Early Retiree Health Under Clinton Plan

By Harry Sutton

Among the many changes in President Clinton's proposed Health Security Act of 1994 is one that constitutes both a major change in national retirement policy and assumption by the larger public of current massive liabilities of major American corporations.

Under the Health Security Act, nearly all American workers over age 55 would be eligible for subsidized early retirement health benefits. If a worker has the required forty quarters of covered employment for OASI retired worker benefits, then at age 55 the worker can withdraw from the labor force and retain health insurance coverage by only paying 20% of the average premium rate for the health alliance in the worker's geographic area.

This is a dramatic departure from current policy. First, nearly all Americans would be able to retire any time after age 55 with full assurance that they would be guaranteed access to health insurance at only 20% of full cost until Medicare eligibility at age 65. Currently, early retirement with heavily subsidized health insurance benefits is available only to workers whose employers are willing to provide such a benefit, and this luxury is limited primarily to workers employed by America's largest and most prestigious corporations. The second dramatic departure from current policy is relieving employers who currently offer health insurance to their early retirees of their responsibility for paying for the insurance. Under Clinton's proposal, these employers' only obligation would be a temporary 3-year assessment of 50% of their savings due to the change in government policy. After 3 years, they would no longer have any financial obligation. However, many of these employers could be expected to pay the employees' 20% of the premium.

There is no compelling analytic reason for making these policy changes a part of the President's proposal. The overall proposal would work equally well if individuals over age 55 were treated similarly to all other individuals under the age of Medicare eligibility.

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A s chairperson of the Actuarial Board for Counseling and Discipline, I can’t afford to be too sensitive. Many misperceptions exist about the ABCD’s work, and erroneous opinions are afloat. Recently, an experienced actuary known for his fierce independence said in total sincerity that the ABCD poses a threat to actuaries comparable to the KGB! And I’m afraid he is not alone in that opinion.

An important part of my task as chairperson is to explain to members that the ABCD is not a power-hungry cabal bent on harassing the innocent, but rather a group of fellow practitioners who strive to uphold the high professional standards already practiced by the overwhelming majority of actuaries. We at the ABCD must persist in our efforts to better explain the real nature of our work.

The ABCD is a young organization. Our early experience tells us when we make an inquiry in response to a complaint about an actuary's conduct, the actuary involved may not react well. Why is this? Well it’s human nature. Most of us are uncomfortable having a peer review our work or challenge it in some way. We are not used to outsiders inquiring about the propriety of our client relations. Also, actuarial standards are new, and too often we have not studied them thoroughly. Certainly, we have not become accustomed to documenting our work product against these standards. And although we know that the threat of actuarial malpractice or other suit on professional matters is the new reality of the 90s, we have not sufficiently modified our daily practice to protect ourselves.

So it is understandable that some view the ABCD as an intruder into the realm of an actuary’s personal practice and ethics. Inquiries, complaints, etc. can be viewed as threats—to independence, ethics, and competence.

Although the ground rules have changed in our world, many actuaries are reluctant to change with them. The longer we have been in practice the harder it is to accept the new conditions. However, we can no longer be lone gunslingers who shoot from the hip, answerable to no one.

After almost 2 years of experience, the ABCD and its staff are aware of these reactions. We are sincerely dedicated to helping actuaries improve their work and practice—by guiding, advising and helping. Punitive action is not our purpose, except in the most egregious situations. It is unfortunate that it is the D for discipline in the ABCD’s name that seems to stick in most people’s minds. We choose to emphasize the C for counseling.

In fact, we stand ready to help in any way that might be useful to members. We receive many informal inquiries and requests for guidance, as well as formal complaints. Any member of the ABCD or our general counsel, Lauren Bloom, may be contacted for assistance. If we don’t have a ready answer to your question, we’ll develop one for you promptly.

Where a potential violation of the standards or code of conduct exists, the matter often can be resolved without formal action. Remember, every actuary who wishes to report a violation is permitted by Precept 16 of the Code of Professional Conduct to take the matter first to the actuary and try to resolve the problem to mutual satisfaction before filing a complaint. Often an apparent breach is really a misunderstanding based on incomplete or incorrect information. By direct talks with the other party, many disputes can be resolved without the intervention of a third party. If that process fails, the ABCD and its staff may be able to help before the matter becomes a formal complaint.

We encourage actuaries to confront honestly the ethical challenges that arise in daily practice. In fact, we stand ready to help, not to threaten.

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Notice From N.Y.

The New York State Insurance Department would like to inform the readers of The Actuarial Update that the state has not yet adopted the equivalent of the Model Standard Valuation Law promulgated by the National Association of Insurance Commissioners in 1990 and amended in 1991. The prognosis for such adoption is now uncertain. The New York Legislature considered, but did not adopt, the equivalent of that model in 1992 and 1993. That proposal was submitted by the State Insurance Department with the assistance of an industry committee organized by the Life Insurance Council of New York. A draft supporting replacement of Regulation 126 was also then prepared.

Therefore, with regard to any cash flow analysis of liabilities and supporting assets as of December 31, 1993, insurance companies should plan to comply with Regulation 126 through the second amendment dated November 25, 1992. The New York State Insurance Department is thus primarily interested in the sufficiency of reserves of the type covered by Regulation 126. Other reserves may be separately analyzed in the materials submitted to New York. Any aggregate reserve test shall continue to comply with Section 95.8(d)(2).

Robert J. Callahan
Chief Life Actuary I
New York State Insurance Dept.
The publicity, part of the actuarial profession in North America's Forecast 2000 public relations program, was organized to coincide with a CIA meeting in Montreal. The report makes four recommendations: increase normal retirement age, change the dropout provision, eliminate the year's basic exemption, and downsize survivors' benefits.

Current government projections call for workers' contributions to rise to 13.25% by the year 2035 to finance the next generation of retirees. If the four options were adopted in their entirety, those rates would rise to only 7% from the current contribution rate of 5%, according to the report.

Three Canadian actuaries made the recommendations at two press conferences on November 11. C.S. (Kit) Moore, chairperson of the task force that produced the report, vice president of M.I.H + A Inc. and former CIA president, and Robert Brown, former CIA president and associate professor of statistics and actuarial science at the University of Waterloo, released the report to media at a Toronto press conference in the morning, then flew to Montreal, where Denis Latulippe, head of the research and development department at the Commission administrative des régimes de retraite et d'assurances, Quebec City, joined them as francophone spokesperson at the Montreal press conference.

Brown and Moore then presented the report at a CIA meeting session.

As CIA meeting attendees arrived on the main meeting floor that morning, they were greeted with an overhead projection of a newspaper clipping under the headline "Actuaries count on pension plan." The column by Ellen Roseman appeared in that morning's Toronto Globe and Mail. Details of the report were embargoed for release, however, Roseman received an advance copy with the understanding that she could write about the report, but could not divulge details to the media at a Toronto press conference. Roseman attended the afternoon press conference in Montreal, and a short item enumerating the recommendations appeared in the next day's Globe and Mail.

Before seven o'clock the morning of November 12, Brown appeared live nationwide on CBC's "Canada AM." At the same time, Moore was being interviewed live on CBC radio. Print media coverage of the report on the C/QPP appeared in the Montreal Gazette, La Presse, Toronto Sun, and The Financial Post, in addition to columns and editorials in the Toronto Globe and Mail.

Accompanying the spokespersons in Toronto were Academy Director of Public Relations Erich Parker and Elizabeth Kelley Grace, senior vice president of Stephen K. Cook & Company, which provides public relations counsel to Forecast 2000. Forecast 2000 is cosponsored by the six major organizations in North America representing actuaries: the Academy, the American Society of Pension Actuaries, the CIA, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

At the Friday CIA meeting luncheon in Toronto, Moore formally presented the Silver Anvil Award to the CIA and current President James Brierley and recognized the efforts of Forecast 2000 staff. The Silver Anvil Award, the most prestigious honor bestowed upon a public relations program by the Public Relations Society of America, was awarded to Forecast 2000 in July. Each of the sponsoring organizations received its own trophy.

Krehbiel is the Academy's assistant director of public relations.
Under Clinton's proposed treatment, early retirees who normally would be self-insured or have competitive health options would shift to the health alliances rather than be included under large employer plans, which would generally be expected to be corporate alliances. The result would be a cost shift away from those employers currently offering early retiree health benefits onto other payers in the system.

Recent comprehensive aggregate data on employers' costs for early retiree health benefits are not readily available. However, data from a 1991 General Accounting Office (GAO) study give some notion of what is probably a lower bound estimate of the magnitude of the cost shift. The GAO study examined the impact on employers' early retiree health liabilities of lowering Medicare eligibility from age 65 to age 60, and throughout the study assumed that Medicare would pick up 70% of the tab now paid by employers offering these benefits.

According to the GAO study, estimated total balance sheet liabilities for retiree health benefits of large corporations were approximately $335 billion in 1991. The study further estimated that reducing the employers' liability by 70% for retirees age 60 to 64 would shave $99 billion off the employer liability. Applying the same relative ratio to liabilities to age 55 to 59 retirees shaves another $26 billion off employer liabilities. Adjusting the GAO numbers to reflect the 80% savings to employers under the Clinton proposal (rather than the 70% used for Medicare in the GAO study) yields a reduction in corporate liabilities for early retirees' health benefits in excess of $140 billion.

Shifting a $140 billion liability from a reasonably small number of large corporations to other health insurance payers is an enormous cost shift. Some of this cost shift, however, may be retrieved indirectly. For example, an estimate based on data from annual corporate reports suggests that approximately 10% of this reduction in corporate liabilities for retiree health belongs to the Big Three auto manufacturers, and indirectly the United Auto Workers and other major unions.

There is speculation that the administration's cost estimates assumed that either the workers in these companies will have wage increases following the next bargaining with resulting increases in federal income tax revenue, or there will be increased corporate profits, again subject to federal income taxes, to partially offset the decrease in early retiree health costs. Unfortunately, the administration has not seen fit to release sufficient information on its cost estimates to evaluate the reasonableness of interactions and offsets assumed.

**Other Compounding Factors**

While important to large corporations and unions, particularly in the automobile and steel industries, the cost savings from early retirees' health insurance that will be shifted to other payers are only a small part of the overall savings that may accrue to major corporations. A more complete estimate of the cost shifting implications has to take account of other factors.

**Prescription Drugs.** In addition to subsidizing corporations' retirees under age 65, the Health Security Act would reduce corporate retiree health liabilities for their retirees covered primarily by Medicare. Prescription drug coverage for the large employers for retirees amounts to between 30% and 40% of claim costs. The prescription drug program for Medicare outlined in the Health Security Act would probably eliminate 25% or more of the corporate expenses for over-65 retiree health care.

While the early retiree health costs of the auto industry may approach 75% of their total liability, it's not clear how the estimated $335 billion would be divided between retirees under age 65 and those over age 65 for all corporations. Assuming approximately a 50/50 overall split, a reduction in liability for these companies for early retiree health care would be an additional $25 billion to $30 billion. The magnitude of these corporate savings is enormous.

**Noncovered Early Retirees.** There are millions of retired people who have not yet reached age 65 and eligibility for Medicare who do not have employer-based retirement coverage. These also would become eligible under the Health Security Act to join a health alliance, with the federal government subsidizing 80% of their cost.

**Retirement Block.** In addition to providing a windfall for early retirees, the Health Security Act is designed to address such factors as "job lock" where people are afraid to move upward to a higher-paying job because of possible loss of limited health insurance coverage. However, there is also what may be called "retirement block." Particularly in such fields as teaching or state government employment, there are a number of people who might have adequate income to retire but cannot afford to pay for health coverage. An estimate is needed for a possibly large induced early retirement, which would greatly increase the subsidies required over and above the subsidies that would go to those under age 65 who are already retired.

**Spouse coverage.** For a number of individuals who have retired, a spouse may continue working in order to maintain health insurance. Particularly when the working spouse is female, the availability of extensive health insurance at only 20% of its family cost would probably induce many of these formerly second wage earners to consider retirement as well.

Members of the administration assert that estimates have been made concerning the number of early retirees who will become re-employed, or who will have a spouse employed. The nature of the coverage of the early retirees would shift the coverage from the employee (assuming the employee doesn't work at all) to the spouse. This would lower the federal subsidy but indirectly shift...
GAAP for Mutual Life Insurers

By Stephen L. White

In addition to their statutory financial statements, stock life insurance companies issue statements in accordance with GAAP (generally accepted accounting principles). Rules for GAAP statements are prescribed by the Financial Accounting Standards Board (FASB). Two requirements of particular importance to life insurers are FAS 60 and FAS 97. FAS 97 defines the accounting for universal life-type policies.

Policyholders of stock life insurance companies are clearly customers. Policyholders of mutual life insurance companies are also owners of the company. It is very difficult to characterize transactions with policyholders as company-customer or company-owner; therefore, FASB exempted mutual life insurers from FAS 60 and FAS 97. Mutual insurers are also exempted from FAS 113 on reinsurance. FASB did not prescribe any alternative to those statements for GAAP statements.

With no explicit definition of GAAP for mutual life insurers, many companies published their statutory financial statements with descriptions such as, "These statements were prepared in accordance with statutory accounting principles, which are considered to be generally accepted accounting principles for mutual life insurance companies." Public accounting firms gave unqualified ("clean") audit opinions on such statements.

In 1992 FASB issued interpretation No. 40. Effective with 1995 statements, a mutual company's statements can be described as GAAP only if they comply with all GAAP requirements except those where explicit exemptions are given. FASB encouraged the American Institute of Certified Public Accountants (AICPA) to recommend an accounting model for insurance activities of mutual insurers.

The AICPA formed a Mutual Life Insurance Task Force under the auspices of its Insurance Companies Committee (ICC) and charged them with developing a model within the framework of FAS 60 and FAS 97. With the 1995 deadline and the time required for exposure, comment and implementation, rapid progress was essential. The task force comprised seven representatives of the public accounting profession and four representatives of the mutual life industry. The Academy appointed Stephen L. White its nonvoting liaison to the task force. Academy members White, Peter Duran, Glen Gammill, Michael Levine, and George Silos discussed the insured and prepared numerous illustrations for the task force.

The primary issues before the task force were:

1. Income should emerge proportional to margins, where margin calculations use the net level premium reserve for guaranteed benefits calculated at the dividend fund interest rate.
2. Premiums should be reported as revenue.
3. Deviations from assumptions cause DAC amortization to be revised retrospectively, as in FAS 97.
4. There should not be a provision for adverse deviation.
5. Generally, DAC amortization should be based on dividends paid in cash.

The actuarial illustrations provided by the Academy volunteers helped the task force reach a recommendation in 6 months, a very short time for such a complex project.

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Tennessee received a Medicaid waiver from the Health and Human Services Department (HHS), to implement its health care program. TennCare is a 5-year demonstration project designed to deliver care to a million Medicaid recipients through managed-care organizations. According to the HHS, the project is also expected to cover an additional 300,000 currently uninsured people in the first year. Under the plan, enrollees with incomes above the federal poverty level—except for those in mandatory Medicaid eligibility groups—will be required to share some of the costs by paying premiums, deductibles, and copayments. Some limitations on hospital and physician outpatient and inpatient care, prescription drugs, and laboratory services will be removed. Outpatient treatment for substance abuse will be covered. The waiver was granted with more than thirty terms and conditions. One condition states the administration will not allow Tennessee to enroll anyone in a plan lacking sufficient qualified practitioners; therefore the Health Care Financing Administration must approve them. TennCare is scheduled to be implemented on January 1, 1994.

The U.S. Tax Court’s decision in Vinson & Elkins v. Commissioner of the IRS was upheld by the United States Court of Appeals on November 29. In the U.S. Tax Court case, the Commissioner of the IRS assessed deficiencies against Vinson & Elkins, disallowing a portion of the deductions, which were passed through to its partners, for contributions to defined benefit pension plans. The U.S. Tax Court found that actuarial assumptions underlying those contributions were reasonable and ruled in favor of Vinson & Elkins. The U.S. Court of Appeals affirmed the Tax Court’s decision, despite the Commissioners’ challenge that the U.S. Tax Court applied both an improper legal standard and a proper one improperly.

Labor Department audits of pension plan assets would be expanded under legislation scheduled to be introduced early in 1994. Under ERISA, all pension plan funds that have been invested in institutions such as insurance companies that are already regulated by federal or state governments are exempt from review by an auditor. The exemption places an estimated $2 trillion in pension fund assets at risk. The loophole also endangers government assets because it guarantees the payment of pension benefits for defined benefit pension plans.

An IRS hearing on proposed mutual insurance company regulations attracted no witnesses, though representatives from the stock and mutual insurance companies had requested to testify and were scheduled to speak. In general, the proposed regulations, issued in September, are used to determine the equity base for purposes of computing the differential earnings amount and recomputed differential earnings amount.

Rep. J.J. Pickle (D-Tex.), an advocate of proper funding of pension plans, will retire next year after more than 3 decades in Congress. Pickle is the third-most senior Democrat on the House Ways and Means Committee and serves as chairman of the Ways and Means Subcommittee on Oversight. Recently, Pickle has promoted legislation seeking to strengthen the Pension Benefit Guaranty Corporation.

The IRS announced that pension plan sponsors are not required to notify participants when plans are amended to comply with the reduced retirement benefit compensation limit mandated by the Omnibus Budget Reconciliation Act of 1993. IRS Announcement 93-146 states that the ERISA Section 204(h) notice is not applicable to plan amendments raising out of statutory changes to qualified plan limits. Despite the fact that there may be a significant reduction in the rate of future benefit accruals under their qualified plans, employers are not required to inform plan participants that the maximum annual compensation that may be considered under the qualified plan will be reduced from $235,840 to $150,000 (as indexed) beginning in 1994.

Vermont Governor Howard Dean proposed universal access to health care in the state by 1995. The governor’s bill proposes a multipayer system with employers contributing at least half the premium costs for their employees. Additional funding for the program would come from increased taxes on beer, tobacco, gasoline, and hospitals. Participation would be mandatory, nearly all residents would be enrolled in an alliance, and delivery would be through both managed care and open plans. As of January 1, 1995 membership in the alliance would be required for workers whose
CLINTON PLAN, continued from page 5

the cost to the spouse's employer, who is much more likely to be a small employer and not one of the very large companies from which the employee retired.

Intergenerational Cost Shifts. There is another source of covering the subsidy rather than direct funding from federal sources. The federal funding of these people is based on the community rate offered through the health alliances. Based on the administration's original estimate of an employee-only cost of approximately $1,800 per year, it is estimated that the average cost per capita per year in the health alliances would run about $1,500 per year, which includes children and other dependents.

Typical actuarial estimates show the cost at ages 55 to 65 for health benefits relative to the average cost of a total population of people under age 65 would be at least double the average cost, or $3,000 per year. With possibly tens of millions of early retirees shifted to the community rated pools, the cost difference would add approximately 10% to the community rate.

Therefore, we are passing a sizable portion of this cost shift to individuals and small employers who are forced to enroll on a community-rated basis in the health alliance. This is in addition to the increase in community-rated cost due to the addition of Medicaid eligibles, the uninsured, and eventual shifting of some Medicare members into the health alliances.

Careful Analysis Needed

To date the Clinton administration has not released all the details on the assumed number of people to be covered in this dramatic and extremely expensive cost shift built into the Health Security Act. Many large, unionized companies would be bailed out by shifting substantial amounts of their current cost to individuals and smaller employers. These provisions have many of the same effects as lowering the age for eligibility for Medicare to age 55. (See Contingencies, March/April, 1992.)

Congress needs the complete data to understand the full implications of these changes before acting. The administration and others should carefully analyze the effects of these sweeping changes on employers who would save large sums of money and on workers who would be released from retirement block. The effect on the basic community rate for individuals and employers to whom this cost in large would be transferred also requires close examination.

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