The Actuarial Update

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In this issue

Enclosures

Included in this month's issue of *The Update* are the following:

- Government Relations Watch
- In Search Of . . .
- ASB Boxscore
- ASB Bulletin and Interpretation 7-D
- Long-Term Care Insurance Exposure Draft

Academy's Expertise Sought on Federal Housing Administration Reform

by Gary Hendricks

In late July of this year, the Congressional Research Service asked the Academy to review and provide commentary on a Price Waterhouse report related to the Federal Housing Administration's Mutual Mortgage Insurance (MMI) Fund.

The Price Waterhouse study, *An Actuarial Review of the Federal Housing Administration's Mutual Mortgage Insurance Fund*, was the bearer of troubling news. The report, initially prepared for Secretary Jack Kemp of the Department of Housing and Urban Development (HUD), made it clear that the FHA had been writing bad business for the past decade—business that was being supported by surplus accumulated in the 1970s and earlier years—and that the program could very well become insolvent.

During the 1980s, the MMI Fund's capital ratio fell from 5.3% of insurance in force to 1.0%, leaving the fund with $2.6 billion at the end of 1989. Moreover, according to the Price Waterhouse report, if there were a recession as serious as the one in the early 1980s, an estimated $11.2 billion would be required to finance defaults on FHA-insured mortgages. With only $2.6 billion in the fund, this would leave an estimated $8.6 billion shortfall for which the federal government would become responsible.

With the savings and loan debacle so fresh in their minds, many federal policy makers were not eager to have the FHA program become insolvent if, as many were predicting, there were a serious economic downturn in the near future. On the other hand, if the FHA MMI Fund was to be made more financially viable by raising the cost of FHA-backed mortgages, people with modest

(*continued on page 4*)

A Working Agreement for the Profession

by Jeanne Casey

This September, a written working agreement was delivered to the presidents and presidents-elect of the six organizations representing actuaries in North America, for presentation to and approval by their boards. The respective organizations now have all approved the agreement. Last year's presidents-elect of these organizations were responsible for drafting the working agreement. This year, as presidents of their respective organizations, they will be the first ones to implement it.

The organizations bound by the working agreement are the American Academy of Actuaries (AAA), the American Society of Pension Actuaries (ASPA), the Canadian Institute of Actuaries (CIA), the Casualty Actuarial Society (CAS), the Conference of Actuaries in Public Practice (CAPP), and the Society of Actuaries (SOA).

The idea of developing and executing a working agreement for these organizations had been recommended by the Task Force on Strengthening the Actuarial Profession in its final report (September 1989). The task force indicated that a strong actuarial profession necessitated better understanding and cooperation among the various actuarial organizations.

Academy President Mavis A. Walters, who participated in drafting the agreement during her term as president-

(*continued on page 3*)

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From a Guest President

Daphne D. Bartlett

New Role for the Academy?

One benefit of becoming president of the Society of Actuaries is that you're given a surprisingly large number of opportunities to let other actuaries know what's on your mind. I'd like to take advantage of this particular one to initiate discussion concerning whether the Academy's role as a membership organization should continue or should change.

A few years ago, the Joint Task Force on Strengthening the Actuarial Profession made some recommendations for strengthening the profession. These were not acceptable to everybody, but it was generally agreed that the various organizations should work together cooperatively, rather than as rivals. Most actuaries belong to more than one organization. It doesn't make sense for us to compete with ourselves.

During the past year, there have been some significant developments that will affect the ways that organizations representing actuaries in North America will work together in the future. These developments hold promise that we might be able to get our actuarial act together to a far greater extent than we have been able to in the past.

First, the preparation of the new working agreement among the organizations representing actuaries in North America may constitute a first step in our commitment to cooperation. It was developed this year by the presidents-elect of the American Academy of Actuaries, the American Society of Pension Actuaries, the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries—the six organizations represented on the Council of Presidents.

The working agreement is intended to establish an institutional memory for successive leaders of the organizations—so our organizations don't waste resources by reinventing the wheel every few years as our leaderships change. The current version of the working agreement doesn't include anything particularly controversial—it merely formalizes organizational roles that already exist. (See story on page 1.) The agreement does provide, however, for continual modification and improvement of the agreement by succeeding groups of presidents-elect.

For example, the 1990–1991 presidents-elect will address, among other things, ways to alleviate the problem of paying multiple dues for those of you who are members of more than one of the actuarial organizations. More about this later.

A second important development resulting from the strengthening of the profession report was the decision to have the presidents and the presidents-elect of the U.S. organizations serve as members of the Academy Board of Directors. After the initial phase-in, this will mean that the Academy's leadership will significantly overlap with the leadership of the other organizations, further enhancing the commitment to cooperation contemplated by the working agreement.

What does all this mean? I think it could result in the creation of a new identity for the Academy for the benefit of all.

Efforts have been made over the years to foster enthusiasm for the Academy as a *membership* organization. These efforts have not been particularly successful. Most actuaries have primary allegiance to another organization. In my opinion, membership in the Academy is often viewed as a professional duty, carrying little emotional weight.

What if we were to change our thinking about the Academy as a membership organization? Considering the presence of the leaders of each of the other U.S. organizations on the Academy's board, could we not now consider the Academy as an organization of *organizations*, rather than of members?

The Academy could become purely a service organization, conducting its government information and public relations programs on behalf of the the profession in the United States. And, as a service organization, the Academy could be funded by the other organizations, rather than by individuals. In short, dues for the other organizations would be increased, and

Academy dues would not exist.

Obviously, lots of work is needed on details such as an appropriate phase-in procedure, how to handle actuaries who are not members of any other actuarial organization or who have no need for Academy services.

If an equitable arrangement could be worked out, the benefits would be significant. Virtually all U.S. actuaries would be automatic members of the Academy and subject to its standards of practice. Eventually, this could lead to a single discipline process and, hopefully, to a single set of continuing education requirements. It might even save some money!

What are the arguments against the idea? There are members of the other organizations who disapprove of the Academy for various reasons and have chosen not to belong to it. They probably won't react to this proposal with enthusiasm. I can understand where they're coming from. It has taken me a long time to realize that there is no realistic way to create a perfect organizational environment.

Yet by not cooperating with each other, we are damaging our professional image before the publics we are trying to serve. Many of these publics have trouble distinguishing between life insurance and casualty insurance. How can we even imagine that they can tell the difference between membership in each of our organizations?

Let's not be so self-satisfied about our individual academic accomplishments that we lose sight of what our profession is all about—serving the public. Each of us has the chance to prove our individual worth as actuaries every day. Why can't we continue to compete with each other as *individuals*, but set aside our organizational differences? Won't we all be better off?

Please let the Academy's board know what you think. If we hear from you, perhaps some meaningful progress can be made.

Bartlett is president of the Society of Actuaries. This past year, while president-elect, she was involved in drafting the working agreement.

Actuarial Compliance Guideline for FASB Rule

In anticipation of the Financial Accounting Standards Board's imminent release of its final accounting standard for postretirement benefits other than pensions, the Retiree Health Care Committee of the Actuarial Standards Board met on December 5 to continue work on an actuarial compliance guideline for the new standard.

1991 Enrolled Actuaries Meeting

Registration materials for the March 13–15, 1991 Enrolled Actuaries Meeting are being mailed to enrolled actuaries early in December. This spring's three-day meeting will offer more than eighty sessions designed to meet enrolled actuaries' continuing education requirements. In years past, registration for the meeting has topped 2,000. Because of the size of the meeting, the convention department is unable to accept on-site registrations. So, if you are planning to attend, please register using the form you receive in the mail. The Sheraton Washington Hotel is the site for the 1991 meeting.

The fee for those registering for the meeting before January 16, 1991 is $440. The fee to register after that date (on or before March 1, 1991—the registration deadline) is $540. For further information, contact the Enrolled Actuaries Meeting Convention Department at (202) 223-8196.

WORKING AGREEMENT
(*continued from page 1*)

elect, said that the agreement "represents a modest first step towards clarifying the responsibilities and duties of the various organizations, so that each of [them] will have a better understanding of how the organizations can work together towards accomplishing mutual goals."

The working agreement spells out a total of thirty directives for the organizations, all aimed at improving communication, fostering cooperation, and clarifying the organizations' respective roles. For example, under the section, "Communications among the Organizations," item (4) reads: "Each organization shall invite the president and president-elect of each of the other organizations to its Annual Meeting. . . ."

Under the heading, "Public Interface," item (6), states: "Each organization will endeavor to encourage the actuarial profession to speak with one voice in each country on actuarial issues in the public arena. The CAS, CAPP, and SOA recognize the AAA in the United States and the CIA in Canada as the organizations responsible for public representation of the actuarial profession. The AAA and ASPA will seek mutually supportive roles regarding relevant pension issues in the U.S. They agree to coordinate on issues affecting actuaries in both organizations and to seek opportunities to cooperate."

"Actuarial Research," item (9), reads: "The SOA and CAS shall be responsible for management of actuarial research with input from and participation of the other organizations. However, the CIA will have responsibility for the management of research issues unique to Canada, coordinating with the SOA or CAS, where appropriate."

Perhaps this first step is not such a "modest" one, after all. By working together to develop this agreement, the presidents of the six organizations have already exhibited the kind of cooperation this agreement is meant to foster. Each year, newly elected presidents-elect for all the organizations will be asked to work together to review the agreement and ensure that it remains current. As leaders of the profession work more effectively to achieve mutual goals, every member of the profession will benefit. Δ

ACADEMY'S EXPERTISE SOUGHT ON FHA REFORM
(continued from page 1)

incomes—people who the FHA program was designed to help—could not become homeowners.

The ensuing debate between Congress and the Administration was a contentious one. Questions were raised regarding the actuarial analysis contained in the Price Waterhouse report, the size of the reserve actually needed in the FHA MMI Fund, and what policies would increase reserves without violating the FHA program's social purpose.

In response to congressional requests for answers to these questions, the Congressional Research Service (CRS) turned to the Academy for an independent, unbiased assessment of the actuarial analysis and options for change contained in the Price Waterhouse report.

Academy members John Angle, Mary Hennessy, and Robert Shapiro formed a special task force to respond to CRS's request. After careful review of the report and discussions with actuary Sam Gutterman, one of the Price Waterhouse report's major authors, and HUD actuary Thomas Herzog, the Academy task force concluded: "Although [we] agree with the conclusions of the study, [we do] not believe the report always goes far enough in pointing out the . . . difficulties confronting this program."

Congress Acts to Put FHA Mortgage Program on Sounder Footing

Among the many changes made by the Omnibus Budget Reconciliation Act of 1990 were those intended to strengthen the finanical status of the Federal Housing Administration's (FHA) Mutual Mortgage Insurance Fund. The changes, which appear in Title II of the act, include:

- Permanently increasing the maximum mortgage amount eligible for FHA insurance to $124,875 in high-cost areas. Under prior law, the maximum eligible mortgage would have reverted to $101,250 after September 30, 1990.

- Abandoning the strict flat-rate, up-front premium of 3.8% and replacing it with an up-front premium of 2.25%; plus an additional annual premium of 0.5% on the remaining insured principal balance for eleven years on mortgages with loan-to-value ratios under 90%, and for thirty years on mortgages with loan-to-value ratios of 90% to 95%. For mortgages with loan-to-value ratios over 95%, the additional annual premium will be 0.55% for thirty years. The new premium-rate structure will be phased in over four years and will become fully effective for mortgages executed on or after October 1, 1994.

- Requiring the Secretary of HUD to ensure that the FHA Mutual Mortgage Insurance (MMI) Fund attains a capital ratio of not less than 1.25% of insurance in force within twenty-four months of enactment (ie., by November 5, 1992).

- Requiring the Secretary of HUD to ensure that the MMI Fund attains a capital ratio of not less than 2.0% within ten years after enactment, and, within twenty-four months after enactment, to submit a report to Congress describing the actions the department will take to ensure that the MMI Fund attains the 2.0% capital ratio.

To assist HUD in meeting the new capital fund objectives, the new law requires that HUD annually conduct an independent actuarial study of the MMI Fund's status and report the study's findings to Congress.

Competitive Mortgage Market

One of the most serious difficulties is the competitive environment in which the FHA finds itself, according to the task force. The task force pointed out that the competition for high-quality mortgage loans has steadily increased. "There are now 13 private mortgage insurance companies [that] wrote almost as much insurance in 1989 as did FHA. Self-insurance remains an option for lenders in the better markets."

Moreover, two other quasi-government organizations, the Federal National Mortgage Association and the Federal Home Loan Mortgage Corporation, also extend guarantees that are tantamount to insurance. According to the task force, "These organizations provide a low-cost alternative to FHA for the better risks."

The bottom line: "Such stiff competition steadily shrinks the pool of insurable prospects who seek FHA financing and leaves the FHA program with increasing numbers of insureds whose premiums, at current rates, do not cover the risk assumed by the MMI Fund. Thus, it is no longer possible for the FHA to offset its losses from poor risks, for whom the FHA premium is too low, with good risks, for whom the FHA premium is too high."

Report Lists Options

The Price Waterhouse report discussed five possible scenarios for changing the program, without making particular recommendations. The report indicated five alternatives: (1) adopt risk-based premium rates; (2) insure larger mortgages by raising the loan limits to 95% of the state's average house price; (3) reduce the loan-to-value ratio by raising the required down payment; (4) increase premiums across the board; and (5) change the premium structure by replacing the current up-front premium structure with a "pay-as-you-go" structure. The Academy task force had strong opinions regarding which of these options were preferable.

Task Force Evaluates Options

"The first step toward improving the MMI Fund's fiscal soundness is to stop insuring the mortgages that have produced the appalling losses of the 1980s," commented the task force, after learning that the average loss upon default in an FHA mortgage is 40% of the mortgage loan.

Adopt Risk-Based Premium Rates. The task force "strongly favors risk-based pricing. The difficulty here is that Congress may find the resulting premiums and down payment too steep for marginal borrowers. If so, the task force suggests that Congress appropriate $250 million a year (or some other

amount) to subsidize the marginal home buyer. The task force believes risk-based pricing is necessary, because Robin Hood pricing, which is what FHA's policy of cross-subsidies amounts to, will not work in a competitive market."

Ensure Larger Mortgages. The task force also viewed favorably raising FHA's limits to 95% of each state's average home price, commenting, "this would allow FHA to write more profitable business and is a good way to build the capital of the MMI Fund."

Reduce Loan-to-Value Ratio. With regard to raising the required down payment for all applicants, the task force thought that this would be a positive step. However, they viewed risk-based premiums as a more effective option, since they provide an incentive for making a larger down payment—the incentive of lower premiums.

Increase the Flat Premium. The task force thought that increasing FHA's current flat premium across the board would be self-defeating, that the concept was wrong. "Large increases in premium would only intensify the fund's current problems by driving more of the good risks into other private-sector or quasi-government programs and leaving only the worst risks with FHA," they said.

Substitute a "Pay-As-You-Go" Structure. The task force also opposed merely changing the up-front premium to a pay-as-you-go premium. This would merely hide a rate increase by restructuring and would have the same negative consequences as increasing the current flat rate premium.

The Price Waterhouse report also had recommended that distributive share payments be stopped until the FHA program no longer faces the threat of insolvency. The Academy task force agreed.

On September 10, the task force's report was delivered to the CRS, which forwarded it to the legislative conference committee that had requested it. (For changes to the FHA program following budget reconciliation, see sidebar, page 4.)

Hendricks is chief economist and director of government information for the Academy.

Provisions of 1990 Budget Reconciliation Act Will Have Impact on Actuaries' Work

by Gary Hendricks and David Bryant

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), which President Bush signed into law on November 5, contains many changes that will impact the work of actuaries. Among the changes in this year's budget reconciliation package (Public Law 101-508) are ones affecting private pension plans, employer-sponsored retiree health plans, the taxation of life and casualty insurance companies, and the Medicare supplemental insurance (Medigap) programs.

Pension Asset Reversions

Beginning immediately, pension practitioners will face new rules when terminating qualified defined benefit pension plans with assets in excess of termination liabilities. Under the new rules for plan terminations, the excise tax on the amount of the reversion to the employer is increased to either 20% or 50%. The 20% excise tax applies to reversions from terminations where one of the following three conditions is met:

(1) After the plan termination, the employer maintains or establishes a qualified (as defined under the new provisions) replacement plan to which the employer transfers 25% of the assets that would otherwise have reverted to the employer. Or,

(2) Upon plan termination, the employer provides pro-rata increases in accrued benefits to all participants (both active and inactive) equal to at least 20% of the maximum reversion the employer could have received. Or,

(3) The employer, as of the plan termination date, is in bankruptcy liquidation under Chapter 7 of the federal bankruptcy code or a similar state law.

Under the rules, benefit increases to participants in the terminating plan can reduce dollar-for-dollar the 25% cushion requirement for the replacement plan, provided the benefit increases under the terminating plan satisfy all applicable qualification rules, including the nondiscrimination rules. Hence, it is theoretically possible to increase the benefits of retirees under the terminating plan and deduct the present value of those benefit increases from the cushion required under a replacement plan that includes only the active workers from the terminating plan.

If the employer does not satisfy one of the three conditions listed above, a 50% excise tax is applied to the actual amount reverting to the employer. As under current law, the full amount of the assets reverting to an employer are not just subject to an excise tax; the full amount of the reversion must also be counted as income for purposes of computing income taxes due the Internal Revenue Service (IRS).

The new asset reversion rules generally apply to reversions occurring after September 30, 1990, with transition relief for reversions that were initiated prior to October 1.

Transfers to Retiree Accounts

Both pension and health actuaries may be called upon by employers to consider whether the employer can and should take advantage of a new provision in the tax code that permits assets from ongoing pension plans to be transferred to accounts set up to finance an employer's health benefits for retirees. Under the new provisions, employers can transfer assets in excess of the full funding limitation from their defined benefit pension plans to section 401(h) accounts that are maintained as part of such plans.

Under the new provisions, the assets transferred to a 401(h) account are not to be included in the gross income of the employer for tax purposes and are not subject to the excise tax on asset reversions. In addition, the defined benefit pension plan does not fail to satisfy the qualification requirements [including the 401(a) requirements] solely on account of the transfer; neither does it violate the requirement that medical benefits under a section 401(h) account be subordinate to the retirement benefits under the pension plan.

To qualify as tax-favored, a transfer to a 401(h) account may be made only once during any taxable year, and it may be made only in taxable years beginning before January 1, 1996. In addition, a number of other conditions must be met in order for the transfers to be made. The dollar value of assets

(continued overleaf)

transferred cannot exceed the amount by which the pension plan's assets are in excess of the pension plan's full funding limitation and may not, in any case, cause the funding level of the plan to fall below a certain threshold. The transferred assets and income thereon must be used to pay the current year's retiree health liabilities, and the amount that can be transferred may have to be reduced by prior contributions to fund these same liabilities. All participants under the pension plan must be vested in their accrued benefits in the same manner that would be required if the pension plan were being terminated.

Also, if an employer makes a transfer from a pension account to an affiliated 401(h) account, the employer must, for a period of four years following the year in which assets are transferred to the 401(h) account, maintain payments for health benefits to retirees at a level no less than the higher applicable employer cost (including benefits plus administrative costs) for the two taxable years immediately preceding the taxable year of the qualified transfer. Notices must be sent to participants, the secretaries of Labor and Treasury, any employee organization representing participants, and the plan administrator.

IRS User Fees Still Apply

Those pension actuaries seeking determination letters and other written responses from the IRS will find that user fees still apply. The fees, established by the Revenue Act of 1987 and expiring on September 29 of this year, have been extended from September 29, 1990 through September 30, 1995. The fee schedule remains the same as it was in September 1990.

Single-employer defined benefit plans will also be paying higher premiums to the Pension Benefit Guaranty Corporation (PBGC). Prior to enactment of OBRA 1990, the base premium was $16 per participant, with an additional premium of $6 per $1,000 of unfunded vested benefits. The additional premium was capped at $34 per participant.

Under OBRA 1990, both the base flat-rate premium and the variable premium for underfunded plans will increase for plan years beginning after December 31, 1990. The flat-rate premium per participant will be $19, and the addition premium per $1,000 of unfunded vested benefits will be $9. The new cap on the variable portion of the premium per participant will be $53. Thus, some plans could pay a total premium per participant of $72 under the new law. Under the old law, the maximum possible premium per participant was $50.

Medigap Insurance Standards

Like pension actuaries, health actuaries will also have to work under new rules in several areas, including new standards for Medicare supplemental insurance. The new Medigap standards are essentially those that were proposed in the Medigap Fraud and Abuse Prevention Act of 1990 (S. 2640 and HR. 4840), a bill whose progress has been tracked in the *Government Relations Watch* since the bill's introduction in May 1990. The primary purposes of the new provisions are to standardize the market and simplify beneficiaries' choices.

Under OBRA 1990, all Medigap policies must meet new simplification standards approved by the National Association of Insurance Commissioners (NAIC), and the total number of different benefit packages (including the core group of basic benefits or any other combination of benefits that may be offered as a separate package) is limited to ten. If the NAIC does not approve such standards, including the development of the different benefits packages, within nine months of enactment, the Secretary of Health and Human Services (HHS) is required to issue standards within eighteen months of enactment.

Although the legislation initially limits the number of packages to ten, it does include provisions to facilitate the development of innovative benefits packages. The Secretary of HHS, upon application by a state, may waive the simplification standards for a period of up to three years in order to demonstrate the offering of new or innovative benefits, including managed-care features. Upon further evaluation of the demonstration benefits packages, the Secretary is required to request NAIC modification of existing standards to incorporate these new benefits packages. The Secretary may modify the existing standards if the NAIC fails to do so in a timely manner. No more than three additional groups of benefits may be added.

The legislation prohibits the sale of Medigap policies in states that do not adopt the NAIC or equivalent standards, or do not have alternative standards approved directly by HHS. After the effective date of the NAIC simplification standards, any person who issues or sells a Medigap policy in violation of the standards will be subject to a civil penalty not to exceed $25,000 for each violation. The additional provisions of Section 1128A of the Social Security Act also apply to the civil money penalties. The law increases civil penalties from $5,000 to $25,000 for false statements of material fact regarding the compliance of a Medigap policy and for mailing a policy into a state for a prohibited purpose. The new enforcement provisions effectively replace the current federal voluntary certification system established by the 1980 Baucus amendments.

In addition, the law increases the loss ratios for individual policies to 65% and requires refunds when payouts fall below that level; requires that Medigap policies be guaranteed renewable; prohibits medical underwriting for Medigap policies for six months after an individual becomes entitled to Medicare Part B; and provides grants to states for consumer counseling of Medicare beneficiaries. Finally, the law also provides for a three-year (1992–95), fifteen-state demonstration project to test the administration's Medicare SELECT proposal, which will allow insurers to offer Medigap insurance through preferred provider organizations.

The law imposes no new restrictions on agent sales commissions. Legislative proposals earlier in the 101st Congress had included restrictions on commissions.

Medicare

The work of health actuaries may also be affected directly or indirectly by changes to Medicare. Among the most publicized changes is the increase in the amount of wages that will be subject to the Hospital Insurance (HI) payroll tax. Under prior law, the first $53,400 of 1991 wages and self-employment income would have been subject to the HI payroll tax of 2.9% (paid half by the employee and half by the employer). Under OBRA 1990, the first $125,000 of 1991 wages and self-employment income will be subject to the HI payroll tax. For years after 1991, the $125,000 cap will be indexed to changes in the average wages in the economy. The new law does not change the wage cap for Social Security: the maximum taxable wage for 1991 for the Old Age, Survivors, and Disability Insurance

(OASDI) program will be $53,400.

A second change to the financing of the Medicare program was an increase in the deductible under Part B of the program. The deductible, which has been $75 for many years now, will be $100 beginning January 1, 1991. The Part B premium will continue to be set at a rate anticipated to cover 25% of projected program costs. Hence, the current monthly premium of $28.60 will increase to $29.90 at the beginning of 1991 and continue to rise, reaching $46.10 per month in 1995.

OBRA 1990 also includes numerous provisions to reduce the growth payments to providers by approximately $28 billion over the next five years. Most of the Part A savings will come from increasing the overall hospital payment by less than the increase in the hospital market basket index. Part B reductions will be achieved primarily by reducing payments for various types of services.

OBRA 1990 also extends the Medicare secondary payer program, a program that enables the Health Care Finance Administration to continue to recoup mistaken payments in cases where another party was supposed to be the primary payer. The program is expected to recoup roughly $6 billion in erroneous payments over the next five years.

Rule Changes on Coverage

OBRA 1990 made two changes to rules for continuation of coverage under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). Prior to OBRA 1990, state Medicaid programs were permitted to pay COBRA health-insurance premiums on behalf of beneficiaries, only if the COBRA-eligible beneficiaries met the financial and other standards for Medicaid eligibility.

OBRA 1990 has broadened the group of people for whom the states may purchase COBRA continuation of coverage. Under the new law, state Medicaid programs have the option of paying COBRA continuation premiums for individuals whose family income is below 100% of the federal poverty level and whose resources are no more than twice the limit applicable for Supplemental Security Income (SSI) in the state. These new rules apply only to workers entitled to coverage under a group health plan of an employer with seventy-five or more employees. The new law applies to medical assistance furnished on or after January 1, 1991.

Also included in OBRA 1990 is a provision stating that employees entitled to COBRA coverage continue to qualify for that coverage for at least one year, even if the employer's size drops below twenty employees. According to the new rule, employees continue to be qualified beneficiaries "if the qualifying event with respect to such beneficiary occurred during the calendar year immediately following a calendar year during which all employers maintaining such plan normally employed fewer than 20 employees on a typical business day."

Increased Taxes for Insurers

Under OBRA 1990, a major source of new revenue will be increased taxes paid by insurance companies through changes in the tax treatment of policy acquisition costs. OBRA 1990 requires insurance companies to amortize policy acquisition expenses on a straight-line basis over a period of 120 months beginning with the first month in the second half of the taxable year. Furthermore, under the new law, the policy acquisition expenses required to be amortized are based on a percentage of the net premiums for the taxable year for insurance contracts in specified categories. The three categories of contracts specified by OBRA 1990 and the percentage for each category are:

Annuity contracts	1.75%
Group life insurance contracts	2.05%
Insurance contracts (including noncancelable or guaranteed renewable accident and health insurance contracts) not included above	7.70%

In addition, the act provides regulatory authority to the Treasury Department to establish additional categories of contracts and the percentage applicable to each new category.

Under the act, net premiums are defined as the excess of (1) the gross amount of premiums and other consideration on specified insurance contracts over (2) return premiums on such contracts and premiums and other consideration incurred for reinsurance of such contracts. A special rule, which depends upon the tax status of the reinsurer, is provided for reinsurance transactions.

The new law includes a shorter, sixty-month amortization period for the first $5 million of amortizable expenses with a phase-out as expenses increase to $15 million. The new amortization provisions are generally effective September 30, 1990.

Tax Treatment of Salvage

OBRA 1990 also increases government revenues by changing the treatment of salvage for property and casualty companies.

Since 1974, Treasury regulations have provided an exception to the requirement that paid losses be reduced by salvage, if under applicable state law or state insurance rules the salvage may not be treated as an asset for statutory accounting purposes. This regulatory exception was removed by temporary Treasury regulations first promulgated December 30, 1987. However, the effective date of these temporary regulations has been deferred several times; currently, the temporary regulations are technically in effect for taxable years beginning after December 31, 1989.

Under the newly enacted provisions of OBRA 1990, the deduction allowed to property and casualty insurance companies for losses incurred, both paid and unpaid, is reduced by estimated recoveries of salvage (including subrogation claims) attributable to such losses, whether or not the salvage is treated as an asset for statutory accounting purposes.

Under the new law, the Treasury Department is required to issue regulations providing for the discounting of salvage taken into account under the OBRA 1990 provisions. However, the Treasury Department's stipulation that amounts of estimated salvage are determined on a discounted basis does not apply to reinsurance recoverable.

Pending issuance of regulations or additional guidance from Treasury with respect to the discounting of estimated salvage recoverable, Congress anticipates that taxpayers will compute discounted salvage in accordance with the principles set forth in the legislative history to the House bill and the Senate amendment, and according to the rules for determining the applicable interest rate for discounting unpaid losses. OBRA 1990 includes provisions for transitional relief.

Summary Covers Major Interests

Although the above summaries are intended to cover the areas of interest to most actuaries, this survey of OBRA 1990 changes is by no means comprehensive. The complete budget reconciliation act fills over 180 pages of small print in the *Congressional Record*, and the managers' conference report explaining the provisions of the act is

(continued on page 11)

Standards Outlook

by Christine Nickerson

New Board Members Appointed

Edward E. Burrows and Harry L. Sutton, Jr. have been appointed to the Actuarial Standards Board (ASB). They will replace George B. Swick and E. Paul Barnhart, whose terms will expire on December 31, 1990. (Swick and Barnhart are charter members of both the Interim Actuarial Standards Board and the ASB.) Jack M. Turnquist was appointed to serve a second three-year term, and Walter N. Miller was appointed to a second one-year term as chair.

Board members are appointed by a selection committee composed of the presidents and presidents-elect of the Academy, the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries. The three-year terms of membership are staggered, so that one-third of the members are appointed annually. The selection committee annually appoints the chairperson of the ASB.

Edward Burrows is president and one of three founders of the Pentad Corporation, an independent actuarial consulting firm providing services related to pensions and other employee benefits. Previously, he worked for the David C. Rothman Company and the Connell Company. He began his actuarial career in 1954, with the Travelers Insurance Company. Burrows has been active in various actuarial organizations: he is a past president of the American Society of Pension Actuaries and a member of the Academy. He holds a B.S. degree from the University of Michigan and is an enrolled actuary under the Employee Retirement Income Security Act.

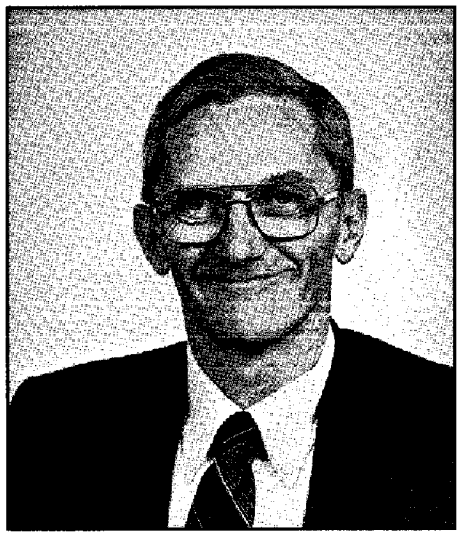
Harry Sutton, an actuary specializing in health-care analysis and actuarial rating practices, is currently in charge of actuarial functions at R.W. Morey, Inc., a major reinsurer of catastrophic health-care services for the HMO industry. Prior to joining Morey earlier this year, Sutton served with Towers Perrin, where he became a leading consultant for the developing HMO movement. Beginning in 1950, he worked nearly twenty-five years for the Prudential Insurance Company in various actuarial areas; he was involved in developing Prudential's entry into the HMO area. Sutton is a charter member of the Academy and has testified at congressional hearings as a member of the Academy's Health Committee. He is a Fellow of the Society of Actuaries and a frequent speaker at the Society's professional programs as well. Sutton was graduated from Williams College, and he received an M.A. in mathematics and actuarial science from the University of Michigan.

October Meeting Highlights

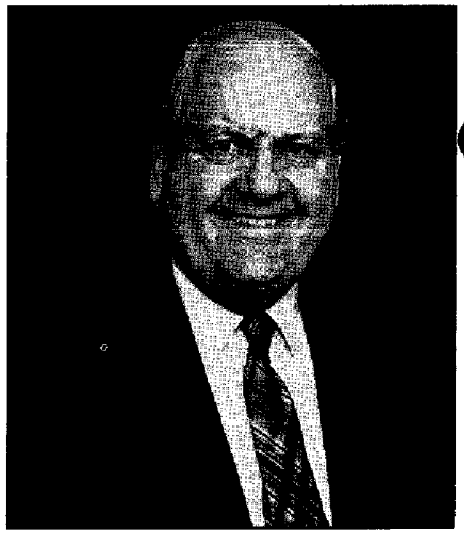
Long-Term Care Standard Exposed. At its October meeting, the ASB approved release of an exposure draft on long-term care insurance. The purpose of the proposed standard is to provide guidance to actuaries practicing in the field of long-term care insurance. The preamble to the proposed standard notes that the related provider and delivery systems for long-term care "are evolving rapidly, driven by changing demographic characteristics, technology, governmental actions, and costs of the systems." The proposed standard provides assistance in understanding the nature of these systems, and it describes recommended practices to guide an actuary in this diverse field.

The proposed standard was developed by the ASB Task Force on Long-Term Care, chaired by Bartley L. Munson. A copy of the exposure draft is enclosed with this issue of *The Actuarial Update*. Comments on the draft are encouraged and are due on February 15, 1991.

Proposed Expert Testimony Standard Reviewed. At the same meeting, the board reviewed the proposed final version of the standard on expert testimony by actuaries and suggested various changes for purposes of clarification. This proposed standard was developed by the Expert Testimony Task Force of the Specialty Committee of the ASB, chaired by Steven A. Harrold. Issued as an exposure draft in January 1990, the proposed standard drew forty-three comment letters. The task force carefully reviewed the comments, and many suggestions were incorporated into the proposed final standard.



Edward E. Burrows



Harry L. Sutton, Jr.

One significant issue that the board did not resolve was the potential inconsistency between "telling the truth" and offering testimony as an "advocate." An example of when this issue could be a problem is in the case of an actuary testifying at a rate hearing on behalf of his or her client or employer. Certainly the actuary would present the facts that support the employer's cause, but would the witness's oath to "tell the whole truth" mean offering comments that might advance the other side of the issue? The board asked the task force to incorporate some suggested changes and to give further consideration to how the interests of advocacy and truth may intersect. The board will review

the revised document at the January ASB meeting.

Proposed HIV Standard Not Promulgated. In other action, the board decided that the proposed standard titled *Guidance on Estimating and Providing for the Cost of HIV-Related Claims Covered under Life and Accident and Health Insurance Policies*, published as a second exposure draft in April 1990, should *not* be promulgated. Comments received on the draft persuaded the ASB that a separate actuarial standard of practice for the HIV claims was not needed. Among the reasons for this action, the ASB noted that *Statement of Actuarial Opinion for Life Insurance Company Statutory Annual Statements*, Financial Reporting Recommendation 7, which is itself an actuarial standard of practice, gives specific advice as to the practices that should be followed by an actuary opining on the adequacy of statutory reserves. In particular, the board noted that the advice in Section 7 of Recommendation 7 on the evaluation of the adequacy of reserves is applicable to all causes of claim.

To clarify the applicability of Recommendation 7 to HIV-related claims, the board has promulgated Financial Reporting Interpretation 7-D, *Estimating and Providing for the Cost of HIV-Related Claims Covered under Life and Accident and Health Insurance Policies*, in order to provide guidance on how HIV-related claims should affect the testing for the adequacy of statutory reserves required by Recommendation 7. A bulletin explaining the ASB's action and the new Interpretation 7-D is enclosed with this mailing of *The Actuarial Update*. Financial Reporting Recommendation 7 may be found in the booklet titled *Financial Reporting Recommendations and Interpretations*, which is contained in the appendix section of the standards handbook.

All meetings of the ASB are open, and members of the profession and the public are invited to attend. The next ASB meeting is scheduled for January 9-10 in Washington, D.C.

Nickerson is director of the standards program.

Legal Lines

by Gary D. Simms

On October 25, the Supreme Court of the state of Washington, in a unanimous 9-0 decision, ruled that the state's insurance commissioner has the authority to regulate insurance practices that are deemed unfair to the public—even if such regulation has an impact on life insurance rates.

In *Omega National Insurance Company, et al. v. Richard G. Marquardt*, the insurer, Omega National, joined by the American Council of Life Insurance and other insurers, appealed an earlier court decision. The previous decision had upheld Insurance Commissioner Richard Marquardt's authority to issue a regulation that would prohibit life insurance policies that (1) have death benefits of less than $25,000 and (2) have benefits during the first ten years that do not equal or exceed the premiums plus interest. The insurers argued that the commissioner's rule amounted to rate regulation of life insurance policies, which is prohibited under Washington law.

The commissioner promulgated the rule pursuant to the state's legislative grant giving the commissioner power to regulate "unfair" insurance practices. According to a finding issued by the commissioner, the purpose of the rule in question was to deal with small life insurance policies issued to older buyers.

In these policies, high mortality rates and heavy expense loading were combined to produce what the commissioner called extremely unfair results. The commissioner argued that unless the policyholder died within a small window of time, the premiums paid would exceed the benefits. He further argued that the marketing of such policies, particularly the intensive mass marketing of small policies targeting senior citizens, tended to be deceptive, was "unfair," and should be prohibited.

The insurers argued that the regulation exceeded the commissioner's authority, because it was tantamount to rate regulation, which, for life insurance products, is prohibited under Washington law. They also argued against the regulation's constitutionality, citing alleged violations of due process and equal protection, and discrimination against the elderly.

The court declined to agree with the insurers' position that the lack of authority to control rates means that the commissioner is prevented from issuing *any* regulation that would have *any* effect on rates.

Noting that Washington law does not provide for rate regulation of life insurance products, the court found persuasive the argument made by the commissioner that the rule issued was "not primarily a rate setting rule; rather, it defines certain types of insurance policies which are, in the Commissioner's judgment, inherently unfair to insurance purchasers."

With respect to the regulation's constitutionality, the court ruled that only "minimal scrutiny" by the courts was necessary in construing the constitutionality of legislative authority, and that the plaintiff insurers bore the "heavy burden of showing that there is no rational basis" for the action taken.

To prevail, the plaintiffs were required to show that the regulation was *contrary* to the purposes of the legislation; they had to "do more than merely challenge the wisdom and expediency of the statute." This, the court found, the plaintiffs had failed to accomplish.

On the issue of whether the rule discriminates against the elderly, the court noted that the rule on its face does not specifically mention older insurance buyers, but applies to purchasers of all age groups.

Finally, the insurers had argued that the rule violates the constitution by being confiscatory. The court responded that nothing in the regulation compelled insurers to continue offering policies with what the insurers believed to be inadequate premiums.

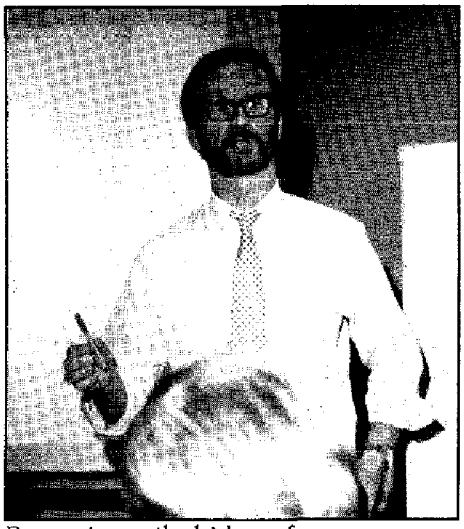
Readers will recall that the Academy submitted an *amicus* brief in this case, attempting to call to the court's attention the issues of risk classification that arise when a *de facto* rate ceiling is imposed without regard to the nature of the risk.

Simms is the Academy's general counsel.

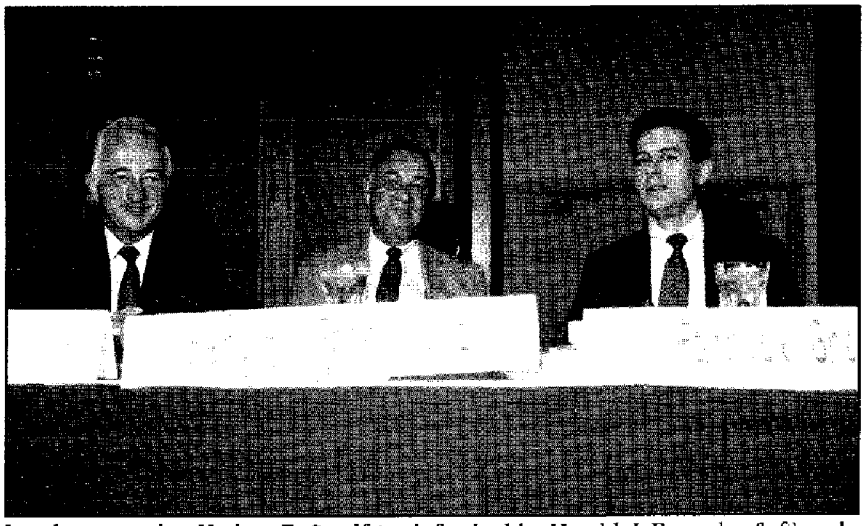
1990 Casualty Loss Reserve Seminar

This year's Casualty Loss Reserve Seminar (CLRS) was conducted September 9–11, at the Hyatt Regency DFW, in Dallas. More than 100 speakers presented sessions on topics of interest to actuaries, risk managers, accountants, and insurance regulators. Sessions were specifically designed to meet the continuing education requirements for actuaries involved with loss reserving. Three session tracks on loss reserving methods—at basic, intermediate, and advanced levels—were offered, along with a wide range of other sessions on special topics. Reserving for involuntary markets, margins for adverse deviations in loss reserving, trends in tort liability, reinsurance commutation, environmental impairment, and medical malpractice insurance were some of the topics added to this year's program. The 1990 program was cosponsored by the Academy, the Casualty Actuarial Society, and the Conference of Actuaries in Public Practice.

The program generates a smile or two.



Regression method à la professor Ben Zehnwirth.



Luncheon speaker Herbert E. Goodfriend, flanked by Harold J. Brownlee (left) and CLRS chairman, Patrick J. Grannan.

Comradery and a welcome break after Basic Methods.

Having moderated one session, Michael Toothman enjoys another from the back row.

Prognosis for Property/Casualty Loss Reserves: Not Healthy Enough

by Ken Krehbiel

Loss reserves for a majority of property/casualty companies have deteriorated somewhat, according to Herbert E. Goodfriend, luncheon speaker at the Casualty Loss Reserve Seminar, September 10, in Dallas.

"Our study, which is an amateur's assessment of reserves, finds that, of the twenty-two companies we followed closely, about 75% are adequate or modestly redundant," said Goodfriend, who is senior vice president and senior analyst for Prudential-Bache Securities. "That's a lower proportion than it was a year ago, which in turn was lower than two years ago. And it's the lowest since we've been doing this study about ten years."

Only a minority of companies' loss reserves improved in 1989, Goodfriend said. He went on to explain that despite the interim securities market volatility and erosion, the balance sheets of the major P/C companies are still relatively strong, even with year-to-year depreciation.

Regardless of whether or not company reserves are understated, industry spokespersons will tell you that the industry must come up with bucks in due course, Goodfriend said. "The fact is that most of the companies have been postponing the moment of truth, hoping to eke out through the fray and get through a terrible time without upchucking and having to come up with major bucks. And that's a rather deft game, which has proved conclusively in the past to be very elusive for most companies to do well."

Goodfriend considers an upturn in the commercial cycle unlikely before mid-1991, barring outside stimuli that "shake the tree." He outlined three possible scenarios. One would be a series of natural catastrophes. "They happened with a vengeance last year," Goodfriend said, "and we might—as we enter the new hurricane season and related storms—get a series of shock waves in the fall and winter."

Second, "securities markets can be hardly described as stable. As somebody who's supposed to be good at business, I can tell you that things ain't so good," Goodfriend said. "The bond and stock markets are quite volatile. They were volatile before Kuwait and the Middle East, and they are likely to remain so. But if they became really volatile and you had a shakeout of the dimensions of two years ago or of 1987 . . . that could overnight cut away some of the capacity. I'm not hoping for that, but that could certainly shake the tree.

"Thirdly, you could have reserve strengthening," he said. "What's an oxymoron: adequate or redundant reserves? Well, reserve strengthening is certainly due.

"Suffice to state that, of course, the federal government takes a different view of the health of your business. They see you as robust, and of course, certain of the individual states and the people's advocates, the demagogues, also see you as deserving of another round of tax increases. Fortunately, I don't think that's going to happen this year. But sure as little apples, they'll be back in 1991 and '92 to try to extract another pound of flesh." Δ

Prudential-Bache Securities VP, Herbert Goodfriend, delivers keynote.

Five (Nontechnical) Tips for Loss Reserving

Qualitative aspects that might make the difference between a good loss reserve evaluation and an excellent one.

1. **Be prepared.** Start with a comprehensive set of questions, and include them in your work papers.

2. **Don't be afraid to ask dumb questions.** Ask for definitions, clarifications, explanations.

3. **Focus on the important issues.** Don't get sidetracked on immaterial issues, however interesting they may be.

4. **Be persistent.** Don't be over concerned about annoying the person you have to get information from. Your work will be evaluated for its thoroughness, not according to whose feathers you did or didn't ruffle.

5. **Plan to ask a second round of questions.** After you gather the first round of information and begin to do your calculations, additional questions will inevitably arise.

This advice is from Walter C. Wright III, senior manager, Price Waterhouse, speaking at the Casualty Loss Reserve Seminar session "Looking Beyond the Numbers," September 11.

1990 BUDGET RECONCILIATION
(continued from page 7)

equally lengthy.

With OBRA 1990, there were additional changes made to the Social Security OASDI program; the nation's housing programs, including the Federal Housing Administration's Mutual Mortgage Insurance Fund (See sidebar on page 4); the federal flood insurance program; and the federal retirement program, as well as changes to a number of environmental programs. All these and other changes may be of interest to actuaries in highly specialized or nontraditional areas of practice.

The full text of OBRA 1990 and the managers' conference report appear in the October 26, 1990 *Congressional Record*, No. 149, Part II.

Hendricks is director and Bryant is assistant director of the Academy's government information program.

Medical Malpractice: Is the Crisis Over?

by Jeanne Casey

The answer to the question is a guarded "yes," according to experts speaking at the annual Casualty Loss Reserve Seminar in Dallas, September 9. James Hurley, actuary and principal with Tillinghast/Towers Perrin, indicated that the crisis of availability of medical malpractice insurance, which peaked in 1974–75, is decidedly over. Even the related crisis in affordability, which has persisted through the mid-1980s, may be easing. Hurley presented physician-and-surgeon claims data from St. Paul Company for report years 1979 through 1988. A pronounced downturn in what had been an annual trend of increase in pure premium of 20% until 1986 may indicate that claim severity, the average cost of settling a claim, has been somewhat mitigated by tort reform, according to Hurley.

Allan Kaufman, a consulting actuary with Milliman & Robertson, said that jury verdict data show that the size of jury awards for all personal injury cases was down 28% in 1986. Kaufman reflected, however, that the statistical variation around the data points of the downward trend means that "the crisis in terms of trying to get the rates right is still there."

Perpectives on medmal trends: Allan M. Kaufman, James J. Olzacki, James D. Hurley, panelists.

Tort reform in the mid-1980s may have influenced the public's attitude toward awarding increasingly large settlements in malpractice cases. Yet, "there is nothing to prevent this awareness from reversing itself," Kaufman pointed out. In projecting the costs of future claims and establishing reasonable rates for malpractice insurance, actuaries will need to consider the probability of just such a trend reversal.

James J. Olzacki, vice president, General Reinsurance Corporation, agreed that the trend could just as easily go up, especially for claim severity. "We have yet to see how the AIDS epidemic will move through the medical system," he noted. He said that the question to ask is no longer "Is the crisis over?" but "What will the *size* of the next crisis be?" Δ

NAIC Blanks Task Force Proposes Amendments to 1991 Casualty Blank

The NAIC's Blanks Task Force has suggested changes to the instructions to the Casualty Blank, which, if adopted at the December meeting of the National Association of Insurance Commissioners (NAIC), will alter requirements for the actuarial opinion on loss reserves beginning with the 1991 blank. Changes proposed for 1991 include the following:

- Paragraph 6 would be amended to conform to the new definition of "qualified actuary" by requiring the opining actuary to state his or her qualifications.
- The scope paragraph would be amended to include, as two separate items: (1) reserve for direct and assumed unpaid losses and (2) reserve for direct and assumed unpaid loss adjustment expenses.
- A new paragraph 11 would be included as follows:

"The actuary should comment in the scope section, as appropriate, on relevant topics such as the following to the extent they affect, or could affect, the loss reserves: discounting, salvage/subrogation, loss portfolio transfers, financial reinsurance, and reinsurance collectibility. If the company reserves will create exceptional values using the NAIC IRIS tests, the actuary should include an explanation."

- The statement calling for "good and sufficient provision" would be replaced by the phrase "make a reasonable provision for all unpaid loss and loss expense obligations of the Company under the terms of its policies and agreements."
- The current paragraph 12 would be amended by adding a requirement that "The actuary should describe the actuarial assumptions and/or methods which have been used."
- A new paragraph on workpapers requires that the statement include assurance that workpapers supporting the actuarial opinion will be maintained at the company and available for examination for seven years.
- A new signature requirement would state as follows: "The statement should conclude with the signature of the actuary responsible for providing the opinion. The signature should appear in the following format:

Signature of actuary
Printed name of actuary
Address of actuary
Telephone number of actuary.

Copies of the proposed amendments are available from the Academy's Washington office.