurred among respondents using Blue Cross and Blue Shield to administer their plans (43 percent in 1990, 46 percent in 1991).

Stop-loss coverage

The number of self-funded employers purchasing stop-loss coverage (reinsurance) dropped slightly in 1991, from 73 percent in 1990 to 71 percent. The decrease occurred among small employers (fewer than 1,000 employees), the heaviest users of stop-loss. Still, 90 percent of small employers purchased some form of stop-loss insurance in 1991, compared to 78 percent of midsized employers (1,000 to 4,999 employees) and 35 percent of large employers (5,000 or more employees).

The decrease in stop-loss use occurred in aggregate, rather than specific, stop-loss coverage. Just under two-thirds of self-insured employers (65 percent) purchased aggregate stop-loss in 1991, down from 69 percent in 1990. At the same time, the aggregate stop-loss trigger point for the typical self-insured plan rose. In 1991, 81 percent of employers with aggregate stop-loss set the trigger point at or above 120 percent of expected claims, compared to only 75 percent in 1990.

By contrast, self-insured respondents buying specific stop-loss insurance rose from 81 percent in 1990 to 85 percent in 1991. This increase was uniform across employer size categories. The typical trigger point for this type of stop-loss coverage increased as well. In 1991, 62 percent of the respondents set trigger points at or above $100,000, compared to 53 percent in 1990.

ADMINISTRATION

Although growth in the use of third-party administrators slowed in 1991, TPAs still gained slightly against commercial insurance carriers in the market for claims administration services. Thirty-one percent of employers now use TPAs, up from 29 percent in 1990, while employers using commercial insurance carriers fell from 48 to 46 percent. (In 1990, the percent of employers using TPAs grew five percentage points.) Just under one-fourth of all respondents use Blue Cross/Blue Shield organizations, and six percent self-administer claims.

TPAs continue to lag behind in New England and the Mid-Atlantic states, where Blue Cross/Blue Shield is strong. Only 18 percent of employers in each of these two regions use TPAs for claims administration, while 35 percent use Blue Cross/Blue Shield.

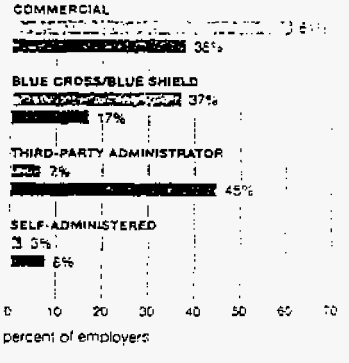
Choice of administrator is strongly influenced by funding method. Commercial carriers and Blue Cross/Blue Shield dominate the insured plans market (61 and 37 percent, respectively). Employers who self-fund have much greater flexibility in selecting administrators: 45 percent use TPAs, 38 percent use commercial carriers, and 17 percent use Blue Cross/Blue Shield.

Organizations with heavily unionized workforces (at least half of all employees) are more likely to use Blue Cross (38 percent) than non-union employers (22 percent). Government employers are more than twice as likely to use Blue Cross (46 percent) as private sector employers (22 percent).

Employers who use Blue Cross change administrators less frequently than others. Over half the respondents using Blue Cross say they have used the same administrator for 10 years or more, compared to only 14 percent of those using TPAs and 30 percent of those using commercial carriers. In fact, nearly a third of the respondents using Blue Cross have done so for 20 years or more.

The average length of time respondents have used their current administrator is eight years.

Type of administrator used, by funding method



Administrative expense

The cost of administration services as a percentage of paid claims averaged 7.0 percent in 1991. This represents an increase of more than one percentage point since 1989, when administrative expense averaged 5.8 percent of paid claims. Insured plans have absorbed most of this increase. Since 1989, average administrative expense for insured plans has risen from 6.9 to 9.3 percent of paid claims, while for self-insured plans it has risen only from 5.1 to 6.1 percent. It is likely that commercial carriers are passing on growing costs for utilization review services and data reports to clients with insured plans. Self-insured employers, on the other hand, can use more cost-effective independent UR vendors. This difference in administrative expense may be one reason employers continue to move toward self-insurance. It should also be noted, however, that self-insured plans tend to be larger and thus are more likely to receive volume discounts.

Administrative expense varies by the type of administrator used. Employers using commercial insurance carriers or Blue Cross/Blue Shield reported an average administrative expense of 7.9 percent of paid claims, while those using TPAs reported an average of only 5.4 percent. While some of the difference may be due to TPAs' greater efficiency, these results also reflect the fact that TPAs are used primarily by larger, self-insured employers.

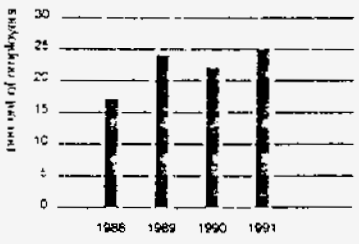
Claim audits and performance agreements

With benefit costs under close scrutiny, plan managers are taking steps to ensure that their administrators support cost management efforts. Over a third (37 percent) of all respondents—and more than half (57 percent) of respondents with 5,000 or more employees—audited claims paid by their administrators within the past two years.

A quarter of all respondents with 1,000 or more employees have negotiated performance standards (up from 22 percent in 1990). These agreements most often include standards for turnaround time (92 percent), administrative error rate (66 percent), financial error rate (64 percent), and percent of benefits paid in error (41 percent). The majority of negotiated

Continued growth in use of performance standards

EMPLOYERS WITH 1,000 OR MORE EMPLOYEES WHO HAVE NEGOTIATED STANDARDS WITH ADMINISTRATOR



agreements (64 percent) are enforced with either penalties for failure to perform up to standard or incentives to perform better than standard.

Satisfaction with administrator

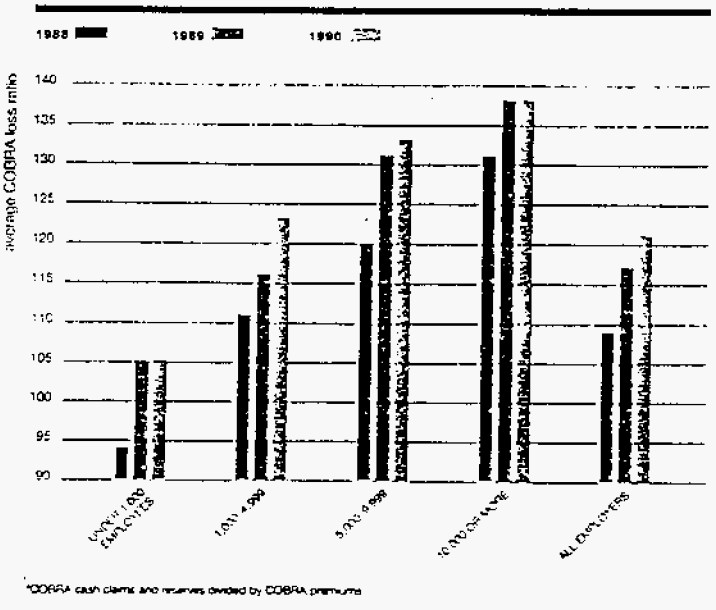
Most employers (84 percent) say their administrators met or exceeded expectations for overall quality of claims processing and timeliness. However, problems with data reporting persist. Nearly a third (32 percent) of employers say their administrator did not meet their expectations in this area. As employers place new emphasis on cost management, they are looking more closely at the financial and utilization data supplied by their administrators and, at least in some cases, discovering its limitations.

COBRA loss ratios

More than half of survey respondents still cannot track their COBRA experience. Among those that can, however, the average loss ratio (COBRA cash claims and reserve increases

COBRA loss ratios continue to rise

AVERAGE COBRA LOSS RATIOS,* BY EMPLOYER SIZE



*COBRA cash claims and reserves divided by COBRA premiums

divided by COBRA premiums) is rising. In 1990, respondents reported an average loss ratio of 117 percent; in 1991, the average reported loss ratio was 121 percent. For 39 percent of employers, the loss ratio is 150 percent or higher.

Coordination of benefits

Exactly half of all respondents use a non-duplication (or "carve-out") approach to COB; 46 percent use full COB. Under full COB, participants can receive up to 100 percent of eligible expenses from a combination of primary and secondary plans; a drawback of this approach is that it can negate employee cost-sharing provisions intended to control utilization. Full COB is most common in the Transportation (67 percent), Utilities (61 percent), and Insurance (59 percent) industries.

Savings attributed to the COB provision have dropped slightly since 1989, from 5.1 percent of paid claims to 4.5 percent.

Docket No. 911188-WS
V. Montanaro Exhibit No ___
Attachment 6
Late Filed Deposition Response
Hewitt and Associates

FLORIDA POWER CORPORATION
RESPONSE TO STAFF'S DEPOSITION
LATE FILED EXHIBIT
DOCKET NO. 910890-EI
DLF # 1
PAGE 1 OF 3
WITNESS: SCOTT C. TWERY
PREPARER: SCOTT C. TWERY

DLF #1: Nonregulated Assumptions

This exhibit shows the health care cost trend rate and the discount rate selected by nonregulated clients of Scott C. Twery for their FAS 106 valuations which have been done or which will be done for Fiscal 1992. Note that the discount rates selected for prior years correspond to the then current reference rates; under FAS 106, these are not necessarily relevant in selecting current and future discount rates. Unless otherwise stated, assumptions are for calendar years and based on January 1 measurement dates.

Fiscal Year	Discount Rate	Health Care Cost Trend Rate
Company A (Assumptions used for valuations of three different plans each year; nine valuations in total.)		
• 1990	9.50%	Initially 15%, then dropping 1% per year to 7%, then dropping to 6% after 2009*.
• 1991	9.50%	Initially 14%, then dropping 1% per year to 7%, then dropping to 6% after 2009*.
• 1992	9.00%	Pre-65: Initially 14%, dropping 1% per year to 7%. Post-65: Initially 12%, dropping 1% per year to 6%.
Company B		
• 1991	8.25%	Pre-65: Initially 17.5%, dropping 1% per year to 7.5%. Post-65: Initially 13.5%, dropping 1% per year to 6.5%.
• 1992	8.25%	Pre-65: Initially 16.5%, dropping 1% per year to 7.5%. Post-65: Initially 12.5%, dropping 1% per year to 6.5%.

*Client rejected separate pre/post-65 assumptions for sake of simplicity.

FLORIDA POWER CORPORATION
RESPONSE TO STAFF'S DEPOSITION
LATE FILED EXHIBIT
DOCKET NO. 910890-EI
DLF # 1
PAGE 2 OF 3
WITNESS: SCOTT C. TWERY
PREPARER: SCOTT C. TWERY

Fiscal Year	Discount Rate	Health Care Cost Trend Rate
Company C		
• 1990 (FY starting 10/01/90)	8.00%	Initially 15%, grading to 7% until 2011, then dropping to 6%*.
• 1991 (FY starting 10/01/91)	8.00%	Initially 14%, grading to 7% until 2011, then dropping to 6%*.
Company D (preliminary)		
• 1992	8.50%	Pre-65: Initially 18%, dropping 1% per year to 7%. Post-65: Initially 13%, dropping 1% per year to 6%.
Company E (covers many plans with common assumptions)		
• 1990 (FY starting 10/01/90)	8.50%	Initially 15%, grading to 7% until 2011, then dropping to 6%*.
• 1991 (FY starting 10/01/91)	8.50%	Initially 14%, grading to 7% until 2011, then dropping to 6%*.

*Client rejected separate pre/post-65 assumptions for sake of simplicity.

Fiscal Year	Discount Rate	Health Care Cost Trend Rate
Company F		
• 1991	8.50%	Current Retirees Pre-65: Initially 19%, grading to 6% for all years after 2010. Post-65: Initially 14%, grading to 6% for all years after 2005. Future Retirees* Pre-65: Initially 18.22%, grading to 7.08% for all years after 2009. Post-65: Initially 16.72%, grading to 6.16% for all years after 2006.
Company G (preliminary valuation)		
• 1991	8.50%	Pre-65: Initially 16%, then dropping 1% per year to 7%. Post-65: No coverage.

*"Average" rates given; separate retiree/spouse assumptions used.

FLORIDA POWER CORPORATION
RESPONSE TO STAFF'S DEPOSITION
LATE FILED EXHIBIT
DOCKET NO. 910890-EI
DLF # 6
PAGE 1 OF 1
WITNESS: SCOTT C. TWERY
PREPARER: SCOTT C. TWERY

DLF #6: Copy of September 1991 Informal Survey Without Company Affiliation

The attached is a listing of the 37 "large" companies' assumptions (preliminary and final) for FAS 106 calculations done before October 1991. The survey was conducted in September 1991 and results reported in October 1991. The assumptions may not all be for the same fiscal years.

FAS 106

ASSUMPTIONS SURVEY FOR LARGE COMPANIES

Company	Discount Rate	Health Trend Rate		Years to Ultimate Rate
		Pre-65	Post-65	
1	9.00%	13.00% - 7.00%	9.00% - 6.00%	10
2	9.50%	18.00% - 9.00%	13.00% - 6.00%	5
3	9.00%	12.00% - 5.00%	12.00% - 5.00%	10
4	9.00%	15.00% - 8.00%	15.00% - 8.00%	15
5	9.00%	11.00% - 6.00%	11.00% - 6.00%	8
6	8.50%	7.50% - 7.50%	7.50% - 7.50%	N/A
7	8.50%	20.00% - 7.50%	20.00% - 7.50%	15
8	8.25%	20.00% - 8.00%	20.00% - 8.00%	8
9	8.00%	20.00% - 8.00%	20.00% - 8.00%	7
10	8.00%	15.00% - 8.00%	15.00% - 8.00%	7
11	8.50%	15.00% - 8.00%	15.00% - 8.00%	7
12	9.00%	13.00% - 8.00%	13.00% - 8.00%	11
13	9.25%	13.00% - 8.25%	13.00% - 8.25%	11
14	9.25%	11.20% - 7.40%	11.20% - 7.40%	11
15	9.00%	15.00% - 7.00%	15.00% - 7.00%	10
16	9.00%	15.00% - 8.00%	15.00% - 8.00%	5
17	9.00%	18.00% - 8.00%	13.00% - 7.00%	7,6
18	9.00%	20.00% - 7.00%	13.00% - 6.00%	10
19	9.25%	7.00% - 7.00%	7.00% - 7.00%	N/A
20	8.75%	20.00% - 7.00%	15.00% - 6.00%	10
21	8.50%	19.00% - 8.00%	15.00% - 7.00%	10
22	9.00%	16.00% - 7.50%	12.00% - 6.50%	10
23	8.00%	20.00% - 8.00%	20.00% - 8.00%	10
24	8.00%	16.00% - 7.00%	16.00% - 7.00%	10
25	8.50%	13.00% - 6.50%	13.00% - 6.50%	18
26	9.00%	12.00% - 12.00%	12.00% - 12.00%	N/A
27	8.50%	10.00% - 10.00%	10.00% - 10.00%	N/A
28	8.50%	17.00% - 7.00%	14.00% - 6.00%	10
29	9.00%	18.00% - 6.00%	15.00% - 6.00%	12
30	8.75%	15.00% - 9.00%	15.00% - 9.00%	11
31	8.50%	17.00% - 7.00%	12.00% - 7.00%	11
32	9.00%	15.00% - 6.00%	12.00% - 6.00%	9,6
33	8.25%	7.50% - 7.50%	7.50% - 7.50%	N/A
34	8.50%	15.00% - 8.50%	15.00% - 8.50%	13
35	9.25%	16.00% - 7.50%	16.00% - 7.50%	9
36	7.25%	15.00% - 7.25%	15.00% - 7.25%	8
37	8.75%	18.00% - 8.75%	18.00% - 8.75%	10

Docket No. 911188-WS
V. Montanaro Exhibit No ___
Attachment 7
TPF&C Survey of Discount Rates

Attachment for:
mo No: 3629
Date: 2/25/92
File No: 3-33,700;
3-33,400

MEDBase '91
Summary of FAS 106 Results

I. Ultimate Discount Rates

DISCOUNT RATE	NO. OF COMPANIES
5.0% or less	0
5.1% to 5.5%	0
5.6% to 6.0%	2
6.1% to 6.5%	1
6.6% to 7.0%	0
7.1% to 7.5%	4
7.6% to 8.0%	39
8.1% to 8.5%	45
8.6% to 9.0%	41
9.1% to 9.5%	9
9.6% to 10.0%	3
over 10.0%	0
TOTAL:	144
Mean	8.49%
Median	8.50%

II. Initial Gross Trend Rate

TREND RATE	PRE-65	POST-65	AVERAGE
6.0% or less	1	6	1
6.1% to 7.0%	6	8	6
7.1% to 8.0%	9	12	11
8.1% to 9.0%	6	8	7
9.1% to 10.0%	4	8	3
10.1% to 11.0%	6	9	11
11.1% to 12.0%	8	13	9
12.1% to 13.0%	5	8	11
13.1% to 14.0%	7	9	11
14.1% to 15.0%	34	21	26
15.1% to 16.0%	12	11	11
16.1% to 17.0%	8	5	7
17.1% to 18.0%	23	15	19
18.1% to 19.0%	2	1	1
19.1% to 20.0%	10	8	7
over 20.0%	2	1	2
TOTAL:	143	142	141
Mean	14.63%	12.96%	13.79%
Median	15.00%	13.00%	14.25%

MEDBase '91
Summary of FAS 106 Results

III. Ultimate Gross Trend Rate

TREND RATE	PRE-65	POST-65	AVERAGE
5.0% or less	7	7	7
5.1% to 5.5%	11	13	11
5.6% to 6.0%	36	34	36
6.1% to 6.5%	17	17	17
6.6% to 7.0%	39	39	38
7.1% to 7.5%	10	11	12
7.6% to 8.0%	15	14	14
8.1% to 8.5%	2	2	2
8.6% to 9.0%	6	6	6
9.1% to 9.5%	0	0	0
9.6% to 10.0%	0	0	0
over 10.0%	0	0	0
TOTAL:	143	143	143
Mean	6.70%	6.69%	6.70%
Median	7.00%	7.00%	7.00%

IV. Discount Rate minus Ultimate Gross Trend Rate

DIFFERENCE	PRE-65	POST-65	AVERAGE
less than -1.0%	2	2	2
-.9% to -.5%	3	3	3
-.4% to -.1%	0	0	0
0.0%	8	8	8
.1% to .5%	3	3	3
.51% to 1.0%	26	25	25
1.1% to 1.5%	21	22	22
1.6% to 2.0%	35	35	35
2.1% to 2.5%	17	16	16
2.6% to 3.0%	13	13	14
3.1% to 3.5%	8	9	8
3.9% to 4.0%	1	1	1
4.1% to 4.5%	2	2	2
4.6% to 5.0%	1	1	1
over 5.0%	0	0	0
TOTAL:	140	140	140
Mean	1.78%	1.78%	1.79%
Median	2.00%	2.00%	2.00%

MEDBase '91
Summary of FAS 106 Results

V. Ultimate Gross Trend minus Ultimate Medicare Trend

DIFFERENCE	NUMBER OF COMPANIES
less than -1.0%	0
-.9% to -.5%	0
-.4% to -.1%	5
0.0%	131
.1% to .25%	4
.26% to .5%	3
.6% to .75%	0
.76% to 1.0%	0
Over 1.0%	0
TOTAL:	143
Mean	0.01%
Median	0.00%

MEDBase '91
Summary of FAS 106 Results

VI. FAS 106 Basis Results

A. By company size

1. APBO

COMPANY SIZE	AVERAGE APBO ('000)	AVERAGE APBO/ACT	AVERAGE APBO/(ACT+RET)
under 1,000	$ 12,311	$ 26,096	$ 14,207
1,000 to 1,999	17,844	12,901	9,247
2,000 to 4,999	65,595	19,892	14,367
5,000 to 9,999	140,845	20,848	14,139
10,000 to 14,999	484,088	40,951	22,185
15,000 to 19,999	397,621	22,322	16,669
20,000 and over	702,479	15,283	11,116
All Companies	192,154	18,282	12,948

2. FAS 106 Expense

COMPANY SIZE	AVERAGE EXPENSE ('000)	AVERAGE EXP/ACT	AVERAGE EXP/(ACT+RET)
under 1,000	$ 1,966	$ 4,168	$ 2,269
1,000 to 1,999	2,831	2,046	1,466
2,000 to 4,999	13,262	4,021	2,904
5,000 to 9,999	46,125	6,827	4,630
10,000 to 14,999	78,188	6,614	3,583
15,000 to 19,999	72,812	4,087	3,052
20,000 and over	132,816	2,889	2,101
All Companies	37,010	3,521	2,493

3. Pay-as-you-go expense

COMPANY SIZE	AVERAGE PAYGO ('000)	AVERAGE PAYGO/ACT	AVERAGE PAYGO/(ACT+RET)
under 1,000	$ 718	$ 1,522	$ 828
1,000 to 1,999	661	478	342
2,000 to 4,999	4,340	1,316	950
5,000 to 9,999	5,937	878	596
10,000 to 14,999	27,918	2,361	1,279
15,000 to 19,999	12,451	699	522
20,000 and over	34,502	750	546
All Companies	9,607	914	647

MEDBase '91
Summary of FAS 106 Results

VI. FAS 106 Basis Results

B. By percentile

1. APBO

PERCENTILE	APBO ('000)	APBO/ACT	APBO/(ACT+RET)
10%	$ 3,355	$ 2,620	$ 2,273
25%	10,067	6,085	4,912
50%	37,570	13,126	10,164
75%	159,637	24,674	16,626
90%	689,429	36,734	24,651

2. FAS 106 Expense

PERCENTILE	EXPENSE ('000)	EXP/ACT	EXP/(ACT+RET)
10%	$ 630	$ 428	$ 381
25%	1,878	1,088	832
50%	7,400	2,360	1,744
75%	30,800	4,438	3,026
90%	122,941	9,230	5,459

3. Pay-as-you-go expense

PERCENTILE	PAYGO ('000)	PAYGO/ACT	PAYGO/(ACT+RET)
10%	$ 102	$ 87	$ 76
25%	316	183	174
50%	1,756	475	356
75%	6,800	1,128	682
90%	26,600	2,062	1,265

MEDBase '91
Summary of FAS 106 Results

VII. Participating Company Size

PERCENTILE	ACTIVES	RETIREES	ACT+RET
10%	475	78	702
25%	1,208	212	1,670
50%	3,198	852	4,139
75%	10,975	3,155	12,795
90%	27,477	11,839	51,007
Mean	10,377	4,201	14,579

MEDBase '91
Comparison with MEDBase '90

I. Discount Rates

DISCOUNT RATE	MEDBase '91	MEDBase '90
5.0% or less	0	0
5.1% to 6.0%	2	2
6.1% to 7.0%	1	1
7.1% to 8.0%	43	53
8.1% to 9.0%	86	112
9.1% to 10.0%	12	18
over 10.0%	0	0
TOTAL:	144	186
Mean	8.49%	8.70%
Median	8.50%	9.00%

II. Initial Gross Trend Rate (Average)

TREND RATE	MEDBase '91	MEDBase '90
6.0% or less	1	1
6.1% to 7.0%	6	6
7.1% to 8.0%	11	38
8.1% to 9.0%	7	26
9.1% to 10.0%	3	7
10.1% to 11.0%	11	4
11.1% to 12.0%	9	6
12.1% to 13.0%	11	6
13.1% to 14.0%	11	6
14.1% to 15.0%	26	29
15.1% to 16.0%	11	14
16.1% to 17.0%	7	5
17.1% to 18.0%	19	16
18.1% to 19.0%	1	1
19.1% to 20.0%	7	18
over 20.0%	2	2
TOTAL:	141	185
Mean	13.79%	12.92%
Median	14.25%	13.00%

MEDBase '91
Comparison with MEDBase '90

III. Ultimate Gross Trend Rate (Average)

TREND RATE	MEDBase '91	MEDBase '90
5.0% or less	7	5
5.1% to 6.0%	47	11
6.1% to 7.0%	55	29
7.1% to 8.0%	26	60
8.1% to 9.0%	8	56
9.1% to 10.0%	0	22
over 10.0%	0	3
TOTAL:	143	187
Mean	6.70%	7.68%
Median	7.00%	8.00%

IV. Discount Rate minus Ultimate Gross Trend Rate (average)

DIFFERENCE	MEDBase '91	MEDBase '90
less than -1.0%	2	3
-.9% to 0.0%	11	28
.1% to 1.0%	28	63
1.1% to 2.0%	57	56
2.1% to 3.0%	30	26
3.1% to 4.0%	9	7
4.1% to 5.0%	3	2
5.1% to 6.0%	0	1
over 6.0%	0	0
TOTAL:	140	186
Mean	1.79%	1.02%
Median	2.00%	1.00%

MEDBase '91
Comparison with MEDBase '90

V. Ultimate Gross Trend minus Ultimate Medicare Trend

DIFFERENCE	MEDBase '91	MEDBase '90
less than -1.0%	0	0
-.9% to -.5%	0	0
-.4% to -.1%	5	2
0.0%	131	154
.1% to .25%	4	3
.26% to .5%	3	13
.6% to .75%	0	0
.76% to 1.0%	0	2
Over 1.0%	0	1
TOTAL:	143	175
Mean	0.01%	0.01%
Median	0.00%	0.00%

MEDBase '91
Comparison of FAS 106 Results

VI. FAS 106 Basis Results

A. By company size

1. APBO

PER ACTIVE	MEDBase '91	MEDBase '90
under 1,000	$ 26,096	$ 28,382
1,000 to 1,999	12,901	19,651
2,000 to 4,999	19,892	18,060
5,000 to 9,999	20,848	17,340
10,000 to 14,999	40,951	9,256
15,000 to 19,999	22,322	14,382
20,000 and over	15,283	23,783
All Companies	18,282	19,895

2. FAS 106 Expense

PER ACTIVE		
under 1,000	$ 4,168	$ 4,911
1,000 to 1,999	2,046	3,547
2,000 to 4,999	4,021	3,063
5,000 to 9,999	6,827	3,192
10,000 to 14,999	6,614	1,855
15,000 to 19,999	4,087	2,715
20,000 and over	2,889	4,286
All Companies	3,521	3,545

3. Pay-as-you-go expense

PER ACTIVE		
under 1,000	$ 1,522	$ 1,123
1,000 to 1,999	478	660
2,000 to 4,999	1,316	558
5,000 to 9,999	878	608
10,000 to 14,999	2,361	215
15,000 to 19,999	699	396
20,000 and over	750	849
All Companies	914	673

MEDBase '91
Comparison of FAS 106 Results

VI. FAS 106 Basis Results

B. By percentile

1. APBO

PERCENTILE	MEDBase '91	MEDBase '90
10%	$ 2,620	$ 3,556
25%	6,085	7,607
50%	13,126	13,513
75%	24,674	25,376
90%	36,734	42,729

2. FAS 106 Expense

PERCENTILE		
10%	$ 428	$ 803
25%	1,088	1,347
50%	2,360	2,543
75%	4,438	4,855
90%	9,230	7,705

3. Pay-as-you-go expense

PERCENTILE		
10%	$ 87	$ 34
25%	183	121
50%	475	359
75%	1,128	845
90%	2,062	1,380

MEDBase '91
Comparison with MEDBase '90

VII. Participating Company Size

A. Number of actives

PERCENTILE	MEDBase '91	MEDBase '90
10%	475	262
25%	1,208	847
50%	3,198	2,461
75%	10,975	6,295
90%	27,477	17,546
Mean	10,377	6,850

B. Number of Retirees

PERCENTILE	MEDBase '91	MEDBase '90
10%	78	0
25%	212	41
50%	852	366
75%	3,155	1,065
90%	11,839	3,437
Mean	4,201	2,005

C. Number of actives plus retirees

PERCENTILE	MEDBase '91	MEDBase '90
10%	702	347
25%	1,670	1,137
50%	4,139	3,015
75%	12,795	7,393
90%	51,007	22,416
Mean	14,579	8,856

Summary of FAS 106 Survey Results for Utilities

06/05/92

*Company Size**	APBO			FAS 106 EXPENSE			PAY-AS-YOU-GO EXPENSE		
	Average APBO ('000)	Average APBO/ACT	Average APBO/TOTAL	Average EXP ('000)	Average EXP/ACT	Average EXP/TOTAL	Average PAYGO ('000)	Average PAYGO/ACT	Average PAYGO/TOTAL
under 1,000	6,281	30,566	21,008	920	4,477	3,077	144	701	482
1,000 to 1,999	0	0	0	0	0	0	0	0	0
2,000 to 4,999	109,341	40,987	28,583	17,412	6,527	4,552	3,181	1,192	832
5,000 to 9,999	134,395	33,892	21,178	23,957	6,042	3,775	5,749	1,450	906
10,000 to 14,999	227,707	31,648	19,645	38,601	5,365	3,330	8,932	1,241	771
15,000 to 19,999	0	0	0	0	0	0	0	0	0
20,000 and over	647,900	29,266	19,479	104,200	4,707	3,133	12,900	583	388
All Companies	211,553	32,004	21,041	34,660	5,244	3,448	5,850	885	582

Percentile	APBO			FAS 106 EXPENSE			PAY-AS-YOU-GO EXPENSE		
	APBO ('000)	APBO/ACT	APBO/TOTAL	EXP ('000)	EXP/ACT	EXP/TOTAL	PAYGO ('000)	PAYGO/ACT	PAYGO/TOTAL
.10%	7,838	11,990	8,246	1,046	1,973	1,336	288	283	220
.25%	73,688	20,172	12,729	11,944	3,291	2,068	905	532	384
.50%	120,573	33,748	21,023	24,593	5,052	3,391	4,182	947	629
.75%	235,300	58,952	35,060	45,200	9,230	5,643	5,900	2,105	1,346
.90%	358,076	64,955	38,781	56,063	11,202	6,504	15,900	2,341	1,413

Percentile	Participating Company Size		
	Actives	Retires	Total
.10%	288	96	384
.25%	2,487	922	3,706
.50%	3,284	1,695	4,530
.75%	6,074	5,022	11,096
.90%	19,575	6,465	25,285
Mean	6,610	3,444	10,054

*Notes: TOTAL is equal to Actives and Retirees; Company Size based on TOTAL

MEDBase '91 Survey for Utilities

06/05/92

I. Ultimate Discount Rates

Discount Rate	Number of Companies
7.50%	1
8.00%	4
8.25%	3
8.50%	7
8.75%	2
9.00%	1
Total	18
Mean	8.35%
Median	8.50%

II. Initial Gross Trend Rate

Trend Rate	PRE-65	POST-65	Average
4.75%	0	2	0
7.25%	0	0	2
9.75%	2	0	0
10.00%	0	1	0
12.00%	4	4	4
12.50%	0	0	1
14.00%	1	0	0
14.50%	1	1	1
15.00%	2	1	1
16.00%	1	1	1
17.00%	0	0	1
18.00%	2	2	2
20.00%	1	2	1
Total	14	14	14
Mean	14.14%	13.50%	13.82%
Median	14.00%	12.00%	12.50%

III. Ultimate Gross Trend Rate

Trend Rate	PRE-65	POST-65	Average
5.25%	2	2	2
5.50%	2	2	2
6.00%	2	2	2
6.50%	1	1	1
7.00%	3	3	3
7.25%	1	1	1
7.50%	3	3	3
Total	14	14	14
Mean	6.48%	6.48%	6.48%
Median	6.50%	6.50%	6.50%

III. Discount Rate minus Ultimate Gross Trend Rate

Difference	PRE-65	POST-65
0.00%	1	1
0.50%	1	1
1.00%	4	4
1.50%	3	3
1.75%	1	1
2.00%	3	3
2.50%	2	2
2.75%	1	1
3.00%	2	2
Total	18	18
Mean	1.69%	1.69%
Median	1.50%	1.50%

Notes:	1 – Four plans reported a flat trend rate (three at 7.00% and one at 8.00%)
	2 – The Ultimate Gross Trend Rate was equal to the Medicare Trend Rate for each Company

FORTUNE TOP 50
UTILITIES
POST RETIREMENT WELFARE DISCLOSURE
1990 FISCAL YEAR
SURVEY HIGHLIGHTS

Sep-91

EXHIBIT

Company	1990 Post-Retirement Welfare Cost In ($000)	1989 Post-Retirement Welfare Cost In ($000)	Discussed FAS 106 Disclosure	FAS 106 Disclosure Estimate/Impact	Advance Funding	Comments
American Electric Power	$18,200	$14,800	Yes	Adverse impact if deny recovery from rates	Yes	$24 million VEBA contribution in 1990
American Information Tech.	$124,700	$105,100	Yes	No mat impact expected; depend on reg treatment	Yes	$115.5 Mill VEBA contribution in 1990
Arkla	$6,800	$4,900	Yes	Expect significant increase in expense		Expect to adopt FAS 106 in 1993
Baltimore Gas & Electric	$11,464		Yes	No material impact expected		Costs not provided by rates will be deferred
Bell Atlantic	$183,400	$231,000	Yes	Exp increase expense; depend on reg treatment		
Bellsouth			Yes		Yes	Expect to adopt in 1993; plan NTO amort
Carolina Power & Light	$2,700	$3,000	Yes	Exp increase expense; depend on reg treatment		Expect to adopt FAS 106 in 1993
Centerior Energy	$6,500	$5,000	Yes	No material adverse impact exp; dep on reg treat		
Central & South West			Yes	Expect increase in expense		Costs not provided by rates will be deferred
CMS Energy	$20,000	$17,000	Yes	Expect significant increase in expense		Plan NTO amort
Columbia Gas System	$10,200	$6,600	Yes	Expect significant increase in expense		Expect to adopt in 1993; plan NTO amort
Commonwealth Edison	$42,235	$42,362	Yes	APBO $419.7 mill, assets $183.7 mill @ 1/90	Yes	Accrual acctg adopted in 1980
Consolidated Edison of New York	$30,400	$24,700	Yes	Exp increase in expense to be recovered in rates		Costs exclude retiree life
Consolidated Natural Gas	$13,493	$11,219	No			
Detroit Edison	$19,066	$15,694	Yes	No material impact exp; depend on reg treatment		Expect to adopt in 1993; plan NTO amort
Dominion Resources	$6,800	$6,300	Yes	Est $340 mill NTO; exp expense to incr 6 times		Expect to adopt in 1993; plan NTO amort
Duke Power	$10,200	$6,800	Yes	Expect significant increase in expense		
Entergy			Yes	Expect significant increase in expense		Costs not provided for by rates will be deferre
Florida Progress			Yes	Exp increase in expense to be recovered by rates		$20.6 mill accrued @ 12/31/90
FPL Group			Yes	Exp increase expense; depend on reg treatment		
General Public Utilities	$10,700	$9,800	Yes	Exp increase in expense to be recovered in rates		
GTE	$82,000	$68,000	Yes	Exp increase in expense to be recovered in rates		
Gulf States Utilities	$4,722	$4,051	Yes	Est $20-40 mill expense		

FORTUNE TOP 50
UTILITIES
POST RETIREMENT WELFARE DISCLOSURE
1990 FISCAL YEAR
SURVEY HIGHLIGHTS

Sep-91

EXHIBIT

Company	1990 Post-Retirement Welfare Cost in ($000)	1989 Post-Retirement Welfare Cost in ($000)	Discussed FAS 106 Disclosure	FAS 106 Disclosure Estimate/Impact	Advance Funding	Comments
Houston Industries			Yes	Currently evaluating impact		
Illinois Power			Yes	No material impact exp; expect recovery in rates		Expect to adopt FAS 106 in 1992
Long Island Lighting	$29,410	$27,155	Yes	Impact not determined; expect recovery in rates		Expect to adopt FAS 106 in 1993
New York State Electric & Gas	$4,100	$3,200	Yes	No material impact exp; expect recovery in rates		
Niagara Mohawk Power	$14,900	$11,800	Yes	Est $300–400 mill NTO; imp dep on reg treatment		
Northeast Utilities	$11,133	$9,618	Yes	Expect recovery from rates		
Northern States Power	$7,189	$7,421	Yes	No material impact exp; depend on reg treatment		
Nynex			No			
Oglethorpe Power			No			
Ohio Edison	$7,265	$5,946	Yes	No material adverse effect if recovery in rates		Expect to adopt FAS 106 in 1993
Pacific Gas & Electric	$18,200	$17,600	Yes	No material impact exp due to exp reg treatment		Expect to adopt in 1993; plan NTO amort
Pacific Telesis Group			Yes	No material impact expected		Espect to adopt in 1993; plan NTO amort
Pacificorp	$9,000	$7,000	Yes	Expect significantly greater expense		Expect to adopt FAS 106 in 1993
Panhandle Eastern			Yes	Could result in substantial equity reduction	Yes	
Pennsylvania Power & Light	$7,200	$4,700	Yes	Could result in substantial cost increase		
Philadelphia Electric			No			
Pinnacle West Capital			Yes	No significant impact exp if recovey in rates		Expect to adopt FAS 106 in 1993
Potomac Electric Power	$2,900	$2,500	Yes	Exp increase in expense to be recovered in rates		
Public Service Enterprise Group			Yes	Main effect on stmt of finl pos; not on income stmt		
SCE Corp	$24,300	$21,200	Yes	Est $700 mill APBO @ 12/90		Expect to adopt in 1993; plan NTO amort
Southern	$32,000	$30,000	Yes	Expect increase in cost; depend on reg treatment	Yes	Expect to adopt FAS 106 in 1993
Southwestern Bell	$89,600	$73,200	Yes	Impact could be material; depend on reg treatment	Yes	
Tele-Communications						

FORTUNE TOP 50
UTILITIES
POST RETIREMENT WELFARE DISCLOSURE
1990 FISCAL YEAR
SURVEY HIGHLIGHTS

Sep-9

EXHIBIT

Company	1990 Post-Retirement Welfare Cost In ($000)	1989 Post-Retirement Welfare Cost In ($000)	Discussed FAS 106 Disclosure	FAS 106 Disclosure Estimate/Impact	Advance Funding	Comments
Texas Utilities	$13,152	$11,390	Yes	No material impact exp; depend on reg treatment		
Transco Energy			Yes	Impact unknown; expect recovery in rates		
Union Electric	$11,000	$9,000	Yes	No significant impact if recovery in rates		Expect to adopt FAS 106 in 1993
US West	$83,000		Yes	Expect additional costs to be recovered in rates	Yes	
AVERAGES	$28,468	$25,561				
COUNT OF COMPANIES INCLUDED IN AVERAGES	34	32				
COUNT OF CO. DISCUSSING FAS 106 DISCLOSURE			45			

NOTES: BLANKS INDICATE VALUE NOT STATED
RESULTS FOR 1 COMPANY IS NOT AVAILABLE
-Tele-Communications

Docket No. 911188-WS
V. Montanaro Exhibit No __
Attachment 8
GTE's August 7, 1989
Letter to the FASB

GTE Corporation

One Stamford Forum
Stamford, CT 06904
203 965-2000

Bruce E. Haddad
Vice President - Comptroller

August 7, 1989

Mr. Timothy S. Lucas
Director of Research and Technical Activities
File Reference No. 078
Financial Accounting Standards Board
401 Merritt 7, P.O. Box 5116
Norwalk, CT 06856-5116

Dear Mr. Lucas:

We appreciate the opportunity to respond to the Exposure Draft of the proposed Statement of Financial Accounting Standards, "Employers' Accounting for Postretirement Benefits Other Than Pensions."

GTE Corporation agrees with the Board's objective in addressing the financial accounting and reporting issues concerning the matter of employers' obligations for postretirement benefits to employees. We agree with the Board that the promise of an employer to provide benefits to an employee during his/her retirement period in exchange for services should be recognized as those services are provided.

It is generally acknowledged that the economic issues that will arise from this accounting change are so significant that the business community has some very real and deep concerns that extend far beyond applying technically correct accounting principles in this area. The adoption of this standard as proposed in the Exposure Draft would, in all probability, have a significant adverse effect on many companies.

Those enterprises operating under a favorable competitive environment would probably attempt to raise prices to help offset increased expenses resulting from the accounting change. This would very likely intensify inflationary pressure on our economy. In addition it would place many U.S. companies at a pricing disadvantage with foreign competitors. While many of these competitors have similar retirement obligations, they are generally funded on a pay-as-you-go basis through government sponsored plans or otherwise. This pricing disadvantage could result in the discontinuance or substantial curtailment of many company postretirement benefit plans, and result in increased pressure on Social Security and government funded healthcare plans.

Because of these potential impacts, we agree that the transition process requires a practical approach to mitigate the potential disruption to financial statements without compromising their usefulness. To better accomplish the Board's objectives and make implementation of the new standard more widely accepted, we believe that a greater degree of flexibility needs to be permitted, recognizing the unusual and significant impact the new standard will have on U.S. companies. Therefore, we believe that a number of changes should be made to the Exposure Draft before the Statement is finalized. Our recommendations are as follows:

1. Method of Adoption - Permit as an option the restatement of prior period results. However, companies that cannot withstand this reduction in shareholders' equity should be permitted to amortize the transition obligation to equity or, in the case of regulated companies, to income as such amounts are recovered through the ratemaking process, consistent with FAS No.71. This would ensure comparability of future earnings statements with companies electing restatement.

2. Attribution Period - The cost of these benefits should be allocated over the periods in which services are rendered, that is through the expected date of retirement rather than through the date of full eligibility.

3. Healthcare Inflation Rate - Use a more stable rate in lieu of a healthcare inflation rate, which has experienced unusually high growth rates. The use of a medical inflation rate or a general inflation rate, would assure more reliable estimates of future benefits.

4. Discount Rate - Permit the use of a discount rate that would reflect the cost of funds that are expected to be used to settle these obligations, such as an enterprise's cost of capital.

5. Disclosures - Eliminate the requirement to disclose the effect of a one-percentage-point change in the healthcare inflation rate, which would cast doubt on management's ability to reasonably estimate costs.

6. Implementation - Make the provisions of the standard effective three years after the issuance of a final Statement, with earlier adoption permitted, which would ensure adequate time to properly adopt the new accounting and iron out potential problems in debt covenants, etc.

7. FAS 96 impact - Adequately address the interaction of the proposed standard with FAS 96 by simplifying scheduling requirements and allowing for probability in determining the impact of the accounting for the tax effects of the related temporary differences.

A discussion of each of these proposals follows.

1. Method of Adoption

We agree with the Board that, "unlike the effects of most other accounting changes, a transition obligation for postretirement benefits generally reflects, to a considerable extent, the failure to accrue the obligation in the earlier periods in which it arose rather than the effects of a change from one accrual method of accounting to another." Therefore, we believe that the Exposure Draft should have permitted more flexibility in approaches, including restatement.

However, the Board dismissed the restatement method as an alternative and limited the accounting to the practical approach set forth in the Exposure Draft, recognizing that in doing so "a conceptually defensible (and preferable) alternative may be eliminated". While we agree that a practical approach is desirable, we disagree that this approach should be restricted to only one course of action to the exclusion of all others. Further, we do not agree with the practical approach suggested by the Exposure Draft.

We believe that regulated companies should be permitted to amortize this transition obligation in accordance with ratemaking practices. This flexibility also is needed by government contractors, where recovery of the transition obligation may be prescribed by government regulation. Other companies should be permitted to amortize the transition obligation over the remaining service lives of active plan participants to equity rather than to income. Such an approach would avoid distorting future years' earnings with costs which more properly should have been reflected in prior years, as well as increase the comparability of earnings with companies who choose to restate. In addition, we believe it would significantly increase the acceptability of this accounting change by U.S. industries. Accordingly, we believe the "amortization to equity" approach is the most practical solution to a most difficult problem for nonregulated companies.

Alternatively, another approach is to allow the "grandfathering" of the current accounting for existing employees and retirees. That is, the current pay-as-you-go accounting would be continued for all existing employees and retirees, while the new accounting would be applied for employees whose service begins after the implementation date of the new standard. Appropriate disclosure of the unrecorded obligation would, of course, be required. Although this approach is quite different from the FASB proposal, it is another practical approach which would mitigate many of the concerns associated with adoption of the new accounting.

2. Attribution Period

GTE believes that since postretirement benefits are given by the employer in exchange for services provided by the employee, they should be allocated over the periods in which services are rendered. This period would be from the date-of-hire through the employee's expected date of retirement (full-service-period), instead of through the full eligibility date as proposed in the Exposure Draft.

While we agree that at the date of full eligibility, an employee has done all that is required to be entitled to receive benefits, in reality, the employee generally continues to render service beyond this date. It should be the function of an accounting method to allocate costs over the full period the company realizes a benefit. To require the full recognition of an employee's postretirement costs at the date of full eligibility is inconsistent with this concept.

Further, the proposed accounting fails to recognize that two events must occur before an employer must begin to satisfy its obligation; the employee must become eligible and also retire. To allocate costs over the shorter period does not recognize the actual benefits an employer receives for this promise which accrue over all of the years an individual is employed.

3. Healthcare Inflation Rate

The most significant and controversial assumption that the Exposure Draft introduces is the Healthcare Inflation Rate. This rate is used to determine the estimate of future per capita claims cost. These future costs are generally derived from the historical claims costs adjusted for assumed healthcare cost trend rates and the effects of coverage by Medicare and other benefit providers.

To accumulate the information necessary to develop even the historical per capita claims cost will be difficult for most companies. The demographics alone affect the per capita claims cost in numerous ways; i.e. usage patterns in different areas of the country, by different sexes, by different ages, for differing plans. It is obvious that this is an enormous task and certain rough estimates will, of necessity, be required. Although, there is a historic trend on which to rely, the variables inherent in such an estimate will significantly reduce the precision with which costs can be estimated. When you add the additional requirement to utilize estimated healthcare cost trend rates, the estimation problem is exacerbated.

As discussed in the Exposure Draft, the development of a healthcare trend rate requires estimates of such factors as healthcare inflation, changes in technology, changes in utilization rates, how medical treatment is delivered and changes in the health of plan participants. These estimates must be applied to the historic trends as well as broken down by demographics. The added dimension of the healthcare trend rate takes

what were reasonable estimates with a relatively low confidence factor and pushes them beyond the limits of "reasonable estimates".

Therefore, GTE believes that a more stable rate such as a "medical inflation rate" should be used. This rate takes into account the more predictable expected medical price increases and excludes health cost increases due to changing technology and utilization patterns, which are the most unreliable components of the healthcare cost trend rate.

Alternatively, the Board should consider the use of the general inflation rate which would be more stable and which would recognize that companies will over time be able to bring future medical cost increases more in line with the general rate of inflation. If such a rate were used, differences from actual experience would be treated as actuarial gains or losses, subject to the treatment proposed by the Exposure Draft.

4. Discount Rate

GTE believes that limiting the calculation of the discount rate to the methodology proposed in the Exposure Draft is inappropriate. The use of a hypothetical settlement rate as proposed is difficult to support since currently there is no ready market available to settle these obligations. Therefore, it is probable that benefits for unfunded plans will be paid with funds generated from operations or raised through debt or equity financing. Accordingly, we believe that the company's cost of capital would more appropriately reflect the rate at which obligations of unfunded plans will be settled and should be used as the discount rate for these plans.

We understand that the Board disagrees with this approach. The Board believes that it would reduce comparability since the cost of capital differs among companies. However, we believe that if the cost of capital is the cost of paying these benefits, using it as the discount rate will better reflect these economics in the financial statements. Comparability should provide assurance that differences can be seen, not hidden. The latter would occur if a similar discount rate is used for all companies with unfunded plans.

5. Disclosures

GTE disagrees with the proposal that would require the disclosure of the effect of a one-percentage-point change in the healthcare inflation rate. We feel that it is generally understood that assumptions are inherent in the determination of such costs, and to arbitrarily require the disclosure of the effect of a change in one assumption would cast doubt on management's best estimates, thereby bringing into question the integrity of the amounts recognized and disclosed in the financial statements. Also, the proposed disclosure may cause undue confusion, as

a reader may assume that such an amount represents the maximum possibility of error in the estimate. Statement of Financial Accounting Concepts No. 5 specifies that information contained in the footnotes should amplify, explain and be essential to understanding information contained in the financial statements. The proposed disclosure amounts to a "what-if" disclosure that is confusing and misleading and does not fulfill the stated conceptual guidelines. Therefore, it should be eliminated.

6. Implementation

In order to allow companies sufficient implementation time, GTE feels that the Board should make the provisions of this standard effective a full three years after the issuance of a final Statement. We feel this time will be necessary for most companies, who will need to spend a good deal of time and effort obtaining needed plan and demographic data to perform a retiree health valuation. Companies will also have to rely on their actuaries, insurance carriers and other parties to obtain information regarding retiree claims experience, since such data is not generally kept "in-house". Additionally, the adoption of the new standard will cause many enterprises to be in violation of their debt covenants as well as raise significant questions with credit agencies, analysts, etc., which could impair their ability to raise capital at reasonable rates. Additionally, regulated companies and government contractors need sufficient time to address the impact of these costs with various regulatory agencies, which is an extended and complex process.

Therefore, we believe that three years should be the minimum time allowed to ensure that enterprises can effectively work these problems through to adequately protect shareholder interests. On the other hand, early adoption should be permitted for those companies that prefer such an election.

7. FAS 96 Impact

We also believe that the FASB has not adequately addressed the effects of the proposed accounting when considering the provisions of FAS 96 and their impact. Specifically, under current tax law, all or a portion of the expense may not be deductible until the benefits are actually paid. Under FAS 96, this could result in recognition problems related to deferred tax assets and the scheduled turnaround, resulting in a portion of the expense falling to the "bottom line" with no corresponding tax benefit. Due to the possible enormity of this obligation, it could significantly impact a company's future earnings. Therefore, provisions for simplifying the scheduling process or allowing for probability in the recognition of the income tax effects of these temporary differences need to be addressed.

GTE is pleased to have had the opportunity to express its views on the proposals contained in the Exposure Draft, and we hope our comments will assist the Board in reaching its final conclusions. Detailed responses to the twenty-one issues raised by the Board are attached as Exhibit A.

Very truly yours,

Bruce E. Haddad

Attachment

BEH/dm

Docket No. 911188-WS
V. Montanaro Exhibit No ___
Attachment 9
Godwin's Comment FASB's ED
November 3, 1989

Godwins

March 13, 1992

Mr. Bruce Davis
Senior Administrator Welfare Benefits
GTE Service Corporation
One Stamford Forum
Stamford, CT. 06904

Dear Bruce:

Re: Godwins Comments on FAS 106

As you requested, I have attached the comments made by David McLeish (our CEO) to the FASB during their hearings on Accounting for Other Post Employment Benefits.

Please give me a call if you have any questions.

Sincerely,

Peter J. Neuwirth, F.S.A.
Regional Director

PJN:mk\D273
Enc.

Godwins Inc.
549 Pleasantville Road, North Building
Briarcliff Manor, New York 10510

(914) 747-2002
FAX (914) 742-3215
FAX (914) 742-3220

540057

DAVID J.D. McLEISH
CHAIRMAN AND CHIEF EXECUTIVE OFFICER
GODWINS INTERNATIONAL HOLDINGS INC.
EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT
BENEFITS OTHER THAN PENSIONS
WASHINGTON, D.C.
NOVEMBER 3, 1989

540058

Godwi

I HAVE SET MYSELF A CHALLENGING OBJECTIVE. THAT OBJECTIVE IS TO PERSUADE YOU THAT THE TRADITIONAL THINKING WHICH UNDERPINS THE ACCOUNTING TREATMENT OF EMPLOYEE RETIREMENT BENEFITS IS FUNDAMENTALLY FLAWED: MORE SIMPLY, THAT IT IS WRONG.

IT IS THE THINKING WHICH LED TO STATEMENT 87 DEALING WITH ACCOUNTING FOR PENSION BENEFITS. IT IS THE SAME THINKING WHICH NOW IS IN DANGER OF PRODUCING WHAT, IN MY VIEW, WOULD BE AN EQUALLY ILLOGICAL STANDARD TO DEAL WITH ACCOUNTING FOR OTHER POST RETIREMENT EMPLOYEE BENEFITS.

IN THE CASE OF OPEB, HOWEVER, THE ANOMALIES CREATED WOULD BE EVEN GREATER THAN THOSE ALREADY CAUSED BY STATEMENT 87 (WHICH THEMSELVES ARE SUBSTANTIAL), BECAUSE THE CREATION OF EMPLOYER LIABILITIES IN THE OPEB AREA -- AND THE PRACTICE OF FUNDING THEM -- ARE AT AN EARLIER STAGE OF EVOLUTION THAN IS THE CASE WITH PENSIONS.

WHAT I FIND EMBARRASSING, IN THE PRESENCE OF YOUR AUGUST BOARD, IS THAT THE TRADITIONAL THINKING I AM CRITICIZING ORIGINATES NOT WITHIN YOUR ACCOUNTING PROFESSION BUT WITHIN MY OWN PROFESSION, THAT OF THE ACTUARY. MY PROFESSION HAS BEEN REMARKABLY SUCCESSFUL IN MY VIEW IN LEADING YOUR PROFESSION ASTRAY, ALBEIT INNOCENTLY, WITH THE RESULT THAT YOU ARE NOW IN DANGER OF EXTRAPOLATING TO OPEB, THINKING WHICH, I BELIEVE, SHOULD NOT HAVE WITHSTOOD CRITICAL SCRUTINY WHEN IT WAS FIRST APPLIED TO PENSIONS.

540059

Godwins

THE ACTUARIAL PROFESSION HAS DEVELOPED A VARIETY OF METHODS FOR CALCULATING PENSION CONTRIBUTIONS AND EACH RESULTS IN ITS OWN PATTERN OF BUILD-UP OF ASSETS WHICH, UNFORTUNATELY, MY PROFESSION REFERS TO AS "ACTUARIAL LIABILITIES". DESPITE THIS DESCRIPTION, THE CALCULATED NUMBERS SELDOM, IF EVER, CORRESPOND TO LIABILITIES IN ANY LEGAL SENSE SINCE THEY ARE SIMPLY AN INCIDENTAL BY-PRODUCT OF A METHOD WHOSE PRIMARY FOCUS IS TO CALCULATE A CONTRIBUTION.

EACH METHOD PAYS DUE REGARD TO THOSE PROVISIONS OF THE RELEVANT PLAN WHICH DETERMINE WHAT EMERGING BENEFITS WILL BE, BUT THE METHODS PAY NO REGARD TO THOSE PROVISIONS OF THE PLAN WHICH DETERMINE WHAT, IF ANY, ACCRUING LIABILITIES THERE MIGHT BE. THE USE, BY ACTUARIES, OF THE TERM "ACTUARIAL LIABILITIES" TO DESCRIBE WHAT IN REALITY IS AN ANTICIPATED ACCUMULATION OF ASSETS PERHAPS HAS BEEN ONE OF THE GREATEST IMPEDIMENTS TO EFFECTIVE COMMUNICATION BETWEEN OUR TWO PROFESSIONS.

FURTHERMORE, THE CONSTRAINT OF SEEKING A REASONABLY STABLE RATE OF ~~[illegible]~~ CONTRIBUTION, COUPLED WITH THE PRACTICE OF DEALING WITH A GROUP OF EMPLOYEES AS A CLOSED GROUP, RATHER THAN ONE REPLENISHED BY NEW ENTRANTS, LEADS TO THE ACCUMULATION OF ASSETS AND THE CORRESPONDING DETERMINATION OF SO-CALLED ACTUARIAL LIABILITIES FREQUENTLY FAR IN EXCESS OF THE ACCRUED LIABILITIES WHICH TRULY EXIST.

540060
Godwins

I ADVOCATE AN ALTERNATIVE APPROACH WHICH LOOKS THROUGH THE OPPOSITE END OF THE ACTUARIAL TELESCOPE. IT IS CALLED THE DEFINED ACCRUED BENEFIT METHOD. IT BEGINS BY DETERMINING WHAT LIABILITIES TRULY DO ACCRUE AND HOW AND WHEN THEY ACCRUE HAVING REGARD TO THE FACTS AND CIRCUMSTANCES. IT THEN CALCULATES WHAT CONTRIBUTION OR, IN THE ABSENCE OF FUNDING, WHAT PROVISION, IS NECESSARY IN EACH FUTURE YEAR, PROJECTING FAR INTO THE FUTURE, TO ENSURE THAT ALL BENEFIT PAYMENTS ARISING IN EACH YEAR ARE PROVIDED FOR AND THAT THE ACCUMULATED PROVISION AT THE END OF EACH YEAR MATCHES THE TRUE ACCRUED LIABILITIES AT THE SAME POINT IN TIME.

FREQUENTLY THE TRUE LIABILITIES BUILD UP MORE SLOWLY AND RESULT IN ACCRUED LIABILITIES AT A LOWER LEVEL THAN THE ACTUARIAL LIABILITIES DERIVED FROM MOST TRADITIONAL ACTUARIAL METHODS AND, IN PARTICULAR, AT A LOWER LEVEL THAN WOULD BE DERIVED FROM THE ACTUARIAL METHOD FAVORED BY STATEMENT 87 AND, BY ANALOGY, MUCH LOWER THAN DERIVED FROM THE METHOD FAVORED IN THE OPEB EXPOSURE DRAFT.

IF, IN THESE CIRCUMSTANCES, I WERE TO USE THE APPROACH I ADVOCATE BUT STILL DEAL WITH THE EMPLOYER'S WORKFORCE AS A CLOSED GROUP RATHER THAN ONE REPLENISHED BY NEW ENTRANTS MY PROJECTIONS WOULD RESULT IN A CONTRIBUTION AS A PERCENTAGE OF PAYROLL WHICH INCREASED STEADILY YEAR BY YEAR. THIS WOULD BE SO EVEN IF THE TRUE LIABILITIES DID INDEED BUILD UP IN THE WAY ASSUMED UNDER STATEMENT 87 BUT THE INCREASE WOULD BE STEEPER IF, AS IS LIKELY IN PRACTICE, THE LIABILITIES BUILD UP MORE SLOWLY. THIS IS A FEATURE WHICH I KNOW HAS, TO SAY THE LEAST, A CERTAIN LACK OF APPEAL TO THE ACCOUNTANT.

HOWEVER, I HAVE NEVER UNDERSTOOD WHY THE ACCOUNTANT, WHO STRESSES A DESIRE TO USE A GOING CONCERN APPROACH, HAS ACCEPTED AN IMPLICIT ASSUMPTION BY THE ACTUARY OF NO NEW ENTRANTS WHICH, IF BORNE OUT IN PRACTICE, WILL MEAN THAT THE GOING CONCERN EVENTUALLY STOPS GOING. INDEED THE APPROACH FAVORED BY THE ACCOUNTING PROFESSION, QUITE SIMPLY, IS NOT A GOING CONCERN APPROACH: IT WOULD BE MORE ACCURATELY DESCRIBED AS A DYING CONCERN APPROACH!

IF, INSTEAD, MY APPROACH IS USED COUPLED WITH A NEW ENTRANT ASSUMPTION WHICH DEMOGRAPHIC PROJECTIONS INDICATE WOULD MAINTAIN THE GOING CONCERN WITH A SENSIBLE CONFIGURATION OF ITS WORKFORCE, IT IS MUCH MORE LIKELY THAT, WHATEVER THE LEVEL AT WHICH LIABILITIES ACCRUE, THE PROJECTED CONTRIBUTION RATE WILL BE REASONABLY STABLE.

BUT EVEN IF IT IS NOT: WHAT THEN? THE EXPOSURE DRAFT WOULD SOLVE WHAT IT SEES AS A PROBLEM IN THE REPORTED RESULTS OF OPERATIONS BY ACCUMULATING A LIABILITY IN THE STATEMENT OF FINANCIAL POSITION: IN EFFECT BY USING THE BALANCE SHEET TO SMOOTH OUT AN OTHERWISE INCREASING CONTRIBUTION PATTERN AND THEREBY CREATING FALSE LIABILITIES. THIS STRIKES ME AS RATHER ODD IF I AM CORRECT IN BELIEVING THAT, GIVEN A CHOICE, THE EMPHASIS OF THE ACCOUNTING PROFESSION IS ON THE REPRESENTATIONAL FAITHFULNESS OF THE COMPANY BALANCE SHEET. PRESUMABLY THE LIABILITY IS AN "ACCOUNTING LIABILITY" AND JUST AS WITH THE "ACTUARIAL LIABILITY" I REFERRED TO EARLIER, I WOULD OBSERVE THAT IT WOULD NOT REPRESENT A TRUE LIABILITY IN ANY LEGAL SENSE NOR INDEED IN ANY OTHER SENSE THAT NORMALLY WOULD BE ATTACHED TO THAT WORD.

540062
Godwins

SUGGESTIONS BY OTHER RESPONDENTS THAT YOU SHOULD SEEK TO DRAW A DISTINCTION BETWEEN WHAT MIGHT BE REFERRED TO AS "LIABILITIES" AND WHAT MIGHT BE CALLED "OBLIGATIONS," IN MY VIEW WOULD LEAD ONLY TO GREATER CONFUSION RATHER THAN LESS. SURELY WHAT WE SHOULD BE SEEKING TO RECOGNIZE IS ONLY AMOUNTS WHICH CONSTITUTE CLAIMS AGAINST THE COMPANY'S RESOURCES: WHATEVER NAME THEY MAY BE GIVEN.

I WOULD REGARD IT AS MISLEADING ENOUGH WERE THE APPROACH OF THE EXPOSURE DRAFT TO LEAD ONLY TO A TEMPORARY ANOMALY WHICH WOULD WORK ITSELF OUT OVER TIME. MANY APPEAR TO FALL INTO THE TRAP OF BELIEVING THIS TO BE SO BY THINKING IN TERMS OF THE WORKFORCE AS A CLOSED GROUP OR, WORSE STILL, BY THINKING IN TERMS OF THE INDIVIDUAL EMPLOYEE. AFTER ALL IN EITHER CONTEXT THE EXISTING EMPLOYEES' BENEFITS HAVE TO BE PAID EVENTUALLY SO THE LIABILITY WOULD EVENTUALLY DISAPPEAR.

HOWEVER, IN THE CONTEXT OF THE GOING CONCERN, EVENTUALLY NEVER COMES AND THE APPROACH OF THE EXPOSURE DRAFT WOULD LEAD TO THE COMPANY CARRYING PERMANENTLY IN ITS STATEMENT OF FINANCIAL POSITION SUBSTANTIAL ACCRUED LIABILITIES WHICH, IN REALITY, DO NOT EXIST, EITHER BECAUSE IN TRUTH THERE IS NO SUCH LIABILITY OR BECAUSE THE LIABILITY HAS NOT YET ARISEN AND BELONGS TO A LATER GENERATION OF FINANCIAL STATEMENTS.

THERE ARE INDICATIONS THAT SOME ANALYSTS SHARE MY MISGIVINGS, ALTHOUGH FOR DIFFERENT REASONS. THERE HAVE BEEN PRESS REPORTS THAT MOODY'S AND STANDARD AND POOR'S MAY SEEK TO ADJUST COMPANIES' FINANCIAL STATEMENTS IN REGARD TO SUCH LIABILITIES BUT, BEYOND AN ASSUMPTION THAT THE TRUTH MAY LIE SOMEWHERE BETWEEN ZERO AND THE NUMBER GENERATED BY THE PROPOSED STANDARD, THERE IS LITTLE THEY CAN DO.

ONLY AN EXAMINATION OF THE TRUE FACTS AND CIRCUMSTANCES AND ACTUARIAL CALCULATIONS CONSISTENT WITH THOSE FACTS AND CIRCUMSTANCES WOULD YIELD NUMBERS WITH ANY DEGREE OF RELEVANCE. AND LET ME EMPHASIZE THAT THE RELEVANT NUMBER COULD INDEED LIE ANYWHERE IN THE RANGE BETWEEN ZERO AND WHAT I WILL CALL "YOUR NUMBER"--AND WHERE IT LIES IN THAT RANGE WILL DIFFER SIGNIFICANTLY FROM COMPANY TO COMPANY.

MAY I SAY THAT I DEEPLY SYMPATHIZE WITH THE ACCOUNTANT WHEN FACED IN THE PENSIONS FIELD BY ACTUARIES WHO, FOR WHAT APPEARS TO BE THE SAME PLAN, ADOPT A VARIETY OF METHODS OF CALCULATION WHICH, EVEN IF ALL THE ASSUMPTIONS USED ARE THE SAME, RESULT IN VASTLY DIFFERENT NUMBERS BEING CERTIFIED AS THE SO-CALLED "ACTUARIAL LIABILITIES" OF THE PLAN.

Godwins

THE TRAGEDY, AS I SEE IT, IS THAT, IN SEEKING STANDARDIZATION THE ACCOUNTANT CHOSE ONE OF THE MANY ACTUARIAL METHODS AND DETERMINED IT SHOULD BE APPLIED TO ALL PLANS. THIS DID NOTHING TO ADDRESS THE ANOMALY THAT THE CHOSEN METHOD BEING APPLIED AS A STANDARD METHOD MUST IGNORE THE ACTUAL FACTS AND CIRCUMSTANCES WHICH DETERMINE HOW LIABILITIES ACCRUE: FACTS AND CIRCUMSTANCES WHICH CAN VARY WIDELY FROM PLAN TO PLAN. THIS APPROACH WHICH IS EMBODIED IN STATEMENT 87 IS PROPOSED AGAIN IN THE OPEB EXPOSURE DRAFT.

WERE IT ONLY THE ANALYSTS WE HAD TO BE CONCERNED ABOUT IT WOULD BE BAD ENOUGH, BUT THERE ARE MORE WORRYING REPERCUSSIONS. IT IS PERFECTLY POSSIBLE THAT THE REQUIREMENT TO ESTABLISH PROVISIONS FOR LIABILITIES WHICH I CONTEND DO NOT EXIST COULD LEAD TO A GENERATION OF SHAREHOLDERS BEING DEPRIVED OF DIVIDENDS WHICH THEY WOULD OTHERWISE ENJOY. IN THE EXTREME IT COULD LEAD TO SOME ORGANIZATIONS CEASING TO EXIST DUE TO APPARENT FAILURE TO MEET CAPITAL REQUIREMENTS. THE IRONY WOULD BE APPARENT WHEN SUCH AN ENTITY, IN LIQUIDATION, WAS ABLE TO MEET ALL ITS OBLIGATIONS WITH ASSETS TO SPARE BECAUSE THE LIABILITY WHICH CAUSED ITS LIQUIDATION EVAPORATED WHEN THAT LIQUIDATION OCCURRED.

LET ME FINISH BY RE-EXPRESSING THE ESSENCE OF MY CONCERN:

IN YOUR EXPOSURE DRAFT YOU CONCLUDED THAT POST RETIREMENT BENEFITS SHOULD NOT BE ATTRIBUTED BEYOND THE DATE FULL ELIGIBILITY FOR THOSE BENEFITS IS ATTAINED. WHY THEN DO YOU NOT SIMILARLY CONCLUDE THAT POST RETIREMENT BENEFITS SHOULD NOT BE ATTRIBUTED IN ADVANCE OF THE DATE FULL OR PARTIAL ELIGIBILITY FOR THOSE BENEFITS IS ATTAINED.

AS ACCOUNTANTS YOU READILY ACCEPT THE IMPACT ON THE COST OF EMPLOYEE BENEFITS WHICH FLOWS FROM THE DETAILED BENEFIT DESIGN PROVISIONS OF THE RELEVANT PLAN. WHY THEN DO YOU CHOOSE SINGULARLY TO IGNORE THE PROVISIONS OF THE PLAN WHICH RELATE TO HOW AND WHEN LIABILITIES ACCRUE?

CONSISTENCY, I SUBMIT, WILL ONLY BE ACHIEVED WHEN, IN DETERMINING ACCRUED LIABILITIES FOR ACCOUNTING PURPOSES YOU SIMILARY RELY ON THE RELEVANT PROVISIONS OF THE PLAN AND ACCEPT THAT, AS WITH OTHER BENEFIT PROVISIONS, THESE WILL VARY FROM COMPANY TO COMPANY.

OUR WRITTEN SUBMISSION REFLECTS THE PHILOSOPHY I HAVE PUT FORWARD THIS AFTERNOON AND I SHALL BE HAPPY TO ANSWER ANY QUESTIONS ON THAT SUBMISSION OR ARISING OUT OF THESE REMARKS.

I TRULY APPRECIATE THE OPPORTUNITY TO AIR OUR VIEWS ON THIS VERY IMPORTANT SUBJECT. THANK YOU VERY MUCH.

540066

Godwins

Docket No. 911188-WS
V. Montanaro Exhibit No ___
Attachment 10
Proposed Actuarial Compliance
Guideline for SFAS 106

ASB

ACTUARIAL STANDARDS BOARD

EXPOSURE DRAFT

Proposed Actuarial Compliance Guideline

Compliance with Statement of Financial Accounting Standards No. 106 Employer's Accounting for Postretirement Benefits Other Than Pensions

Comment Deadline
March 15, 1992

Developed by the
Retiree Health Care Committee
of the ASB

October 1991

EXPOSURE DRAFT

PROPOSED ACTUARIAL COMPLIANCE GUIDELINE

COMPLIANCE WITH STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106 EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS

Comment Deadline: March 15, 1992

Developed by the
Retiree Health Care Committee of the ASB

Approved for Exposure
Actuarial Standards Board
October 1991

TABLE OF CONTENTS

EXPOSURE DRAFT

October 1991

TO: Members of the American Academy of Actuaries and Other Persons Interested in Employers' Accounting for Postretirement Benefits Other Than Pensions

FROM: Actuarial Standards Board (ASB)

SUBJ: Exposure Draft of Actuarial Compliance Guideline for Compliance with Statement of Financial Accounting Standards No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions (SFAS 106)

Enclosed in this booklet is an exposure draft of a proposed actuarial compliance guideline for actuarial calculations required under SFAS 106, promulgated by the Financial Accounting Standards Board (FASB). The purpose of the guideline is to set forth generally accepted actuarial principles for such calculations. Because this document is a standard for compliance with an outside requirement (i.e., an accounting standard), certain procedures may or may not be generally accepted for other actuarial purposes.

Please review the exposure draft and give the ASB the benefit of your comments and suggestions. Written comments will be acknowledged. All responses will be considered in preparing the final guideline. Please address your comments to:

Compliance Guideline for SFAS 106
Actuarial Standards Board
1720 I Street, N.W., 7th Floor
Washington, D.C. 20006

The deadline for receipt of comments: March 15, 1992

Background

The ASB adopted an actuarial standard of practice in October 1988 addressing the measurement and allocation of actuarial present values of retiree health care and death benefits (ASOP No. 6). In December 1990, the FASB adopted a statement of financial accounting standards addressing employers' accounting for postretirement benefits other than pensions (SFAS 106).

Both standards pertain to similar benefits, primarily welfare benefits for retired employees. The long-term measurements required are a relatively new and developing actuarial practice. In light of this, the ASB asked its Retiree Health Care Committee to develop a guideline for actuaries to use in providing the information needed for employers to comply with SFAS 106. The length of the guideline reflects the perceived need to provide more information than usual because it is designed for this relatively new area of practice.

The committee recognized that SFAS 106 implies more precision and accuracy than exist in this area of actuarial practice. The relatively long-

term nature of the obligations, the significant year-to-year variations in trend rates, and the underlying political and economic nature of the benefits almost assure substantial variations between actual results and expected results.

The guideline is not intended as the sole source of reference for actuarial practitioners. It is directed to actuaries who are presumed to be familiar with either group health or pension benefits, and who are embarking on calculations for SFAS 106. The intent in developing it was to identify areas which can cause problems, and to give general guidance.

This draft was developed by the Retiree Health Care Committee of the ASB. It was approved for exposure by the ASB on October 10, 1991.

PROPOSED ACTUARIAL COMPLIANCE GUIDELINE

COMPLIANCE WITH

STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106

EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT BENEFITS

OTHER THAN PENSIONS

PREAMBLE

Section 1. Purpose, Scope, and Effective Date

1.1 Purpose - This actuarial compliance guideline provides guidance to actuaries in complying with Statement of Financial Accounting Standards No. 106 (SFAS 106), Employers' Accounting for Postretirement Benefits Other than Pensions, adopted by the Financial Accounting Standards Board (FASB) in December 1990. As in SFAS 106, postretirement benefits other than pensions will have the short name of postretirement benefits in this guideline.

1.2 Scope - SFAS 106 and pronouncements of the FASB set forth required practices with respect to calculations for SFAS 106. SFAS 106 applies to the employer's obligation for postretirement benefits. Benefits that cease prior to or at retirement are not included under SFAS 106. This guideline is believed to accurately represent current understanding of SFAS 106 as it pertains to actuarial calculations; the guideline is not an actuarial standard of practice. In the event of a conflict between this document and SFAS 106 or other guidance from the FASB, the actuary should rely on the FASB for a definitive determination.

Primary emphasis in the guideline is on health care benefits. Death benefits are also a concern in the guideline, but less discussion is given to them because they are generally well defined and comparatively simpler to measure. The guideline does not specifically address other postretirement benefits covered under SFAS 106 such as long-term care, tuition assistance, day care, legal services, and housing subsidies provided after retirement (SFAS 106, par. 6). This guideline does not apply to income replacement benefits such as disability income. Welfare benefits provided for in pension plans and accounted for under the FASB's Statements of Accounting Standards Nos. 87 and 88 are not accounted for under SFAS 106.

1.3 Effective Date - This guideline is effective three months after final adoption by the Actuarial Standards Board (ASB). It is applicable on a prospective basis only.

Section 2. Definitions

2.1 Accumulated Postretirement Benefit Obligation (APBO) - The actuarial present value of benefits attributed to employee service rendered to a particular date. (SFAS 106)[1]

2.2 Active Plan Participant - Any active employee who has rendered service during the credited service period and is expected to receive benefits, including benefits to or for any beneficiaries and covered dependents, under the postretirement benefit plan. (SFAS 106)

2.3 Actuarial Present Value - The value, as of a specified date, of a future benefit cost or series of benefit costs, where each amount:

a. is adjusted for the probable effect of events (such as changes in price levels, compensation levels, Medicare, marital status, etc.;
b. reflects the probability of the occurrence of the event (such as survival, death, disability, termination of employment, utilization of services, etc.) on which payment is conditioned, and
c. is discounted according to an assumed rate (or rates) to reflect the time value of money. (ASOP 6)[2]

2.4 Amortization - For the purposes of SFAS 106, amortization means the systematic reduction of the principal portion (only) of an asset or liability. This is to be distinguished from a level principal and-interest, mortgage-type reduction scheme (see subsection 5.10 for a more detailed discussion).

2.5 Assumed Per Capita Claims Cost (by Age) - The annual per capita cost, for periods after the measurement date, of providing the postretirement health care benefits covered by the plan from the earliest age at which an individual could begin to receive benefits under the plan through the remainder of the individual's life or the covered period, if shorter. (SFAS 106)

2.6 Attribution Period - The period of an employee's service to which the expected postretirement benefit obligation for that employee is assigned. (SFAS 106)

---

1 (SFAS 106) following a definition denotes that it is an extract from the Glossary of SFAS 106.

2 (ASOP 6) following a definition denotes that it is an extract from Actuarial Standard of Practice No. 6, Measuring and Allocating Actuarial Present Values of Retiree Health Care and Death Benefits

2.7 Benefit Formula - The basis for determining benefits to which participants may be entitled under a postretirement benefit plan. A plan's benefit formula specifies the years of service to be rendered, age to be attained while in service, or a combination of both that must be met for an employee to be eligible to receive benefits under the plan. A plan's benefit formula may also define the beginning of the credited service period and the benefits earned for specific periods of service. (SFAS 106)

2.8 Contributory Plan - A plan under which retirees or active employees contribute part of the cost. (SFAS 106)

2.9 Cost-Sharing (Provisions of the Plan) - The provisions of the postretirement benefit plan that describe how the costs of the covered benefits are to be shared between the employer and the plan participants. Cost-sharing provisions describe retired and active plan participants' contributions toward their postretirement health care benefits, deductibles, coinsurance, out-of-pocket limitations on participant costs, caps on employer costs, and so forth. (SFAS 106)

2.10 Credited Service Period - Employee service period for which benefits are earned pursuant to the terms of the plan. (SFAS 106)

2.11 Curtailment (of a Postretirement Benefit Plan) - An event that significantly reduces the expected years of future service of active plan participants or eliminates the accrual of defined benefits for some or all of the future services of a significant number of active plan participants. (SFAS 106)

2.12 Defined Benefit Postretirement Plan - A plan that defines benefits in terms of monetary amounts (for example, $100,000 of life insurance) or benefit coverage to be provided (for example, up to $200 per day for hospitalization, 80% of the cost of specified surgical procedures, and so forth). (SFAS 106)

2.13 Defined Contribution Postretirement Plan - A plan that provides postretirement benefits in return for service rendered, provides an individual account for each plan participant, and specifies how contributions to this account are to be determined, rather than specifying amount of benefits the individual is to receive. (SFAS 106)

2.14 Discount Rate - For the purposes of SFAS 106, discount rate means the interest rate used in developing present values.

2.15 Expected Postretirement Benefit Obligation (EPBO) - The actuarial present value as of a particular date of the benefits expected to be paid to or for an employee, the employee's beneficiaries, and any covered dependents pursuant to the terms of the postretirement benefit plan. (SFAS 106)

2.16 Full Eligibility (for Benefits) - The status of an employee having reached the employee's full eligibility date. Full eligibility for benefits is achieved by meeting specified age, service, or age and service requirements of the postretirement benefit plan. (SFAS 106)

2.17 Full Eligibility Date - The date at which an employee has rendered all of the service necessary to have earned the right to receive all of the benefits expected to be received by that employee (including any beneficiaries and dependents expected to receive benefits). (SFAS 106)

2.18 Gross Eligible Charges - The cost of providing the postretirement health care benefits covered by the plan to a plan participant, before adjusting for expected reimbursements from Medicare and other providers of health care benefits plans and for the effects of cost-sharing provisions of the plan. (SFAS 106)

2.19 Health Care Cost Trend Rate (HCCTR) - An assumption about the annual rate(s) of change in the cost of health care benefits currently provided by the postretirement benefit plan, due to factors other than changes in the composition of the plan population by age and dependency status, for each year from the measurement date until the end of the period in which benefits are expected to be paid. The HCCTR implicitly considers estimates of health care inflation, changes in health care utilization or delivery patterns, technological advances, and changes in the health status of the plan participants. Differing types of services, such as hospital care and dental care, may have different trend rates. (SFAS 106)

2.20 Incurred Claims Cost (by Age) - The cost of providing the postretirement health care benefits covered by the plan to a plan participant, after adjusting for reimbursements from Medicare and other providers of health care benefits and for deductibles, coinsurance provisions, and other specific claims costs borne by the retiree. (SFAS 106)

2.21 Net Incurred Claims Cost (by Age) - The employer's share of the cost of providing the postretirement health care benefits covered by the plan to a plan participant; incurred claims cost net of retiree contributions. (SFAS 106)

2.22 Net Periodic Postretirement Benefit Cost (NPPBC) - The amount recognized in an employer's financial statements as the cost of a postretirement benefit plan for a period. Components of NPPBC include service cost, interest cost, actual return on plan assets, gain or loss, amortization of unrecognized prior service cost, and amortization of the unrecognized transition obligation or asset. (SFAS 106)

2.23 Optional Health Care Delivery Systems - Differing systems for delivery of health care that may be offered to plan participants for their election. Examples are health maintenance organizations and other managed-care health plans, retirement communities that provide health care, and fee-for-service indemnity plans.

2.24 Pay-Related Plan - A plan that has a benefit formula that bases benefits or benefit coverage on compensation, such as a final-pay or career-average-pay plan. (SFAS 106)

2.25 Per Capita Claims Cost by Age - The current cost of providing postretirement health care benefits for one year at each age from the youngest age to the oldest age at which plan participants are expected to receive benefits under the plan. (SFAS 106)

2.26 Plan - An arrangement that is mutually understood by an employer and its employees, whereby an employer undertakes to provide its employees with benefits after they retire in exchange for their services over a specified period, upon attaining a specified age while in service, or a combination of both. A plan may be written or it may be implied by a well-defined, although perhaps unwritten, practice of paying postretirement benefits or from oral representations made to current or former employees. (SFAS 106)

2.27 Plan Participant - Any employee or former employee who has rendered service in the credited service period and is expected to receive employer-provided benefits under the postretirement benefits plan, including benefits to or for any beneficiaries and covered dependents. (SFAS 106)

2.28 Service Cost (Component of Net Periodic Postretirement Benefit Cost) - The portion of the expected postretirement benefit obligation attributed to employee service during a period. (SFAS 106)

2.29 Settlement (of a Postretirement Benefit Plan) - An irrevocable action that relieves the employer (or the plan) of primary responsibility for a postretirement benefit obligation and eliminates significant risks related to the obligation and the assets used to effect the settlement. Examples of transactions that constitute a settlement include (a) making lump-sum cash payments to plan participants in exchange for their rights to receive specified postretirement benefits and (b) purchasing nonparticipating insurance contracts for the accumulated postretirement benefit obligation for some or all of the plan participants. (SFAS 106)

2.30 Substantive Plan - The terms of a postretirement benefit plan as understood by an employer that provides postretirement benefits and the employees who render services in exchange for those benefits. The substantive plan is the basis for the accounting for that exchange transaction. In some situations an employer's cost-sharing policy, as evidenced by past practice or by communication of intended changes to a plan's cost-sharing provisions, or a past practice of regular increases in certain monetary benefits may indicate that the substantive plans differs from the extant written plan. (SFAS 106)

2.31 Termination Benefits - Benefits provided by an employer to employees in connection with their termination of employment. They may be either special termination benefits offered only for a short period of time or contractual benefits required by the terms of a plan only if a specified event, such as a plant closing, occurs. (SFAS 106)

Section 3. Background and Historical Issues

The FASB promulgated SFAS 106, Employers' Accounting for Postretirement Benefits Other Than Pensions in December 1990. SFAS 106 requires major changes in the way postretirement benefits are accounted for and presented in employers' financial statements. Much of the information required will have to be furnished by actuaries. Users of this guideline are assumed to be familiar with the content and terminology of SFAS 106, and with Actuarial Standard of Practice No. 6, Measuring and Allocating Actuarial Present Values of Retiree Health Care and Death Benefits.

Section 4. Current Practices and Alternatives

4.1 Use of Calculations - Actuarial Standard of Practice (ASOP) No. 6, subsection 6.3, permits unsupported deviations from the standard if required to comply with constraints imposed by "other entities with rule-making authority." The FASB and SFAS 106 qualify as such authority. However, if actuarial calculations are to be used for purposes other than for SFAS 106, all requirements of ASOP No. 6 apply, and the actuary should disclose and be prepared to support deviations from the standard.

4.2 Approximations and Materiality - SFAS 106 allows the use of reasonable approximations (SFAS 106, par. 15). In addition, materiality is always a consideration when deciding on the amount of effort and expense that should be incurred when complying with any accounting standard (SFAS 106, page 38, following par. 115).

4.3 Determination of Materiality - Since the actuary may not be aware of whether (a) the employer maintains other postretirement benefit plans, (b) postretirement benefit matters are significant relative to the employer's total operations, or (c) the employer requires a more thorough SFAS 106 valuation regardless of materiality, the actuary should consult with the employer before determining the approximations to use when complying with SFAS 106. Ultimately, the employer and the auditor are responsible for determining materiality.

4.4 Standard of Materiality - Actuaries are typically concerned with the valuation of a single plan. An entire plan, however, may not be material in the context of the employer's financial statements. In such case, the actuary may be able to focus primarily on some other requirement of that plan, and then comply with the requirements of SFAS 106 in a manner that minimizes the additional effort required. Other plans will be material in total, but have relatively immaterial components of cost or disclosure. In these cases, the actuary may still be able to make use of approximations. Still other plans will be material in all respects, and the actuary should more carefully consider which approximations may be appropriate (SFAS 106, par. 15).

4.5 Materiality of Non-U.S. Plans - The discussion in subsections 4.2, 4.3, and 4.4 of this guideline relating to materiality and approximations may be of special importance with respect to non-U.S. plans. The actuary should be aware that SFAS 106 applies to non-U.S. plans to the extent that they are included in U.S. financial statements prepared in accordance with generally accepted accounting principles (GAAP) (SFAS 106, par. 85). Even if postretirement benefits are material in the context of an employer's financial statements, the non-U.S. plan(s) may not be, in which case more extensive use of approximations could be appropriate (SFAS 106, par. 15). In the extreme case, the plan may not materially affect the employer's financial statements regardless of how the valuation is done.

4.6 Accounting Practice - Accounting practice requires that the excess of expense charged over the amount of cash disbursed be accounted for as an accrued liability on the financial statement balance sheet. Prior to SFAS 106, postretirement benefits were typically accounted for by the pay-as-you-go method. Under this method, the expense charged was equal to the cash disbursed, resulting in no balance sheet accrued liability. Under SFAS 106, the NPPBC is likely to exceed cash disbursed for benefits, resulting in balance sheet accrued liabilities equal to the excess of NPPBC over cash disbursed. When cash disbursed exceeds NPPBC, either a balance sheet prepaid expense (an asset) is generated, or a previously credited accrued liability is reduced. These balance sheet items should be reflected, as required, when performing SFAS 106 determinations.

COMPLIANCE GUIDELINE

Section 5. Analysis of Issues and Recommended Compliance

5.1 Procedure to Measure Actuarial Present Values and Allocate Costs - In order to prepare these actuarial calculations, the following steps should be taken:

a. Select a measurement (calculation) date (subsection 5.2)

b. Determine plan provisions and benefits to be valued (subsection 5.3)

c. Gather data appropriate for the calculations
   i. Plan participant data (subsection 5.4)
   ii. Benefits/claims cost (subsection 5.5)
   iii. Asset data (subsection 5.9)

d. Select actuarial assumptions
   i. Health care cost trend rate (subsection 5.6)
   ii. Other assumptions (subsection 5.7)

e. Determine cost allocation procedures

i. Attribution (cost) method (subsection 5.8)

ii. Asset values (subsection 5.9)

iii. Amortization methods (subsection 5.10)

f. Develop accounting information

i. Net periodic postretirement benefit cost (subsection 5.11)

ii. Disclosure and balance sheet items (subsection 5.12)

iii. Effect of settlements, curtailments, and terminations (subsection 5.13)

5.2 Measurement Date - The measurement date is the date as of which actuarial calculations are performed. Typically, the measurement date is the last day of the employer's fiscal year. SFAS 106 (par. 72) permits consistent use of any date as a measurement date, as long as it is within three months prior to the end of the fiscal year (e.g., for an employer with a calendar fiscal year, the measurement date must be between 9/30 and 12/31). The NPPBC for an employer's fiscal year is usually determined by values calculated as of the measurement date in the prior fiscal year. There may be interim measurements in the course of a year, but these do not change the measurement date.

Example - In many instances, the plan year and fiscal year will be a calendar year (1/1 to 12/31). In such situations, the measurement date is typically 12/31. For the 1993 fiscal year (1/1/93 to 12/31/93):

a. NPPBC is calculated from values determined as of 12/31/92.

b. Financial statement disclosure information as of 12/31/93 is developed from the values determined as of 12/31/92, projected to 12/31/93 (except assets, if any; actual 12/31/93 assets should be used). The projected APBO at 12/31/93 equals APBO at 12/31/92 plus service cost plus interest cost minus benefits paid from 1/1/93 to 12/31/93 plus changes in APBO due to changes in actuarial assumptions.

5.3 Plan Provisions/Benefits to Be Valued - For a brief discussion of welfare plan provisions and benefits see Appendix, subsection A5.3.

5.3.1 Substantive Plan - The plan to be valued is the substantive plan. The substantive plan is the plan as understood by the employer and the retirees. Generally, the written plan provides the best evidence as to what the substantive plan is. However, often the only written material is a summary plan description which may be incomplete or out-of-date. This is particularly true of the cost-sharing provisions, especially retiree contributions. Unwritten provisions or plans can often be discerned from past practices and oral communications with current or former employees (SFAS 106, par. 23-27).

5.3.2 Temporary Deviation from Substantive Plan - If the employer temporarily deviates from the substantive plan in a way that changes the employer's share of the benefit costs incurred in the current or past periods, the gain or loss resulting from such deviation should be recognized immediately, without the benefit of the corridor or other delayed recognition alternatives (SFAS 106, par. 61 and 302). Similar future decisions may indicate a practice, implying an amendment to the substantive plan.

5.3.3 "Hidden" Cost - There may also be plans where the employer's contributions are not readily apparent. These plans should also be measured.

Example - A plan for which the retirees are purportedly paying the whole cost but which, in fact, is being subsidized because the retiree premium has been set below the actual cost of the retirees' benefits. This could include a situation in which early retirees pay the average premium for a group that includes active employees.

5.3.4 Grouping of Participants and Benefits - The concept of a plan in the postretirement benefit field is not well defined. However, grouping of participants and their associated plan benefits for valuation purposes could affect the measurement amount, the amortization period, the net amount of gains and losses, or the 10% amortization corridor.

Generally, participants and their benefits may be combined unless there is a reason not to combine them. Combination is heavily influenced by the facts and circumstances of the situation. Asset restriction to particular participants and/or benefits would require separate valuations. The employer's corporate structure may or may not require separate valuations. For example, central control of the benefit levels (even though there are different benefits for various locations or subsidiaries) would allow a combined valuation. On the other hand, each subsidiary may control its own benefit levels, allowing separate valuations. The following circumstances do not necessarily require separate valuations: (1) different administrators; (2) election of benefit type (e.g., indemnity, health maintenance organization); (3) benefits differing by geographical area. Aggregation of plans for disclosure purposes (SFAS 106, par. 75-78) will influence the grouping. Combining or separating groups only to alter the measurement amounts is not appropriate.

5.4 Participant Data - The actuary should be aware of the kinds of participant data needed for the valuation. For a brief discussion of data sources see Appendix, subsection A5.4. Some considerations specific to SFAS 106 calculations are discussed in subsections 5.4.1 through 5.4.5.

5.4.1 Pension Plan Data - Census data developed from pension plans may be incomplete; i.e., may exclude participants with less than one year of service, may exclude participants under age 21, or may not include all retirees.

5.4.2 Dependents - Specific information on the dependents of current active participants is usually ignored in favor of an assumption on the probability of having dependents at retirement. Data on spouses of actives near retirement age, or spouses of recent retirees may be useful in developing assumptions as to dependents.

5.4.3 Retirees - For retirees and surviving spouses, it is usually important to know whether the retiree has a covered spouse, and, if available, the date of birth of the spouse. Dependent children are sometimes ignored in situations where retirees have very few dependent children, the cost of their benefits is small, or their period of coverage is short.

In plans with retiree contributions, it is important to know who has chosen to participate.

5.4.4 Specific Benefit Provisions - Additional demographic data may be needed because of specific benefit provisions. For example, benefits may depend upon service or salary at retirement or they may depend on the location. If the retiree has a choice of plans, it is important to know which plan the retiree has chosen, and what other choices the retiree has.

5.4.5 Adjustments - Consideration should be given to any demographic differences which may exist between the population which is the subject of the valuation and the population upon which the data are based. It may be necessary to adjust the data for these differences.

5.4.6 Counting Participants to Determine Effective Date - A later effective date is allowed for plans of employers that are nonpublic enterprises and that have no more than 500 plan participants in the aggregate (SFAS 106, par. 108). Note that the 500 threshold pertains to participants in the post-retirement benefit plan; it is not simply the sum of active employees plus current retirees. Consequently, a determination of the expected number of participants in the plan is required. The formula used for this determination is the second formula in subsection 5.10.2.

5.5 Claims Cost - A primary component of the calculations required by SFAS 106 is the employer's share of the assumed claims cost of providing postretirement benefits (SFAS 106, par. 35). Available historical claim information should be considered in developing the current claims cost (SFAS 106, par. 37). The current claims cost is trended to develop the assumed claims cost.

The objective of this section is to clarify terms and methodology for arriving at an assumed per capita claims cost.

5.5.1 Per Capita Claims Cost - Per capita claims cost equals the current annual gross eligible incurred charges per individual for postretirement benefits covered by the plan for each age from the youngest to the oldest at which plan participants are expected to receive benefits. In the development of current per capita claims cost, historical claims will usually be adjusted for the change in the level of gross eligible charges from the midpoint of the data period to the midpoint of the measurement period.

5.5.2 Health Care Cost Trend Rate - Current per capita claims cost should be trended for each future plan year on the basis of the health care cost trend rate. For a detailed discussion of trend see subsection 5.6.

5.5.3 Assumed Per Capita Claims Cost - The result of applying the health care cost trend rate to the per capita claims cost will generally be an assumed per capita claims cost for each age and each succeeding year in which retirees are expected to receive benefits.

5.5.4 Employer's Share of Assumed Per Capita Claims Cost - To determine the employer's share, the assumed per capita claims cost is reduced by (a) Medicare and other coordination-of-benefits provisions, (b) cost-sharing provisions (deductible, coinsurance, maximum benefit provisions), and (c) retiree contributions.

5.5.5 Factors Affecting the Calculation of Per Capita Claims Cost - In calculating per capita claims cost, the actuary should consider the following factors:

a. Different Types of Health Care Services - Per capita claims cost may be able to be subdivided into health care service areas which are expected to change at different rates over time or as participants become older (e.g. hospital, drug, or dental).

b. Retirees, Dependents, and Disabled Retirees - Per capita claims cost may be able to be calculated separately for retirees, dependents and disabled retirees (see subsection 5.5.7).

c. Other Demographic Factors - If appropriate data are available, costs may reflect other demographic factors, such as sex and geographic area.

d. Incurred Basis - Per capita claims cost should be on an incurred rather than a paid basis.

e. Plan Administration Expenses - These may either be included in the cost data or accounted for separately.

f. Credibility - In general, credible claims data, if available, from the specific group being valued should be the primary source of input for the per capita claims cost.

5.5.6 Aggregate Claims Data Conversion - When claims data, as described in subsection 5.5.1, are not available, aggregate paid claims data for retirees under age 65 and retirees aged 65 and older will often be available.

a. Matching Claims and Participant Data - On occasion the aggregate paid claims data may be provided by the health plan administrator and the participant data may be provided by the pension plan administrator. In these, as in other instances, it is important to match both data sources. Particular attention should be paid to health maintenance organization enrollees, surviving spouses, disabled participants, and retirees who have received a lump-sum pension benefit. Dependent claims by age should be allocated consistently to the retiree's or dependent's age (subsection 5.5.7).

b. Conversion to Per Capita Claims Cost - Paid claims should be converted to aggregate covered charges, taking into account the plan's cost-sharing provisions and Medicare. Care should be taken to include estimates of the charges for individuals who have not met the deductible (including both submitted charges and charges incurred but not submitted). Adjustment should be made for claims not reported as paid because of coverage under stop-loss arrangements. Claim reserves should also be reflected. The adjusted aggregate covered charges data can be converted to per capita claims cost by taking into account the numbers of participants.

c. Distribution By Age - Per capita claims cost may be distributed over each year of age (or age ranges) at which there are expected to be retirees, using a table of aging factors which reflects the differences in health care costs at different retiree ages. It is necessary to use at least two cells: participants under age 65 and 65 and older.

d. Reconciliation - As a check, the sum of the costs developed at each age, multiplied by the number of retirees and dependents at those ages, should equal the expected aggregate cost for retirees under age 65 and aged 65 and older for the time period used. Judgment should be used when the data contain abnormal fluctuations or are not fully credible.

5.5.7 Dependent Per Capita Claims Cost - The actuary should consider the following methods to develop dependent per capita claims cost:

a. Direct Cost Development - Sometimes, claims data and demographic data containing the age and possibly the sex of each covered dependent are available. Dependent per capita claims cost can then be developed in a manner similar to that of retirees.

b. Prorating of Claims - This method can be used when there are no demographic data for dependents or when dependent claims are included in retiree claims data. A pro rata share of dependent health care claim costs can be included in the average claim cost for each retiree. It should be noted that retirees under age 65 can have spouses over age 65 and vice versa. If the proportion of surviving spouses is expected to change, this should be taken into account.

c. Ratio of Census - This method can be used when dependent claims are known but dependent demographic data are not known. The actuary can estimate a dependent census using the ratio of numbers of dependents to number of retirees and an appropriate age set-back/-forward. Dependent per capita claims cost can then be developed in a manner similar to that of retirees.

d. Other Considerations - In some instances, it is appropriate to ignore dependent children due to low frequency, short expected future dependency periods, data limitations, or expenses which have been considered elsewhere. Special consideration should be given to disabled dependent children who continue coverage beyond the normal dependent child termination date.

If benefits for surviving spouses are not lifetime benefits this fact should be taken into account.

5.5.8 Stochastic Development of Claims Cost - The methodology discussed in subsection 5.5.1 is a deterministic approach in which the valuation uses a projected average claim in each year of the projection period.

A stochastic (or probabilistic) method provides recognition of how variations in claim size (and other factors) can affect the claims cost developed for each future projection year. The actuary should make assumptions about or develop claim occurrence frequencies and distributions of claims by size (a claim continuance table). The underlying claim occurrence frequencies and distributions by size are derived by analysis of the employer's own experience or the experience of similar groups. A Monte Carlo method is then used with the claim frequencies and size distributions to simulate total claims for each year of the projection period.

5.5.9 Data Not Available or Not Credible - Alternative methods may be appropriate when actual retiree cost data are not available or not credible, or when participant data are limited. In these instances, experience of similar retiree groups (considering demographics, industry and location), aging of claims from the active group or retiree premiums may be appropriate.

Underwriting techniques may be used to determine current annual per capita claims cost or annual premiums by age for the specific or similar population and plan being valued. It is not necessary for the group to be insured at these rates; the purpose is rather to allocate current costs to a stand-alone retiree population without subsidy from active employees.

SFAS 106, par. 41, allows the use of an incurred claims cost as long as the actuary can show that the results remain the best estimate of future costs (subsection 5.6.1).

The methods and assumptions used should be appropriate to the situation and should be disclosed.

5.5.10 Active Employee Premium Not Generally Appropriate For Early Retirees - If conventional premiums are used as a substitute for claims data, care should be taken to make certain that the data used are reasonable and appropriate to the situation. For example, some insurance companies or employers include retirees under age 65 in their active employee data base. In these instances, it would be inappropriate to use the composite average premium payable for active and retired employees under age 65 as an estimate of the claim costs for retirees under age 65. The differences in average ages of active employees and retirees under age 65 as well as differences in claim costs at the same age (since poor health may be a cause of retirement before age 65) may cause retiree claim costs to be significantly higher than average active employee claim costs. However, in some circumstances, it may be appropriate to use composite premium for a community-rated HMO or Blue Cross/Blue Shield Plan. When health care coverage is combined with other coverages, premiums should be adjusted to the level appropriate for a plan that covers retirees only.

5.5.11 "Retiree-Pay-All" Benefits - SFAS 106 only applies to plans with employer contributions. However, an experience-rated plan in which retirees under age 65 pay the active employee rate would not be considered "retiree-pay-all" since the rate might not cover the full cost of the early retirement benefits.

5.5.12 Changes in Plan Election Pattern - Changes in the retiree health care election pattern should be considered. Many employers are modifying their plans to increase employee

contributions and restrict eligibility. Future retirees may have different election patterns than current retirees. In particular, the prevalence of dependent spouse coverage may decline because of dual wage earners, other demographic changes, higher dependent cost, etc.

Changes in plan election patterns and in the plan delivery system should be considered in calculating claim costs. These include the recent introduction of managed care, HMOs, preferred provider organizations (PPOs), and other cost management programs. Future retirees may be more likely to elect HMOs or PPOs because of wider availability and greater acceptance.

5.6 Health Care Cost Trend Rate - A valuation of postretirement health care benefits requires a projection of claims cost into the future. In order to project claims cost, it is necessary to predict both incurred expenses and separately, the impact of specific plan provisions such as deductibles and copayments. Current per capita claims cost (i.e., gross eligible charges) should be projected based on explicit trend assumptions relative to the circumstances of the employer and the plan. This assumption is called the health care cost trend rate (HCCTR).

5.6.1 Defining the Trend Rate - In the context of SFAS 106, the HCCTR has been given a very narrow definition (SFAS 106, p. 198). This definition is not directly comparable to "medical trend" as customarily understood in the health and welfare benefit community, since HCCTR is the increase in gross eligible charges, while "medical trend" commonly refers to the expected increase in incurred claims. Specifically, there are three major differences. First, medical trend customarily covers only a one- or two-year period for rating or budgeting purposes, whereas HCCTR is a long-term economic assumption. Second, medical trend is usually defined on a global basis (i.e., actives and retirees together). Third, medical trend frequently contains elements not included within the definition of HCCTR, such as:

a. leveraging due to cost-sharing features of the plan such as deductibles and out-of-pocket limits,

b. changes in the demographics of the covered population with respect to age or family status,

c. adverse selection due to flexible benefits election, COBRA, HMOs, etc.;

d. recoupment of prior losses,

e. federal- or state-mandated benefits, and

f. margin for fluctuations, both implicit and explicit.

Although changes in costs due to these other factors are not included in the HCCTR, some of these factors should be recognized separately for valuation purposes.

For these reasons, an employer's best estimate of the HCCTR for SFAS 106 calculations might bear little resemblance to the increase in aggregate costs predicted by its insurer.

5.6.2 Leveraging - In projecting postretirement health care claims cost, the actuary should reflect the effect of various plan provisions on the year-to-year pattern of employer-provided benefits. For example, fixed-dollar deductibles will leverage an employer's cost faster than the assumed health care cost trend rate. The example in the Appendix, A5.6.2, illustrates different types and effects of leveraging.

Though leveraging from fixed-dollar cost sharing provisions inflates an employer's costs, this is not included as a part of the HCCTR. The SFAS 106 definition restricts the HCCTR to an economic assumption largely outside the employer's control. Plan provisions are presumably within an employer's control and their effect is measured independently. However, the plan's cost-sharing provisions can have an impact on the HCCTR because of their effect on utilization of health care services.

5.6.3 Medicare - Claims cost for retirees eligible for Medicare are extremely sensitive to both the absolute value and the relative change in Medicare reimbursements. The manner in which Medicare payments are recognized is also significant (see Appendix, A5.3.1, for a description of the various methods).

The HCCTR is defined as the rise in gross eligible charges before Medicare reimbursement. Erosion or increase in relative Medicare reimbursements can leverage incurred claims costs faster or slower than the underlying HCCTR However, SFAS 106, par. 40, requires that any assumptions as to future Medicare reimbursement levels be based solely upon current law.

Notwithstanding the above, some indirect effects of Medicare are actually included within the definition of HCCTR. Medicare cost-shifting occurs when providers are forced to accept artificially low reimbursement from Medicare. This shortfall has historically been offset by increases in unit prices to the non-Medicare population. These price increases are a component of the HCCTR even for ages prior to Medicare eligibility.

Recognizing the different practice patterns, pricing structures and weighting by type of service, the actuary may wish to consider different HCCTRs for the Medicare and non-Medicare populations.

5.6.4 GNP Constraint - In selecting the HCCTR, the actuary should recognize that current HCCTRs are quite high. However, it is not usually appropriate to assume that these short-term rates could be sustained indefinitely. Ultimately, the growth in health care expenditures will be constrained by the nation's ability to afford ever-increasing health care costs.

The actuary should recognize that national health costs as measured by the national health expenditure (NHE) index cannot indefinitely exceed the rate of growth of other economic sectors. Hence, NHE cannot continually consume an ever-increasing portion of the gross national product (GNP). This limitation will usually lead to the choice of select and ultimate HCCTRs (subsection 5.6.5).

The actuary should be aware that health care costs that are under the scope of SFAS 106 are only one segment of total NHE. The HCCTR assumption for one particular employer (or group of employers) is unlikely to match the assumed rate of growth of health care costs in the nation as a whole (i.e., NHE).

5.6.5 Select and Ultimate - In most situations, the actuary will choose a select and ultimate HCCTR (a rate that varies year to year). Occasionally, it may be appropriate to use a weighted level average HCCTR for all projection years. If choosing this method, the actuary should:

a. be prepared to demonstrate that the weighted average HCCTR produces results that are not materially different from the select and ultimate method.

b. recognize that the APBO by class (i.e., retirees, actives eligible to retire, and other employees) may be distorted even though the total APBO is appropriate. This shortcoming can be overcome by choosing a different level HCCTR for each class.

5.6.6 Type of Service - Health care costs change at different rates for different types of health care services (e.g., hospital, physicians' services, drugs, dental). In the selection of the HCCTR the actuary should consider the various types of health care services that are actually covered under the plan being measured as well as their relative weights within that plan. Separate claims costs (with separate HCCTRs) by type of service can be used, or more commonly, an aggregate claims cost can be used with a blended HCCTR across all types of services.

5.6.7 Incurred Claims Cost - SFAS 106, par. 41, allows the use of the incurred claims cost. In this context, the term "incurred" is used to distinguish net claims payable by the

plan from gross claims. Under this method, the actuary would use an explicit adjustment to the HCCTR to account for the leveraging effect of the plan features. The actuary could project the incurred claims cost directly by adding an appropriate adjustment (6.0% in the leveraging example in Appendix, A5.6.2, line 6) to the first year HCCTR and by projecting retiree contributions separately. The adjustment would be derived by modeling future claim patterns and would usually vary by duration.

Usually, the actuary should not simply apply the HCCTR directly to the net incurred claims cost (Appendix, A5.6.2, line 8). This would implicitly assume that all plan provisions (including Medicare reimbursements and retiree contributions) are automatically indexed with the HCCTR (SFAS 106, par. 41).

5.6.8 Sensitivity - SFAS 106 requires employers to disclose the effects of a one percentage point increase in the HCCTR on the APBO and the sum of the service and interest costs. For example, if obligations are being measured with an HCCTR starting at 14% and grading down to 7%, the sensitivity test would be performed with a revised HCCTR of 15% grading down to 8%.

When computing the effects of the sensitivity test, the discount rate and all other independent assumptions are to be held constant. Certain other assumptions such as retiree contributions and leveraging loads under SFAS 106, par. 41, may be directly dependent on future cost levels. In particular, leveraging would ordinarily be higher, given higher trend rates. These assumptions should be adjusted accordingly to remain consistent with the higher projected cost levels.

5.7 Actuarial Assumptions Other than HCCTR - Determination of postretirement benefit costs requires the use of various actuarial assumptions. See ASOP No. 6, subsection 5.5, for a detailed discussion, and Appendix, A5.7, for a general discussion.

5.7.1 Consistency with SFAS 87 - Both SFAS 87 and SFAS 106 require the employer to select explicit assumptions such that each assumption represents the employer's best estimate solely with respect to that assumption. This seems to imply that the assumptions should be the same for a given group of employees for measurement of their pension and postretirement obligations. However, the assumptions used for SFAS 87 are not a safe harbor for SFAS 106 purposes. A critical review should be made of each significant assumption used for SFAS 87 to determine if it is appropriate for SFAS 106 purposes. Internal consistency of actuarial assumptions is an important step in the valuation process. Nevertheless, there may be reasons for using different assumptions. Two examples follow:

a. Certain assumptions are material for one purpose but not the other (e.g., a complex salary scale for pensions can be simplified for measuring a modest postretirement life insurance plan).

b. Certain assumptions might be weighted by salary to produce accurate SFAS 87 liabilities, but the weighting would need to be modified to measure SFAS 106 liabilities.

5.7.2 Explicit Assumptions - The requirement to use explicit assumptions (SFAS 106, par. 29) means that one assumption should not be intentionally used to subsidize another, e.g., setting both the discount rate and the HCCTR below expected levels. SFAS 106 also requires the use of "best estimates." However, nothing requires that each assumption explicitly account for each potential variable; for example, the turnover assumption need not vary by age, sex, service, salary, etc. The assumptions used should be at a level of complexity consistent with the materiality of the assumption, the reliability and credibility of the data, and the size of the group. Assumption of a single retirement age could be appropriate for valuing a pension plan having full actuarial reduction at early retirement, while retirement decrements by age are more likely to be appropriate for valuing a postretirement health care plan providing essentially full benefits at early retirement.

5.7.3 Discount Rate - The discount rate is determined using rates of return on currently available high-quality fixed-income investments whose cash flows match the timing and amount of expected benefit payments (SFAS 106, par. 31). This rate is independent of the funded status of the plan and the cost of capital to the plan sponsor. The heavier weighting of postretirement health care liabilities toward longer durations may result in higher discount rates relative to pension plans, if the yield curve is positive.

5.7.4 Return on Plan Assets - The assumed return on assets is the long-term rate assumed to be earned on plan assets and contributions expected to be made during the valuation period (SFAS 106, par. 32). Determination of an appropriate rate would reflect rates of return on current assets as well as reinvestment, and is similar to the same rate determination for a pension plan. Any taxes paid by the fund, e.g., in a taxable VEBA for postretirement health care benefits, should be netted against the expected return on assets. If taxes are paid by the sponsor, the gross return is used in calculating accrual cost. (SFAS 106, par. 32)

An unfunded plan requires no assumption for return on assets.

5.8 Attribution - Attribution is the process of assigning the expected cost of benefits to periods of employee service.

5.8.1 Attribution Period - The attribution period is the period of service over which the individual's costs are allocated.

a. Beginning - The attribution period begins on the date the employee is hired, unless the plan's provisions indicate that a later date should be used. Such a later date usually is the date on which credited service begins, except when the credited service period is nominal in relation to the employment period (SFAS 106, par. 44).

b. Ending - The attribution period ends on the full eligibility date. Note that the determination of the full eligibility date is not always apparent (SFAS 106, par. 21).

5.8.2 Annual Recognition - The portion of the EPBO attributed to a particular year within the attribution period is generally equal to the EPBO divided by the number of years in the attribution period. However, some plans have a benefit formula which attributes a larger portion of the benefit to early years of service than to later years. For such plans the benefit formula is used for attribution (SFAS 106, par. 43).

5.8.3 Examples - Attribution examples are given in the Appendix, A5.8.3, and in SFAS 106, par. 412.

5.9 Plan Assets - Advance funding of postretirement benefit plans was not a common practice at the time this guideline was written. Few plans would have a significant amount of assets. Consideration needs to be given to whether or not assets exist, and if so, how they should be valued.

5.9.1 Current Assets - To qualify as an asset for SFAS 106 purposes, an asset must be segregated and its use restricted to providing postretirement benefits (SFAS 106, par. 63, 64). Possible assets may be in an IRC 501(c)(9) trust, or in a pension plan under IRC 401(h), or in insurance contracts (SFAS 106, par. 67-71). The actuary should also consider the possibility that assets for postretirement benefits may have been accumulated as claim stabilization reserves, retired lives reserves, waiver of premium reserves, or long-term disability reserves.

5.9.2 Measurement of Assets - For cost purposes, a market-related [actuarial] value of plan assets is permitted (SFAS 106, par. 57). The market-related value can be fair (market) value or a formula amount. If a formula is used, spreading of changes in fair value is to be over not more than 5 years. A corridor could be used to assure that the market-related value remains reasonably related to fair value. The formula must treat positive and negative fluctuations in a parallel manner.

5.9.3 Use of Market-Related Value for First Year's Cost - Certain complications arise when a value other than fair value is used for the first year's postretirement benefit cost determination. This is because the net obligation (asset) at transition must be based on fair value. As the initial difference gets reflected in future years' market-related values, the portion related to this initial difference will require separate treatment. Specifically, the cumulative unrecognized net gain or loss subject to amortization (subsection 5.11.7) has to be decreased or increased by the portion of the initial excess of market-related value over fair value which is not yet reflected in fair value. Note that this requires the actuary to be able to determine at any time how much of the initial difference has been reflected in the then current market-related value. If the formula does not treat each year's asset fluctuation separately, it may be necessary to make an arbitrary allocation (e.g., if the initial difference were $100, then $20 of the total adjustment in each of the next five years could be assumed to be on account of the initial difference). Once the entire initial difference is assumed to have been reflected, no further special adjustments are necessary.

5.10 Amortization - The method of determining the amortization payment is different from standard actuarial practice. Amortization amounts are not mortgage-type payments and no compound interest factors are involved. Instead, the calculation involves a separate determination of the interest and principal components. The interest component is part of interest cost (subsection 5.11.2). Amortization of principal is generally over the remaining service period of those expected to receive benefits. Each year's principal amount is equal to that year's amortization fraction applied to the total to be amortized. Note that the length of the period over which a particular obligation is to be amortized may differ, depending on the source of the obligation or the plan sponsor's election to defer or not.

Source of Obligation	Average Expected Service	Immediate Recognition Allowed?	Reference
Gains or losses	to expected retirement date	yes	5.11.8
Net transition asset or obligation	to expected retirement date[4]	yes	5.11.10
Prior service cost	to full eligibility date	no	5.11.12

[4] If less than 20 years, may use 20 years.

5.10.1 Projected Future Period of Service of Those Active Employees Expected to Receive Benefits (SFAS 106, pars. 51-52) - In order to compute SFAS 106 principal amortization payments, it is necessary to compute the projected future years of service at the applicable date for each plan participant. Since contingencies are involved in determining possible death, termination, etc., it is possible that only a fraction of an employee will be counted. The service period is either to the full eligibility date or to the expected retirement date, depending on the source of the obligation to be amortized.

a. Amortization of Gains or Losses or the Net Transition Obligation or Asset - The amortization period is to the expected retirement date. An employee is counted only if the employee is expected to receive a benefit. The count added to each year from the beginning of the applicable period to the expected retirement date is only for that fraction of the employee expected to reach that retirement date. No count is added for employees who terminate (in whole or in a fraction thereof) before reaching the expected retirement date.

b. Amortization of Prior Service Cost - The amortization period is to the full eligibility date. An employee is counted only if the employee reaches the full eligibility date and is expected to receive a benefit. The count added to each year from the beginning of the applicable period to the full eligibility date is only for that fraction of the employee expected to reach the full eligibility date with continued survival to the expected retirement date. No count is added for employees who will terminate (in whole or in a fraction thereof) before reaching the expected retirement date, even if the employee reached the full eligibility date.

5.10.2 Calculations - For a particular employee, the expected future service will be the difference between either the full eligibility age or the retirement age and the attained age only if there are no preretirement decrements. Expected future service will be the present value of a unit per year of future service at a zero interest rate only if there are benefits payable for all decrements at all durations. Otherwise, the computation for a particular employee is:

$$\sum_{t=0}^{u-x-1} \left\{ \sum_{s=1}^{r-x-1} \left[{}_sp^{(T)}_x \sum_d q^{(d)}_{x+s} \quad E^{(d)}_{x+s} \right] \right\}$$

for all decrements $d^{[5]}$, where:

x = attained age

r = the age when the probability of retirement is 1

u = the ending date for counting service, i.e., either the full eligibility age (for amortizing prior service) or r (for amortizing transition items or experience differences)

$E^{(d)}_{x+s}$ = 1, if a positive employer-provided benefit is projected to be payable based on termination of employment by decrement d at age $x+s$. $E^{(d)}_{x+s} = 0$, otherwise.

If decreasing amortization over the entire working lifetime is contemplated (subsection 5.11.12), subtotals are required for each value of t.

If level amortization over the average future years of service is contemplated (subsections 5.11.8, 5.11.10, and 5.11.12), it is also necessary to compute the total number of employees expected to receive benefits. Each employee's contribution to the total is computed for all decrements $d^{[5]}$ as:

$$\sum_{t=0}^{r-x-1} \left\{ \sum_d {}_tp^{(T)}_x \quad q^{(d)}_{x+t} \quad E^{(d)}_{x+t} \right\}$$

Notes: 1. All employees who have reached r are excluded from the count.

5 Modifications to the formulas in subsection 5.10.2 are appropriate to reflect the time during the year when the decrement is assumed to occur.

2. For prior service amortization, all employees who have reached the full eligibility age are excluded from the count.

Approximations will generally be satisfactory, especially where the decrements for which benefits are or are not payable are very small.

5.10.3 Regular Plan Amendment Patterns - A history of regular plan amendments may indicate a period of economic benefit shorter than the period to full eligibility of the active participants (SFAS 106, par. 54). The existence of such a history does not necessarily imply that a shorter period is required. If, however, the employer determines that the period of economic benefit is shorter, then a more rapid amortization period will have to be used. There may also be substantive commitments to make future amendments (SFAS 106, par. 26). If the employer reports that such commitments exist, the calculations should reflect the commitment.

5.11 Actuarial Calculations for Determining Reported Net Periodic Postretirement Benefit Cost - In this subsection the more common method of determining the NPPBC will be discussed. Less common circumstances to be considered in the development of the NPPBC are:

a. temporary deviations from the substantive plan (subsection 5.3.2)

b. settlements, curtailments, and special termination benefits (subsection 5.13)

c. the pay-as-you-go constraint (SFAS 106, par. 112)

Usually, the NPPBC consists of the following elements (SFAS 106, par. 46):

- Service cost
- Interest on the accumulated postretirement benefit obligation, service cost, and distributions
- Actual return on plan assets
- Amortization of unrecognized prior service cost, if any
- Gain or loss, to the extent recognized
- Amortization of unrecognized net obligation or asset at transition

The NPPBC is computed at the beginning of the measurement period according to one formula, but it is disclosed at the end of the

measurement period using a different formula which produces the same numerical result. There may be more than one measurement in a year--for example, because of a plan change the NPPBC for the balance of the year following an interim measurement should reflect the values determined as of that point in time. However, the gains or losses arising at interim measurement dates are not used for determining the minimum amortization for the year.

Computation at beginning of year	Disclosure at end of year
[a] Service cost	[a] Service cost
[b] + interest cost	[b] + interest cost
[c] - expected return on market-related value of assets	[e] - actual return on fair value of assets
	[f] +(-) gain (loss) from expected return on assets during year
[d] +(-) principal amortization payments on net obligation (asset) at transition, unrecognized prior service cost, (unrecognized negative prior service cost), and unrecognized net loss (gain)	[d] +(-) principal amortization payments on net obligation (asset) at transition, unrecognized prior service cost, (unrecognized negative prior service cost), and unrecognized net loss (gain)

The reported NPPBC is the same computed either way (and may be positive or negative). The first way permits the total to be determined relatively early in the year; the second way is the "final" allocation which is the way SFAS 106 requires postretirement benefit cost components to be disclosed. In disclosing the results, items [d] and [f] are combined and called "net amortization and deferral."

5.11.1 Service Cost - Service cost is calculated on a per individual basis. Each year's service cost is computed as of the end of the prior fiscal year. It is the EPBO divided by the attribution period for those who have not reached the full eligibility date (SFAS 106, par. 47). Interest on the service cost for some or all of the measurement period may be included as part of the service cost.

5.11.2 Interest Cost - The discount rate as of the beginning of the measurement period, applied to the APBO at that time and the service cost and expected distributions for the period, produces the interest cost for the year (SFAS 106, par. 48). The calculations should reflect appropriate fractions of a year for amounts which are not as of the start of the measurement period. In particular, interest on the service cost must be included in the interest cost to the extent that it has not been included in the service cost.

5.11.3 Expected Return on Market-Related Value of Plan Assets - A reduction in plan costs for expected investment return is determined by applying the expected rate of return on plan assets as of the measurement date to the market-related value at the beginning of the period and to the expected contributions less distributions for the year, with appropriate fractional adjustment (SFAS 106, par. 57).

5.11.4 Actual Return on Fair Value of Plan Assets (SFAS 106, par. 49) - At the end of the measurement period, the actual return on plan assets is determined based on beginning and ending fair values, as:

> Ending fair value minus beginning fair value minus contributions plus distributions.

Once this amount is calculated, a gain or loss from return on assets is determined as:

> Actual return on fair value of plan assets minus expected return on market-related value of plan assets.

Both the actual and expected returns should reflect the tax expense or benefit (SFAS 106, par. 49).

5.11.5 Computation of Current Gain or Loss (SFAS 106, pars. 56-58) - Each year an expected year-end APBO is computed as the beginning APBO plus service cost (subsection 5.11.1) plus interest cost (subsection 5.11.2) minus expected distributions plus or minus adjustments to the APBO on account of changes in prior service cost (subsection 5.11.12) or due to events accounted for under the rules for settlements and curtailments (subsection 5.13). An expected year-end fair value of assets is computed as the starting fair value plus the expected return on market-related value (subsection 5.11.3) plus actual contributions less expected distributions. The difference can be thought of as the expected unfunded APBO. The difference between that amount and the actual unfunded APBO (year-end APBO less year-end fair value) is the gain or loss for the year, and any required amortization will first be reflected in the following year's cost. Note that any change in the APBO due to changes in the discount rate or other assumptions becomes part of the computed gain or loss.

5.11.6 Cumulative Unrecognized Gain or Loss (SFAS 106, par. 59) - Each year, the previous cumulative unrecognized gain or loss is increased by the current gain or loss and decreased by any amortization of principal (subsection 5.11.8). No interest adjustments are made in this process, since they are included in the interest cost (subsection 5.11.2).

5.11.7 Gain or Loss Subject to Amortization (SFAS 106, par. 58) - Only a portion of the cumulative unrecognized gain or loss computed under subsection 5.11.6 is subject to being amortized. The excess of fair value over market-related value must be subtracted from the cumulative unrecognized gain or loss to get the amortizable amount. Gains or losses arising from a temporary deviation from the substantive plan are to be recognized immediately (subsection 5.3.2).

5.11.8 Amortization of Gains or Losses (SFAS 106, pars. 59-60) - A method should be chosen to amortize the unrecognized gain or loss subject to amortization (subsection 5.11.7). The method should fulfill three requirements:

a. gains and losses should be treated in a parallel manner

b. the smallest total amount to be amortized is the excess of the cumulative unrecognized amount over 10% of the greater of the APBO and the market value of the assets, and

c. the amount amortized annually is at least the total to be amortized divided by the average expected future service to expected retirement age of then present employees expected to receive benefits (or the average remaining life expectancy for plans where all or almost all of the participants are inactive).

The cumulative unrecognized amount, the 10% test, the average expected future service, and the minimum amount to be recognized are recomputed each year and are independent of prior years' amounts, so that it is possible to have amortization in one year but not in the following one.

5.11.9 Net Obligation or Asset at Transition (SFAS 106, par. 110) - The net obligation (asset) at transition (i.e., at the initial application of SFAS 106) is computed as the difference between (a) the APBO and (b) the asset value, where the asset value is the fair value of plan assets plus any accrued postretirement benefits liability or less any prepaid postretirement benefits cost in the employer's balance sheet. An excess of (a) over (b) results in a net obligation; an excess of (b) over (a) results in a net asset at transition. Employer contributions receivable by the plan are

excluded from plan assets since they are included in the employer's balance sheet accrual. Note that if immediate recognition is elected, the effect of certain plan changes adopted after December 21, 1990 may have to be excluded from the transition obligation (SFAS 106, par. 111).

5.11.10 Amortization of Net Obligation or Asset at Transition (SFAS 106, par. 112) - If delayed recognition is elected, the net transition amount is amortized in equal installments of principal, generally over the average future service to expected retirement age of those who, as of the date of transition, are expected to receive benefits (subsection 5.10.1). If this period is less than 20 years, it is permissible to elect to use a 20-year period instead. Where all or almost all of a plan's participants are inactive, an average remaining life expectancy should be used (SFAS 106, par. 112).

5.11.11 Prior Service Cost (SFAS 106, pars. 50 and 51) - Since the initial unfunded actuarial accrued liability, as adjusted for accruals, is the net obligation (asset) at transition, and since all experience variations and assumption changes are treated as losses or gains (SFAS 106, par. 56), prior service cost consists solely of increases (decreases) in the APBO due to plan changes subsequent to transition. Prior service costs should be adjusted when the commitment to make the changes is made, even if in midyear. Bargained, adopted, or publicly announced future plan changes should be included, even if they have effective dates deferred beyond the end of the current year or are not yet in the plan. Each NPPBC component reflects a proration for the fraction of a year remaining after the commitment to change (subsection 5.11).

5.11.12 Amortization of Prior Service Cost (SFAS 106, par. 52-53) - Whenever benefits for prior service are improved, a prior service cost is computed (subsection 5.11.11). Immediate recognition of an increase is not allowed. However, if a plan amendment results in a decrease, the reduction should apply first to unrecognized prior service costs, and then to unrecognized transition obligations. An amortization program for the principal amount required to be amortized is established at the time the commitment is made. The amortization period for an amendment is the expected future service to full eligibility date of all employees expected to receive benefits, not just those who benefit from the amendment. Each year's minimum amortization amount is a percentage of the prior service cost arising from the amendment. The percentage for the year is derived from the ratio of the expected future service to be worked in that year to the expected future service to be worked in all years from the date of amendment. Each year's minimum amortization is based on the percentage of the projected future service to full eligibility of employees expected to receive benefits (subsection 5.10.1) which is projected to be worked in that year. Equal installments over the average projected future working lifetime to full eligibility date of those expected to receive benefits is allowable.

The entire amortization program is established at the time the commitment is made. Thereafter, it is only changed if a subsequent amendment reduces the APBO (in which case the change in APBO is used to reduce any existing unrecognized prior service cost) (SFAS 106, par. 55), or if a plan curtailment occurs (SFAS 106, par. 96-97), or if facts and circumstances lead the employer to conclude that the expected period of economic benefit should be shortened.

5.11.13 Projections - Typically, participant information needed as of the measurement date will not be available until some time later. Therefore, in the absence of significant changes, the actuary may be working with a projection from a prior calculation while using current economic assumptions and assets. The projections can be done by one of a number of procedures. The actuary's goal is to minimize the difference between the projection and an actual calculation. Either the data or the present values may be projected. Possible procedures include:

a. Assume no change (i.e., a stationary population);

b. Assume a one-year increase in age and service, with or without new entrants;

c. Assume expected experience, with or without new entrants.

The choice of method will depend on the facts and circumstances of each particular case. However it is done, the projection must give a result appropriate to the measurement date. Thus, for example, adjustments to the projection process may be required where there has been a significant change during the year.

5.12 Actuarial Calculations for Disclosure and Balance Sheet Items - SFAS 106 requires that employers disclose certain other actuarial information in addition to the NPPBC and its components (SFAS 106, par. 76). Much of this information is produced as a by-product of the cost determination (subsection 5.11). This section focuses on additional actuarial calculations beyond those used for calculating the cost items.

5.12.1 Measurement Date (SFAS 106, par. 72) - The "as of" date for determining disclosure information will most often be the employer's financial statement date. This date (called the measurement date) can also be any date within the

three months prior to the employer's financial statement date. Assumptions and asset values used are those as of the measurement date. The results may reflect projections based on prior demographic data if the result is a reasonable reflection of the present values as of the measurement date.

5.12.2 Accumulated Postretirement Benefit Obligation - The APBO as of the measurement date for disclosure purposes will usually be the expected APBO derived from the beginning-of-the-year APBO. The expected APBO should reflect plan and assumption changes, as appropriate.

5.12.3 Effect of 1% Increase in HCCTR - The effect on the APBO and certain cost information of a 1% increase in the HCCTR should be disclosed. See subsection 5.6.8 for a discussion of the calculations.

5.13 Settlements, Curtailments, and Special Termination Benefits - SFAS 106 requires special computations whenever a settlement or curtailment occurs and when any special termination benefits are payable (SFAS 106, par. 90-103). These events generally require special calculations to determine the effect in the income statement for the accounting period in which the event occurred. Costs or credits which might otherwise be deferred for an ongoing plan may be recognized earlier. The actual date of recognition will depend on the specific event, and whether the earnings impact is a charge or a credit. The special calculations may require the following three steps:

a. update valuation results as of the date of the event, as if the event had not taken place;

b. determine costs or credits associated with the event, and

c. revise valuation results also as of the date of the event, fully reflecting the changes resulting from the event.

5.13.1 Updated Valuation - As of the date of the event, an updated valuation should be performed as if this date were a measurement date. No changes associated with the event should be reflected. This valuation is to be based on data and assumptions appropriate for the time at which the calculations are being performed.

5.13.2 Items Associated with the Event - To determine the costs of the event, various actuarial present values will be calculated. The actuarial present values will typically be of benefits before and after the event. In addition, the event may result in accelerated recognition of certain unrecognized items. This accelerated recognition may generate a need to make a new determination of the expected years of future service after the event.

5.13.3 Settlements - These events are typically permanent reductions in plan obligations resulting from a transfer of the obligation to an entity outside the control of the plan sponsor. This is normally done by the purchase of an insurance contract to provide all or a portion of the postretirement benefits. Another example would be when the plan sponsor cancels the postretirement benefit plan for a group of employees or participants, either with or without a payment to the participants whose plan was canceled. An arrangement whereby the monthly pension is increased in return for elimination of the postretirement benefit obligation could constitute a settlement of that obligation, since the postretirement health plan has been relieved of primary responsibility for health benefit obligations (SFAS 106, par. 90). The accounting for this event could be a settlement for the postretirement health plan and a plan amendment for the pension plan.

5.13.4 Curtailments - When a covered event occurs which unexpectedly alters either the remaining deferred cost or the expected working lifetime, curtailment calculations are required. Curtailments are an issue because ongoing plan costs often include an element of deferred costs for which the annual charge was determined reflecting the average expected working lifetime of the employee group at the time the deferred cost was established.

It is possible for the postretirement benefits plan to experience a large reduction in the number of plan participants without causing a curtailment of the plan. This would occur if the reduction in number of plan participants were solely among employees who had already reached the earliest eligibility date; there is no expected future service for this group. Thus, a pension plan open window could result in termination benefits and curtailment accounting in the pension plan, without necessarily triggering such accounting in the postretirement benefits plan. If curtailment accounting is not required, gains or losses will be recognized at the time of the next regular valuation.

5.13.5 Special Termination Benefits - These benefits result from the acceptance of offers of enhanced postretirement benefits by active employees in exchange for retirement within a window period, or from an event, such as a plant closing, which triggers contractual benefits. The liability should be recognized when the offer is accepted (SFAS 106, par. 101). Costs for these benefits are given special treatment because they are not routine benefits of an ongoing plan. Examples include reduced retiree contributions, reduced deductibles and copayments in postretirement health benefits, or earlier eligibility.

5.13.6 Multiple Events - Calculations for settlements, curtailments, and special termination benefits are not mutually exclusive. Depending on the situation, any or all of the special calculations may be required, and the order in which they are performed can affect the results. Generally the calculation order should proceed chronologically. Calculation of special termination benefits, however, should never precede curtailment calculations. If a settlement and curtailment occur simultaneously, the order of required calculations can be selected arbitrarily, but once the order is selected with respect to a plan, that order should be followed for similar situations.

5.13.7 Settlement Accounting - The maximum gain or loss subject to recognition is the unrecognized net gain or loss at settlement, including items in the updated valuation before settlement, combined with any remaining unrecognized transition asset. The gain or loss due to remeasurement would reflect the actual impact of the settlement.

> Notes: (a) an unrecognized transition obligation is not included in the above calculations; (b) the amount of the asset transferred does not affect the amount of the settlement gain or loss.

The actual amount of settlement gain or loss to be recognized equals the maximum gain or loss, determined above, multiplied by the proportion of plan APBO settled. If this result is a gain, it is reduced by any unrecognized transition obligation, and the excess is recognized as a gain.

5.13.8 Curtailment Accounting - A flowchart for curtailment accounting is contained in Appendix, A5.13.8. A curtailment of future service will affect plans covered by SFAS 106 differently than it will affect pension plans under SFAS 88 if the earliest date of eligibility under SFAS 106 differs from the expected retirement date under the pension plan, and future service calculations will differ.

5.13.9 Termination Accounting - The loss on account of special termination benefits is equal to (a) the APBO including special termination benefits, minus (b) the APBO for the same participants determined as if they had terminated at the same time without special termination benefits. An example of these calculations is given in the Appendix, A5.13.9.

Section 6. Communications and Disclosures

6.1 Disclosure of Purpose - The actuarial communication for purposes of SFAS 106 should be identified as such, and should disclose that the

results of calculations performed for other purposes (e.g., plan reporting, government requirements, etc.) may differ significantly from the results for purposes of SFAS 106.

6.2 Disclosure of Exceptions - The actuarial communication should disclose any basis of calculations which is inconsistent with the actuary's understanding of the basis prescribed by SFAS 106.

6.3 Sample Disclosure - In the absence of exceptions or other special circumstances, the following sample disclosure is appropriate:

> Actuarial computations under Statement of Financial Accounting Standards No. 106 (SFAS 106) are for purposes of fulfilling certain employer accounting requirements. The calculations reported herein have been made on a basis consistent with our understanding of SFAS 106. Determinations for purposes other than meeting the employer financial accounting requirements of SFAS 106 may differ significantly from the results reported herein.

6.4 Deviation from Guideline - An actuary who uses a procedure which differs from this guideline must include, in any actuarial communication disclosing the result of the procedure, an appropriate and explicit statement with respect to the nature, rationale, and effect of such use.

Supplementary Notes and Discussion

(Paragraph numbering corresponds to subsections in the text of the standard, with the addition of "A")

A5.3 Plan Provisions/Benefits to Be Valued - The types of benefits to be valued are mainly health care and life insurance. The main purpose of this subsection is to provide background for actuaries whose experience has mainly been in pension work. Since the information provided here is brief and necessarily incomplete, an actuary new to this field should not rely on the compliance guideline alone, but should work closely with an actuary with appropriate experience.

A5.3.1 Health Care Plans - The provisions of health care plans vary widely. It is necessary to understand those provisions that are important to the valuation of the plan being valued. The provisions may depend upon the retiree's age, service, location, or date of retirement; the retiree may have a choice of plans.

a. Eligibility may depend on eligibility for a pension; there may be other requirements such as retirement directly from active service, a longer service period, or attainment of a specific age. Many plans provide for dependents' benefits. Sometimes dependents' benefits continue beyond the death of the retiree, however the continuation may not be for the life of the dependent; it may be for a fixed number of years or it may vary.

b. Coverage - Most plans cover most hospital and physicians' services and related expenses. Plans may also cover dental, prescription drugs, vision, hearing, mental and nervous conditions, substance abuse and long-term care. Some plans pay the Medicare Part B premium.

c. Cost-sharing provisions include deductibles, co-insurance, out-of-pocket maximums, maximums (annual, lifetime, per service or per cause), copayments per service and retiree contributions. Cost-sharing provisions may vary by type of benefit, and different cost-sharing provisions may be separate or combined. For example, outpatient mental and nervous coverage may be limited to $25 per visit for 20 visits which may be combined with or separate from a plan's overall deductible and coinsurance.

d. Integration with Medicare is generally done in one or a combination of the following four ways:

i. Coordination of Benefits - Plan benefits are initially determined as if the retiree is not

eligible for Medicare. If the initial plan benefits and the Medicare payments exceed the charges, the initial plan benefits are reduced to the net of charges minus Medicare payments to obtain the actual plan payment.

ii. Medicare Exclusion - Covered charges are initially reduced by the Medicare payment. Plan provisions are then applied to this net amount to obtain the actual plan payment.

iii. Medicare Carve-out - Plan benefits are initially determined as if the retiree is not eligible for Medicare. These initial plan benefits are then reduced by the Medicare payments to obtain the actual plan payment.

iv. Medicare Supplement - Plan benefits are specific additions to Medicare benefits. The benefits may cover some or all of Medicare deductibles, coinsurance, or non-covered charges such as prescription drugs.

e. Example - Assume covered charges of $1,000. Medicare pays $600. The plan pays 80% after a $100 deductible.

Coordination:

Initial plan benefits = ($1,000 minus $100)(0.8) = $720

Actual plan payment = $1,000 minus $600 = $400

Exclusion:

Actual plan payment = [($1,000 minus $600) minus $100](0.8)= $240

Carve-out:

Initial plan benefits = $1,000 minus $100)(0.8) = $720

Actual plan payment = $720 minus $600 = $120

Comparison of Examples:

Integration Method	Paid by Medicare	Paid by Employee	Paid by Plan
Coordination	$600	$0	$400
Exclusion	600	160	240
Carve-out	600	280	120

A5.3 Plan Provisions/Benefits To Be Valued (Continued)

A5.3.2 Life Insurance - The amount of life insurance for retirees may depend on salary at retirement and may be reduced gradually after retirement. Accidental death and dismemberment, or dependent life insurance may also be provided.

A5.4 Participant Data - The primary source of participant data is the employer. However, the employer or the designated administrator often cannot provide the required detail, and other sources may be needed.

a. Employer-Provided Data - The employer should be able to provide aggregate counts of the number of retirees and the number of actives. The employer may also be able to provide other useful information, such as the average or total amount of life insurance in force, the male/female split, the number of retirees with spouses, the number of surviving spouses, and the number of retirees (and spouses) eligible for Medicare. (It is important to know whether spouses' claim costs are classified according to the spouse's age or the age of the retiree.) Even if the detail is available as of the valuation date, aggregate counts at various dates will be useful in developing current claims cost (subsection 5.5).

b. Pension Plan Data - The administrator of a related pension plan may be able to provide the required detail. However, the group of people covered by the pension plan may not be the same as the group of people covered by the postretirement benefit plan. Eligibility rules may not be exactly the same. Pensioners with deferred vested pensions may not be eligible for benefits. Surviving spouses and retirees who selected a lump sum distribution may not be in the pensioner file. There may be no information about spouses of retirees who have not selected a joint and survivor option. Some retirees may be covered by a pension plan which is not administered by the employer, e.g., as the result of an agreement related to the purchase or sale of a unit or because the retirees are covered by a multiemployer pension plan.

A5.6.2 Leveraging

This example illustrates that a 14% HCCTR can be leveraged to a 21.8% increase in per-capita employer payments due to the operation of the specific plan provisions. The 14%, however, is the value to be disclosed as the HCCTR.

PER CAPITA		YEAR 1	YEAR 2% CHANGE	
[1]	Claims cost	$3,000	$3,420	+14.0
[2]	Effective deductible	-170	-174	+2.4
[3]	Effective coinsurance	x88.0%	x88.3%	
[4]	Incurred claims cost (pre-Medicare)	$2,490	$2,886	+15.1
[5]	Medicare reimbursement	-1,800	-2,052	+14.0
[6]	Incurred claims cost	$ 690	$ 814	+18.0
[7]	Retiree contribution	-120	-120	+0.0
[8]	Net incurred claims cost	$ 570	$ 694	+21.8

Plan Provisions

a. comprehensive plan with fixed $200 per-person deductible
b. 80%/20% coinsurance with $1,500 out-of-pocket maximum
c. unlimited lifetime benefits
d. integrated with Medicare on carve-out basis
e. required retiree contributions of $120 per year

Actuarial Assumptions (may vary for different demographic cells)

a. initial per capita claims cost (gross eligible charges) is $3,000
b. the initial health care cost trend rate is 14%
c. 85% of plan participants meet the deductible in Year 1 and 87% in Year 2
d. effective employer coinsurance of 88.0% in the first year is increased to 88.3% in the second year
e. Medicare reimburses 60% of claims cost each year (i.e., no Medicare erosion is assumed)
f. no other primary coverage is available

Discussion of each line of the example:

[1] This represents the initial (and second-year) assumptions for the average cost of health care expenses incurred by participants in this demographic cell. It is largely independent of how these costs will be apportioned by the various payors (retiree, Medicare, other plans, and the

employer). The HCCTR is defined as the year to year progression in line [1].

[2] A $200 deductible does not reduce an employer's cost by $200 for each participant. Some will incur no expense, or have aggregate expenses which do not exceed this threshold amount. Therefore, the actuary should recognize the probabilistic nature of meeting the deductible and assume that only a portion of participants will meet the annual deductible. This probability should vary based on the size of the deductible (i.e., fewer participants are expected to meet a $500 deductible than a $100 deductible) and by year (i.e., of the portion of participants whose annual expenses did not exceed the deductible in one year, the actuary may assume that because of health care inflation, more will meet it in later years.)

[3] Few plans pay all eligible expenses at the same coinsurance rate. For example, claims paid after an individual employee reaches the out-of-pocket limit are usually paid at 100%. The effective coinsurance is the assumption as to the average reimbursement level after the deductible is satisfied. The example assumes that the plan reimburses 88.0% of charges in the first year. Health care inflation increases the likelihood that beneficiaries will reach the fixed dollar out-of-pocket limit each year. Therefore, the effective coinsurance assumption is increased to 88.3% in the second year.

[4] The incurred claim costs (pre-Medicare) are the gross eligible charges after application of the plan provisions but before reduction from Medicare. This would be equal to the incurred claims for a participant under age 65 if the same gross eligible charges were assumed. Note how the incurred claim costs (pre-Medicare) grow faster than the underlying HCCTR because of the fixed-dollar deductible and out-of-pocket limits.

[5] The Medicare reimbursement is the assumption as to the portion of total expenses paid by Medicare. Under the carve-out approach of integration with Medicare, the Medicare reimbursement is directly subtracted from the incurred claims cost (pre-Medicare) to arrive at incurred claims. Our example assumed no increase or erosion of Medicare reimbursement rates. Therefore, it represents the same portion of gross eligible charges in year 2 as in year 1.

[6] Calculated from lines 1-5, the incurred claims represent the average per-capita benefit payment (whether funded by employer or retiree contributions). Note how the leveraging effect on cost after reflecting Medicare integration is significantly greater than the incurred claims cost on line 4.

[7] Retiree contributions represent that portion of incurred claims funded by retiree contributions. Our example assumed that retiree contributions were frozen at $120/year. See SFAS 106, par. 29 on the "Substantive Plan" for the conditions under which future changes in the cost sharing amount can be anticipated.

[8] Net incurred claims cost represents that portion of incurred claims funded by employer contributions. This forms the basis for all SFAS 106 calculations. It may be necessary to value incurred claims and retiree contributions directly (subsection 5.6.7).

A5.7 Actuarial Assumptions Other than HCCTR - Pension and post-retirement welfare plan valuations share many actuarial assumptions, including:

Demographic assumptions:
- Mortality
- Turnover
- Retirement decrements
- Dependent status

Economic assumptions:
- Discount rate
- Consistency among economic assumptions

In addition, two assumptions required by postretirement welfare plans which are not needed for pension valuations are:

- Participation
- Alternate plan elections

In many instances participants in a postretirement welfare plan are covered by a defined benefit pension plan. That plan is a natural starting point in the search for actuarial assumptions to be used in valuing the welfare plan. In this subsection, it will often be assumed that such a plan exists.

A5.7.1 Demographic Assumptions

a. Mortality - Pension plan mortality in the United States has been intensively studied and analyzed. Mortality of pension plan participants has generally improved over time, although not in any smooth or easily analyzed manner. Such a pattern suggests that the "proper" mortality table uses death rates which are a function of both year of birth and age. Such tables are uncommon and rarely, if ever, used for pension valuations. Rather, a table is chosen in which the mortality rates are lower than currently being experienced, and hopefully, represent average rates applicable to the covered group over time.

When considering a mortality table, it is necessary to recognize the back-end loading of health care claims cost payment patterns resulting from applying claim trend relative to pension payment patterns. Because of this back-end loading, postretirement health care valuation results are usually much more sensitive to assumed mortality than pension plan valuations.

When a large portion of the postretirement benefit obligations is due to spouse benefits, as is often the case, the actuary should consider the use of sex-distinct mortality tables for SFAS 106 valuations.

Note: the table on page 135 of SFAS 106 seems to imply that life expectancies rather than probabilities of survival are used to calculate liabilities. This example was simplified for purposes of illustration. It was not meant to illustrate actuarial practice.

b. Turnover - When performing a postretirement welfare valuation on a group covered by a pension plan, the pension turnover assumption is a logical choice. A typical postretirement health care plan has liabilities which are effectively independent of pay level. If the companion pension plan is pay-related, the turnover assumption may or may not be appropriate for the health care valuation.

Since many pension plans exclude employees under the age of 21 or those who have less than a year of service, pension turnover assumptions for those plans may require modification for use with postretirement health care valuations.

c. Retirement Decrements - High sensitivity to retirement age does not apply to many pension plans because of actuarial reduction in benefits for early benefit commencement and reduced benefit amounts. It is crucial to check the retirement decrement assumption used in the pension valuation because the postretirement health care plan is subjected to the highest per capita claims cost in the years immediately prior to Medicare eligibility (at age 65).

Because of the critical nature of this assumption, it is desirable that it be as realistic as possible. Therefore, explicit retirement decrements are strongly preferred to an average retirement age, even if the single age gives correct aggregate results.

d. Dependent Status - The dependent status assumption is crucial to valuing postretirement health care benefits for most plans. It is an important assumption because half of the liability for a postretirement health care plan may come from dependents. Given the fluid nature of American family composition and differences based on age, current dependent status of active employees may not be a good indication of status at retirement. For a contributory postretirement health care plan with low participation rates, active data can be especially misleading. An analysis of the dependent population for recent retirees can provide useful information.

A5.7.2 Economic Assumptions

a. Discount Rate - Postretirement welfare valuations require the use of an interest rate to discount future cash flows. The theoretically correct discount rate can be determined by constructing an immunized bond portfolio which has a cash flow matching that of the postretirement welfare plan and determining the portfolio's rate of return.

b. Consistency among Economic Assumptions - Actuarial assumptions for discount rates, return on assets, trend, and salary scale should take a consistent view of future economic activity. All four economic assumptions contain an implicit assumption for future general inflation levels. For example, if long-term corporate bonds of high quality are believed to return approximately 3% more than the expected consumer price index (CPI) inflation, it would be difficult to support an 11% return on assets in conjunction with a 2% salary scale. The implication would be that prices were rising at 8% per year but pay levels only 2%. A similar analysis should be applied to the ultimate health care inflation rate. The actuary should note that the actuarial standard of practice for valuations of postretirement benefit plans (ASOP No. 6) requires the actuary to consider the implications of the economic assumptions for health care as an ultimate percent of gross national product.

A5.7.3 Plan-Related Assumptions

a. Participation - Virtually all postretirement health care plans offer coverage to retirees who have had similar benefits available as active employees prior to retirement. If both the active and postretirement benefits are noncontributory, it can safely be assumed that all employees participating in the active plan will join the postretirement plan. Where contributions are required of retirees, a participation assumption is

necessary. The contribution provisions of both the active and postretirement plans must be considered to be sure that the actuary has an appropriate pre- and postretirement participant valuation base.

The participation assumption for future years may differ from the assumption for more current years because of changes in retiree contribution levels.

Currently, many employers are revising postretirement health care plans to include higher retiree contributions, both immediately and anticipated in the future. The effect of these provisions on continued participation and average claim costs should be closely monitored. It may be advisable to consider a decrement in addition to death for retired participants to account for those dropping out because of high contribution levels. However, those leaving the plan may well be anticipated to have lower than average claim costs. There were little if any empirical data in this area as this was being written.

b. Alternate Plan Elections - Some postretirement health care plans provide participants with a choice of benefit levels and/or plan types (indemnity, HMO, Blue Cross/Blue Shield, etc.). Alternative plans will often require retiree contributions to equalize employer costs for all options. This provision would seem to make the plan costs independent of retiree election. This assumption may not hold if there are substantially different maximum benefits for various plans. In particular, the actuary may have to take into account the possibility of beneficiaries exhausting indemnity plan benefits and then electing an HMO.

If the employer-provided value of benefits differs among plan options, it is necessary to make assumptions as to the percent of retirees electing the various options.

A.5.3 Attribution Examples for Postretirement Health Care Plans

In both examples, EPBO is defined as the present value of a benefit 100% paid by the employer, i.e., requiring no contributions from retirees.

Example 1:

Employer plan provides a noncontributory postretirement health care benefit to employees retiring on or after age 55 with at least 20 years of service.

Employee	Age at Hire	Attained Age	Current Service	Age at Full Eligibility	Assumed Age at Retirement	APBO EPBO	Service Cost
A	30	52	22	50	55		0
B	35	40	10	50	55	EPBO×(10/25)	EPBO×(1/25)
C	25	45	20	50	55	EPBO×(20/25)	EPBO×(1/25)
D	40	50	10	60	60	EPBO×(10/20)	EPBO×(1/20)

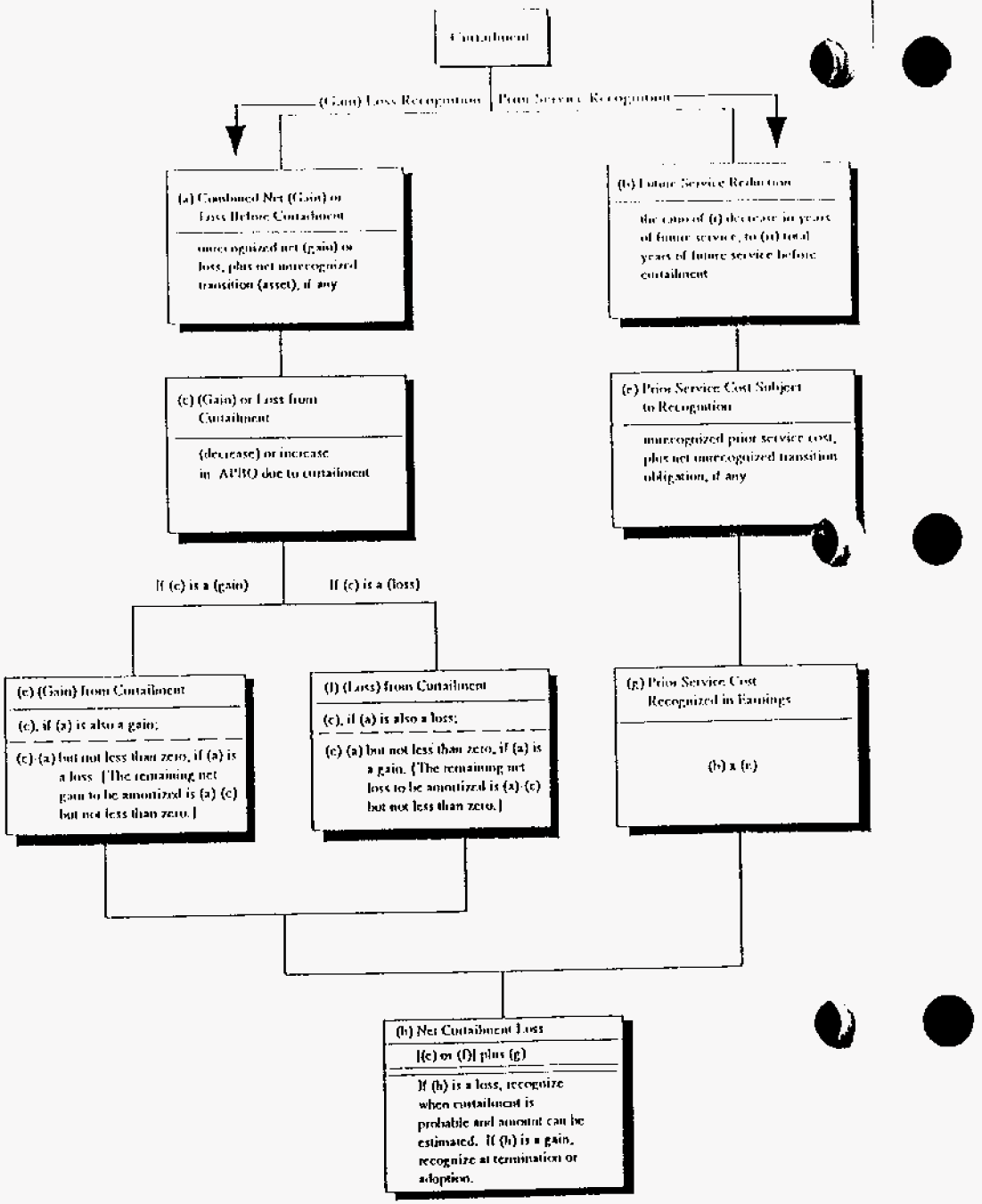
Example 2:

Employer plan provides a contributory postretirement health care benefit to employees retiring on or after age 55 with at least 20 years of service. The employer-provided benefit as a percentage of the cost of coverage is as follows:

Years of Service	Employer-Provided Benefit
20-29	30%
30+	70%

Employee	Age at Hire	Attained Age	Current Service	Age at Full Eligibility	Assumed Age at Retirement	APBO EPBO	Service Cost
A	30	40	10	55	55	EPBO×(10/25)×30%	EPBO×(1/25)×30%
B	30	40	10	55	57	EPBO×(10/25)×30%	EPBO×(1/25)×30%
C	30	40	10	60	60	EPBO×(10/30)×70%	EPBO×(1/30)×70%
D	30	40	10	60	62	EPBO×(10/30)×70%	EPBO×(1/30)×70%
E	30	55	25	55	55	EPBO	0
F	20	35	15	55	55	EPBO×(10/35)×70%	EPBO×(1/35)×70%
G	20	35	15	55	57	EPBO×(10/35)×70%	EPBO×(1/35)×70%
H	40	55	15	60	60	EPBO×(15/20)×30%	EPBO×(1/20)×30%
I	40	55	15	60	62	EPBO×(15/30)×70%	EPBO×(1/30)×70%
J	40	55	15	70	70	EPBO×(15/30)×70%	EPBO×(1/30)×70%

A5.13.8 Curtailment Accounting Flow Chart



A5.13.9 Termination Accounting- Special termination benefits are frequently part of an early retirement incentive program, also called an early retirement window (ERW). The ERW may allow some employees to retire with postretirement benefits who were not eligible to retire with such benefits prior to the ERW.

Example: The plan sponsor has a postretirement benefit program which allows participants to receive benefits if they retire from active employment with at least 15 years of service and are age 55 or older.

The sponsor's ERW allows participants to receive benefits if they retire from active employment with at least 15 years of service and are age 50 or older. The ERW also reduces the participant contributions to postretirement benefits by $200 a year for the first 5 years of retirement.

Participant A is 50 years of age and has 15 years of service when he accepts the ERW. (Without the ERW, he would not be eligible to receive postretirement benefits).

Participant B is 55 years of age and has 20 years of service when he accepts the ERW (He would be eligible to receive postretirement benefits without the ERW).

An assumed retirement age of 60 is used in these examples.

	Items	Participants A	Participants B
[1]	age	50	55
[2]	service	15	20
	Prior to ERW		
[3]	EPBO	$70,141	$70,347
[4]	APBO	52,605	70,347
[5]	P.V. of postretirement benefit[x]	0	95,543
	After the ERW		
[6]	P.V. of postretirement benefit	127,624	95,543
[7]	P.V. of reduced contributions	798	798
[8]	Total P.V. of benefits under ERW	128,422	96,341
	Effect of ERW under SFAS 106		
[9]	Loss on account of termination benefit (current cost) [9] = [8] minus [5]	128,422	798
[10]	Loss (Gain) which is part of normal amortized gain/loss [10] = [5] minus [4]	(52,605)	25,196

[x] benefit the participant is eligible for if retiring immediately without ERW.

Docket No. 911188-WS
V. Montanaro Exhibit No ___
Attachment 11
Special Edition-
Management Report

MANAGEMENT REPORT

SPECIAL EDITION

Produced by the Human Resources and Corporate Communications Departments

November, 1991, #4

On Nov. 21, Tampa Electric employees who are members of the IBEW will vote to accept or reject the TECO Healthplan changes which will be in place Jan. 1, 1992, for all non-covered employees. Members of the OPEIU will also be asked to accept these changes beginning in January.

The plan has three modest changes in it:

- *Prescription costs of $6 plus 20 percent of the remaining cost;*
- *Elimination of the $1,500 carryover provision;*
- *Limitation of $1,000 on certain chiropractic benefits.*

With these changes, the premiums for the TECO Healthplan will remain the same for the third year in a row.

Because there are a number of questions concerning the TECO Healthplan, and the cost of benefits, the Management Report is issuing a special edition to answer some of these concerns and provide insight on the "bigger" Benefit picture.

42 CENTS FOR EVERY SALARY DOLLAR: THE BIGGER BENEFIT PICTURE

Q. Why is more cost-sharing required by employees in the TECO Healthplan?

A. For every straight-time salary dollar, the company pays 42 cents in benefits. That means if your annual salary is $30,000, you receive an additional $12,600 in benefits, making your real salary $42,600.

In 1990, Tampa Electric's benefit costs for active employees totaled $40.8 million. This is an important reason for the need for cost-sharing in medical benefits.

Q. Is the $40.8 million for medical benefits?

A. No, it covers all benefits. Benefits can be divided into three categories: direct benefits; non-productive time paid; and other payroll costs.

Direct benefits include medical insurance, pensions, education, the savings plan, the employee assistance program, life insurance, health education, and other benefits.

Non-productive time benefits include vacation, holidays, short-term disability, and jury duty, among others.

Payroll cost benefits are the company's match to the employee social security tax payment; unemployment compensation, and worker's compensation.

Q. What are the statistics on rising medical costs?

A. According to a recent article in the Tampa Tribune, health care cost for businesses in Florida was $3,040 per employee for 1990. At Tampa Electric, the average annual health care cost per employee was $3,272 for 1990, 8 percent above the Florida average.

Q. Why is it important that all employees on the TECO Healthplan — both covered and non-covered — be on the new plan?

A. Because it's important that all employees on the plan share in the cost. The changes are estimated to save $480,000 in 1992, but more importantly they provide the company more control over future cost increases. It would be unfair to have just one group of employees bearing the burden.

Q. Why the focus on prescription drug costs?

A. In 1988, the prescription drug charges were $577,057, and represented 8 percent of the TECO Healthplan's claims. In 1989, the charges rose to $736,769, an increase of 28 percent. In 1990, drug charges were $979,046, or an increase of 33 percent, and represented 12 percent of the total claims. We clearly can't continue this escalation since it would impact other benefit or salary items.

But even with the new $6-and-20-percent provision, employees on the plan are doing better than before 1987. At that time, co-payment for prescription drugs was 20 percent of the cost after a $200 deductible. On a $960 annual prescription bill, an employee share would have been $352: With the plan that goes into effect Jan. 1, the employee share would be $249.60.

Q. What if the IBEW and/or OPEIU don't vote for the revised plan?

A. Employee cost-sharing of medical benefits is critical. The company will not go beyond the 42 percent in benefits it is already paying. If benefits cannot be reduced in the medical area, they will have to be reduced somewhere else within the compensation or benefit area.

The only other areas the company has to consider are the other direct benefits, the non-productive time benefits or more stringent pay increases in the future.

CERTIFICATE OF SERVICE
DOCKET NO. 920199-WS

I HEREBY CERTIFY that a correct copy of the foregoing has been furnished by U.S. Mail or hand-delivery to the following parties on this 5th day of October, 1992.

Ken Hoffman
Messer, Vickers, Caparello,
Madsen, Lewis, Goldman & Metz
215 S. Monroe St., Suite 701
P.O. Box 1876
Tallahassee, FL 32302-1876

Mat Feil
Division of Legal Services
Fla. Public Service Commission
101 East Gaines Street
Tallahassee, FL 32301

Chuck Hill
Division of Water & Sewer
Fla. Public Service Commission
101 East Gaines Street
Tallahassee, FL 32301

Brian Armstrong
Southern States Utilities
General Offices
1000 Color Place
Apopka, FL 32703

Harry C. Jones, P.E. President
Cypress and Oak Villages Assn.
91 Cypress Boulevard West
Homosassa, FL 34446

/s/
Harold McLean
Associate Public Counsel