THE ACTUARIAL update

AMERICAN ACADEMY OF ACTUARIES
VOLUME 22
NUMBER 7
JULY 1993

McCrossan Group Fosters International Links Among Actuaries

ENCLOSURES

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

In Search Of
ASB Boxscore
ABCD Rules and Procedures
ASB Exposure Draft

By W. Paul McCrossan

The McCrossan Group, an informal association comprising the leaders of actuarial organizations from six nations, met for the second time in Dallas in mid-May. The editors of* The Actuarial Update *have asked the group's originator and eponym, former Canadian Institute of Actuaries President W. Paul McCrossan, to describe for our readers the group's genesis and goals.

Among the challenges facing the actuarial profession in these final years of the twentieth century are those posed by the emerging global economy. The removal of trade barriers, the internationalization of the insurance and related industries, the increasingly global scope of actuarial practice, all will have a profound impact on actuaries. Our profession must be prepared to meet these challenges if it is to thrive in this truly international economy.

Montréal Discussions

In North America, leaders of the six major actuarial organizations meet on a regular basis as the Council of Presidents to discuss common concerns. However, by the time of the meeting of the International Congress of Actuaries in Montréal in May 1992, the time had come to broaden the discussion.

Consequently, as president of the Canadian Institute of Actuaries (CIA) and host of the International Congress, I convened a gathering of the presidents, presidents-elect, and immediate past presidents of the actuarial organizations that are based on the common law tradition of professional qualification. Besides the leaders of the six Canadian and American organizations that participate in the Council of Presidents, these included representatives of the profession from Australia, New Zealand, South Africa, and the United Kingdom.

It became clear from our talks that actuaries in all of the countries present were facing similar professional issues, including:

- ❑ Evolution of actuarial codes of conduct worldwide
- ❑ Possible reciprocal recognition of standards of practice
- ❑ Possible reciprocal recognition of discipline procedures
- ❑ Possible future harmonization of basic mathematical actuarial education requirements
- ❑ Developments in insurance solvency standards and the role of the appointed actuary
- ❑ Developments in actuarial employment.

At the time of the meeting, the American and Canadian actuarial organizations had just finished harmonizing their codes of conduct and disciplinary procedures. The North American Free Trade Agreement was about to be signed and would require similar considerations with respect to agreements with Mexican actuaries.

The British Institute and Faculty of Actuaries indicated that in the European Community actuaries were struggling with many of the same professional issues through the *Groupe Consultatif,*

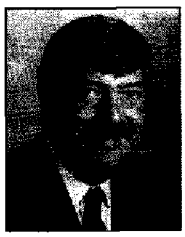
Continued on page 8

ABCD RULES OF PROCEDURE

In this month's mailing of *The Actuarial Update*, readers will find enclosed the Rules of Procedure for the Actuarial Board for Counseling and Discipline. The Rules reflect the ABCD's consideration of comments solicited from members of the participating organizations, and are intended to serve as a reference guide for actuaries and others who wish to familiarize themselves with the operations of the ABCD. We hope you will find them useful.

On June 1 the U.S. Supreme Court handed down its decision in a case of great importance to actuaries, Mertens v. Hewitt. *For Academy General Counsel Lauren Bloom's full account of the implications of the case,* *see page 5.*

FROM A
guest president



Qualification Standards: Too Important to Ignore

By Robert Dobson

My first inclination was to entitle this column "DON'T READ THIS!" I thought perhaps the old trick of reverse psychology would work, and cause people to actually read this editorial.

Standards have never been scintillating reading material, and to most actuaries qualification standards are less than popular. However, in today's environment a thorough knowledge of the general qualification standard (GQS) has become a necessity.

Some may argue that qualification standards are inappropriate because of the fierce competitive pressures we all feel. It is true that today's business climate forces us to take all the business we can get. However, I can assure you from personal experience that in malpractice cases, attorneys use real bullets. Actuaries need all the protection they can muster. We should want to adhere to standards as much from a selfish desire for self preservation as from any perceived duty to the public.

The profession recently faced a controversy on the subject of qualification standards.

Last fall the Academy Board of Directors considered a proposal for a specific qualification standard (SQS) for actuarial work relating to Statement of Financial Accounting Standard (SFAS) 106. The standard would have defined specific education and experience requirements for actuaries making public statements of actuarial opinion involving SFAS 106. The board approved the standard for exposure without endorsement in order to generate comment.

The proposed standard raised a storm of protest from many quarters. It inspired nearly ninety responses, an unheard of amount of interest in actuarial circles. While many in the profession acknowledged that SFAS 106 introduced new complexity to actuarial practice, a majority of those commenting thought the proposed standard was far too restrictive. Among those opposing it was the Pension Issues Committee of the Conference of Consulting Actuaries (CCA). In January the Academy Board agreed to withdraw the standard.

Academy President John Harding explained the board's actions and the rationale for withdrawing the SQS on SFAS 106 in a letter to the membership in March. Unfortunately, a key point is not mentioned until the second page, namely "The Board strongly recommends that actuaries practicing in the SFAS 106 area review the [GQS] and evaluate their own qualifications to practice in this new and complex area . . . Members should also be prepared to verify their qualifications with suitable documentation . . ." Similarly the meat of Jeffrey Petertil's excellent article on the topic (*The Actuarial Update*, March) appears on page 8, " . . . those making communications for purposes of compliance with SFAS 106 should note in particular the need for 'comprehensive and current knowledge of the subjects specifically involved.'"

At almost the same time that the Academy Board was withdrawing the proposed SQS, the CCA Board again was expressing its concern over the increased exposure of actuaries, particularly consulting actuaries, to malpractice litigation. The CCA Board continues to be very concerned about this serious threat. The luncheon speaker at last year's CCA Annual Meeting spoke on this topic and was very [illegible] received.

It has been noted in several places that OB/GYN physicians spend about 20% of their gross revenue for malpractice claims (insurance premiums, selfinsured costs, deductibles, etc.), accountants about 9%, and actuaries 1.5%. Is this a potential growth area for plaintiffs' attorneys? Let us hope not. We must recognize, however, that the old head-in-the-sand approach will not work. We cannot deal with the threat of malpractice litigation by failing to support the development of additional clarifying standards or to comply with already published standards, be they standards of practice or qualification standards.

But what can we say to those who argue that work is work and no actuary can afford to turn it away given our current competitive environment? Based on my personal experience, I can say that not only are the bullets real, but they leave expensive wou[illegible] It takes a lot of $10,000 jobs in a marginal area to cover a million dollar settlement, not to mention legal fees, personal time, and emotional strain. Far better to turn down a project for which your qualifications might be challenged in court, than to suffer potentially dire legal and financial consequences.

At the January 1993 Academy Board meeting, I stated that the board would not be upholding its obligation to the public if we failed to provide guidance on who was and who was not qualified to provide opinions on SFAS 106. The board's withdrawal of the proposed SQS was based on the presumption that the GQS is sufficient. The danger is that the marginally qualified and the unqualified will take refuge in the relative vagueness of the GQS compared to the SQS in this new practice area.

Yes, the GQS is sufficient—if we all read it and comply. A[illegible]e should, as much for ourselves as for the public we serve.

Dobson is president of the Conference of Consulting Actuaries.

letters
TO THE EDITOR

Farley Was the Standard

This month, the Actuarial Standards Board has issued the revised, reformatted exposure draft of Actuarial Standard of Practice No. 3, *Practices Relating to Continuing Care Retirement Communities.*

As chairperson of the committee that drafted the standard, I would like to thank all those who worked so long and hard to develop this standard, and those actuaries who will help refine it further through the exposure process.

While many individuals contributed to the standard, it represents first and foremost the vision of Jarvis Farley (1910–1991). Before audiences on the state and national level, as well as in the continuing care retirement community where he made his home, Farley championed the cause of actuarially based financial management. In the work of our committee, his thought-provoking stands, tireless efforts, and constant advocacy helped make this standard an effective guide for those who will review the financial aspects of retirement communities.

Harold L. Barney
Holicong, Pennsylvania

***The Update* welcomes letters from its readers. Letters for publication should be submitted to "Letters to the Editor," and must include the writer's name, address, and telephone number. Letters may be edited for style and space requirements.**

Workers' Comp Causes Concern

By Christine Cassidy

Insurance industry and labor groups are expressing concern over the Clinton administration proposal to include the medical portions of workers' compensation and auto insurance in its national health care reform plan. The administration's Health Care Task Force is examining two options that would keep company-by-company experience rating in place, thus promoting better workplace safety procedures, but that also would reduce administrative burdens, fraud, and abuse. The task force also intends to fold the medical portion of auto insurance into the plan.

Under one option, the workers' compensation system would continue to collect funds for health care as well as wage replacement benefits. However, no separate forms would be required, and providers would gain no advantage by certifying a patient's injury for workers' compensation. Payment would be capitated whether or not the injury was work related.

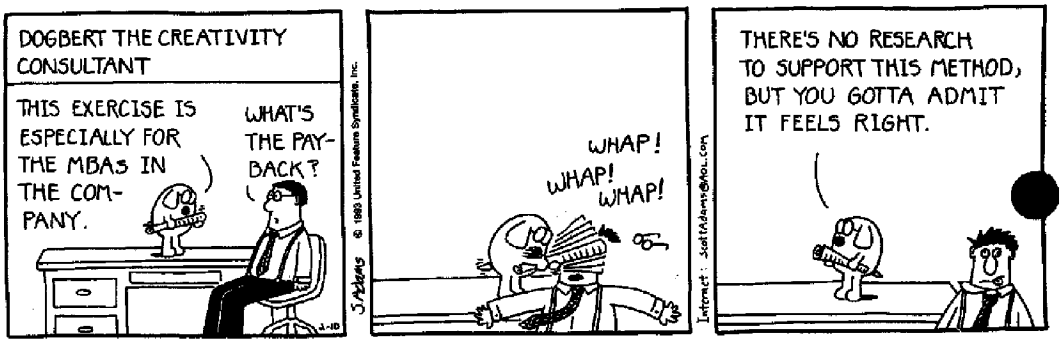
The other proposal would separate the medical portion of workers' compensation from the wage replacement component. The task force has estimated that this would result in a one-time workers'compensation rate reduction for business of 15% to 20%.

Differing state laws add to the complexity of folding workers' compensation into a national plan. The task force has been working with the National Association of Insurance Commissioners to devise a scheme that would work in all states. The task force recognizes that changes must be phased in slowly.

Many believe these proposals would add new claim costs and administrative expenses, and lead to increased insurance premiums. Many legal and social questions also come into play: How will current benefits be affected? What rights will employees have? Can employees still sue their employer? What impact will reform have on workplace safety? On employers? On safe driving incentives? On the insurance industry itself?

Workers' compensation needs to be reformed. Continuing with the current system will aggravate the shift of health care costs onto the workers' compensation and the health care delivery systems. However, the route to a solution could be difficult.

Cassidy is government affairs liaison for the Academy



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CALENDAR

Society of Actuaries
Annual Research
Conference
August 19–21

National Association
of Insurance
Commissioners
Fall Meeting
September 12–14

Casualty Loss Reserve
Seminar
September 13–14

Actuarial Board for
Counseling and
Discipline Meeting
September 28

Academy Annual
Meeting
October 6

Actuarial Standards
Board Meeting
October 13–14

Society of Actuaries
Annual Meeting
October 17–20

American Society of
Pension Actuaries
Annual Meeting
October 17–20

Conference of
Consulting Actuaries
Annual Meeting
October 25–27

Canadian Institute
of Actuaries
General Meeting
November 11–12

Casualty Actuarial
Society
Annual Meeting
November 14–17

National Association
of Insurance
Commissioners
Winter Meeting
December 5–9

ASB Mulls New Standards

By Gary Corbett

Seven witnesses, representing life insurance companies, actuarial consulting firms, and a trade association, testified at a public hearing of the Actuarial Standards Board (ASB) on March 4 in Chicago. The hearing focused on the question of developing actuarial standards of practice for the determination and illustration of policyholder dividends and other nonguaranteed elements in life insurance policies.

Thirteen written statements also were submitted, including five from regulators, two from public interest groups, two from Academy committees, and four from insurance company actuaries. The hearing brought forth a diversity of opinion. Any additional thoughts or comments from *Update* readers will serve to further the profession's dialogue with regulators on the issues raised in this article.

Nonguaranteed Elements

Two broad categories of insurance and annuity contracts have current premiums and/or benefits not fixed and guaranteed from the date of issue: participating contracts and nonparticipating contracts, which today may include nonguaranteed elements. Nonguaranteed elements are benefits or charges that may vary at the discretion of the issuing company, such as are contained in universal life contracts, indeterminate premium policies, and so-called "excess interest" policies.

Neither state statutes nor actuarial standards of practice currently provide instructions and guidance to the actuary in the determination of nonguaranteed elements in nonparticipating policies. Actuarial Standard of Practice No. 1 *does* require that the actuary fully document and describe how nonguaranteed elements are determined, but imposes no requirements concerning the methods used.

What Is Equity?

Statutes in a number of states require insurance policies to be fair or equitable, or at least not *un*fair or *in*equitable. In approving policies, some regulators believe they must determine whether policyholders would be treated fairly under the proposed policy form. They requested the ASB's assistance in defining what equity means where nonguaranteed elements are concerned.

No Common Meaning

There is, it seems, no common understanding of the meaning of *equity* in a nonparticipating policy, which has no surplus to be divided as there is in the case of participating policies.

At one extreme there were witnesses who emphasized the similarity of nonguaranteed elements to policyholder dividends. They would apply something akin to the contribution principle to nonguaranteed elements. Others contended that the contribution principle is a means of allocating divisible surplus only, and no comparable amount exists to allocate for nonparticipating policies.

Policies that credit higher interest rates in early years and lower rates in later years came in for criticism. Some characterized such policies as "bait and switch" and thought they should be restricted by regulation or by actuarial standards of practice. Other witnesses held that this was only an illustration problem; i.e., a company could market such a policy provided it did not illustrate level interest rates when it had no intention of continuing the rates in later years.

Is it required that expenses be spread in some equitable manner or that profit and contingency margins relate to the risk being undertaken or the service being provided by the insurer? Most speakers opposed trying to control the pricing of products at the front end. Competition leads to lower loads for some ages and underwriting classifications than for others, and regulating such loads would in effect constitute price regulation.

Other questions on which comments are sought include: Should nonguaranteed elements in a policy reflect variations in experience that differ from those expected at issue? Should companies be permitted to change loadings for expenses after issue? If loadings are changed for subsequent issues, should they be changed for inforce policies as well? Does it make a difference if loadings are increased or decreased?

Sales Illustrations

Hearing witnesses agreed that abuses do exist in sales illustrations for both nonguaranteed elements and policyholder dividends. Robert Nelson of the National Association of Life Underwriters called for ASB involvement in developing more precise, detailed definitions and rules governing "supportability" and current experience in sales illustrations. Witnesses discussed the effectiveness of company disclosures required in Schedule M, Exhibit 8, and the accompanying interrogatories, concluding that such disclosures had little impact.

Witnesses were asked if the ASB could act in the absence of regulation requiring that an actuary sign off on illustrations. Some speakers urged action by the profession (including the ASB) in the absence of such regulation; others urged joint action by the profession and regulators.

Comments Welcome

At its April meeting the ASB concluded that no standard of practice should be developed at this time to cover these areas. Instead, the Academy's Life Practice Council will determine how to address these important subjects.

The Academy is seeking comments on the determination and illustration of policyholder dividends and other nonguaranteed elements to share with the regulatory community. Send your thoughts to Academy Assistant Director of Government Information David Bryant.

Corbett is ASB vice chairperson.

legal LINES

Supreme Court Limits Nonfiduciaries' Liability

By Lauren Bloom

Courts have indicated that actuaries who provide professional services to employee benefit plans, but who do not manage, control or dispose of plan assets, are not fiduciaries for purposes of ERISA and, therefore, do not have a fiduciary's duties and liabilities to a plan and its participants. However, a question remains as to whether an actuary or other nonfiduciary who knowingly assists a fiduciary to breach his or her duty should share the fiduciary's liability for compensatory damages to be paid to the plan participants. That question was placed before the U.S. Supreme Court in *Mertens v. Hewitt Associates*, No. 91-1671 (*Hewitt*).

The *Hewitt* case arose out of the Pension Benefit Guaranty Corporation's termination of Kaiser Steel Company's pension plan. The plan participants alleged that the trustees breached their fiduciary duty and that Hewitt Associates, the actuarial firm that served the plan, knowingly participated in the alleged breach by, among other things, allowing the trustees to set unreasonable plan assumptions and failing to disclose the plan's funding inadequacies. This alleged breach of fiduciary duty, according to the participants, led to the plan's termination, with the participants receiving only 25–30% of the vested pension benefits to which they claimed to be entitled under the plan. The participants sought to obtain money damages from Hewitt to compensate them for their loss of benefits.

The Academy filed an amicus curiae brief in support of Hewitt arguing, in essence, that: 1) ERISA does not provide a cause of action for money damages against nonfiduciaries who participate in a fiduciary breach; 2) imposition of such damages would be disproportionate to the limited responsibilities of actuaries who provide professional services but who are not fiduciaries; 3) actuaries who breach their duties to a plan face substantial penalties without the imposition of compensatory damages through the activities of the Joint Board for the Enrollment of Actuaries and the activities of the Actuarial Board for Counseling and Discipline; and 4) the participants here had not alleged facts that would amount to a fiduciary breach, so no "knowing participation" in such a breach could have occurred.

In a 5–4 decision, the Supreme Court held that ERISA does not authorize suits for money damages against nonfiduciaries who knowingly participate in a fiduciary's breach of duty. Assuming for purposes of argument that a violation of ERISA occurred, the Court found that the compensatory damages sought by the plan participants were outside the scope of the statutory remedies provided by ERISA. The participants, therefore, could not look to Hewitt as a source of money damages to compensate them for the trustees' breach of fiduciary duty.

The Court was careful to note that other, equitable remedies could still be sought from nonfiduciaries who knowingly participated in a fiduciary's breach of duty. For example, an actuary who knowingly understated a plan's liabilities to minimize the sponsor's payment obligations could be ordered by a court to revise his or her work product, and to refrain from such intentional understatement in the future. (An actuary who violated such an order could then be held in contempt of court.) Money damages might also be sought, to the extent that the nonfiduciary derived any unjust profit from his or her knowing participation in a fiduciary's breach of duty. Further, the *Hewitt* decision does not indicate whether ERISA prevents plan participants from suing an actuary or other nonfiduciary for professional negligence under state law; such a state lawsuit could provide separate grounds for a claim for compensatory damages. At this time, however, the Supreme Court has held that ERISA prevents plan participants from seeking compensatory damages from actuaries or others who provide professional services to plans, but who are not themselves fiduciaries, even if those individuals assist a fiduciary to violate his or her responsibilities to the plan.

Bloom is the general counsel for the Academy.

On June 14 the Supreme Court decided another case with important implications for actuaries, Concrete Pipe and Products of California v. Construction Laborers Pension Trust. *See next month's* Update *for a full report.*

CAN THE STATES REFORM HEALTH CARE ?

Dr. P. David Helms, president of the Alpha Center, a nonprofit organization providing technical assistance to states in health care policy, testified on June 8 before the House Ways and Means Subcommittee on Health.

In his testimony Helms emphasized that although states are enacting health care reform legislation on their own, they need and welcome federal support and guidance. He outlined the following actions as appropriate for the federal government to pursue to support and supplement state efforts:

- ❑ Mandate participation by all parties in the system, including employers and individuals. Universal access to insurance cannot be achieved through voluntary means.
- ❑ Establish a standard uniform financing system. A major impediment to the states' achieving universal access is the political near-impossibility of deciding how to finance such broad access. A federally specified uniform financing system could reasonably require states to maintain their current levels of financial contributions.
- ❑ Establish a standard uniform benefit package. A national standard benefit would assure greater equity nationwide.
- ❑ Set clear and consistent national policies for key aspects of operating a reformed health care system.

According to Helms, states should be held accountable for mutually agreed-upon goals on quality, access and cost containment, rather than being subjected to specific federally mandated processes to achieve these goals. This will allow the states the needed flexibility to perform their expanded roles.

AMERICAN ACADEMY OF ACTUARIES

STATEMENT OF REVENUE AND EXPENSES

Summary Report from the Treasurer

Highlights of the Academy's audited financial statements for 1992 are included in this issue of *The Actuarial Update.*

Note that the auditor's opinion does not include any qualifying reservations. During 1992, revenue exceeded expenses by $529,444, thus increasing the fund balance to $1,779,808.

There were no major increases in expense over 1991 results.

The 1993 budget projects that total income will modestly exceed the net cost of operations. The fund balance will continue to increase because of investment income on reserves.

James R. Swenson
Secretary/Treasurer

AAA 1992 FUNCTIONAL ALLOCATION

Dues income	$2,875,009
Dues rate	295
Membership base	9,745

Item	Per Member*
Government information	$ 68
Public relations	31
Member communications	34
Organizational services	(1)
Interorganizational liaison	10
Executive/administrative	47
Actuarial Standards Board	33
Contingencies	23
Actuarial Board for Counseling & Discipline	9
Change in reserves	41
Dues rate	$ 295

*Net of non-dues income.

STATEMENT OF REVENUE AND EXPENSES YEAR ENDED DECEMBER 31, 1992

Revenue:	
Membership dues	$2,875,008
Membership application fees	29,255
Interest	122,970
Administrative services*	107,400
Academy Alert subscriptions	35,923
EA meeting distribution	114,025
CLRS distribution	41,380
Advertising income	241,602
Service fees (ABCD & ASB)	99,258
Magazine subscriptions	1,821
Other	19,920
	3,688,562
Expenses	3,159,118
Excess (deficiency) of revenue over expenses	$ 529,444

*Staff and overhead costs relating to the Enrolled Actuaries Meeting and Casualty Loss Reserve Seminar.

STATEMENT OF EXPENSES YEAR ENDED DECEMBER 31, 1992

	Academy Operations	Actuarial Standards Board	Actuarial Board for Counseling and Discipline	Total
Staff salaries	$972,007	$ 128,847	29,386	$1,130,240
Employee insurance	70,144	9,298	2,121	81,563
Payroll taxes	66,672	8,838	2,016	77,526
Retirement plan	134,402	17,816	4,063	156,281
Temporaries and consulting fees	12,054	—	—	12,054
Rent	184,863	24,505	5,589	214,957
Telephone	16,350	2,167	494	19,011
Postage and freight	114,177	23,086	5,239	142,502
Travel and related expenses	120,553	41,911	34,254	196,718
Committee meetings	59,321	18,814	3,594	81,729
President & president-elect travel	15,718	—	—	15,718
General office supplies & rentals	78,534	10,410	2,374	91,318
Printing	145,543	94,377	17,716	257,636
Service agreement (SOA)	68,075	—	—	68,075
Auditing & accounting	16,340	2,166	494	19,000
Insurance	16,289	2,159	492	18,940
Depreciation & amortization	53,182	7,050	1,608	61,840
Subscriptions & periodicals	25,119	3,330	759	29,208
Public relations	78,473	1,294	652	80,419
Academy Alert	12,584	—	—	12,584
Contingencies	279,445	—	—	279,445
Professional services	3,524	—	—	3,524
Income taxes	21,199	—	—	21,199
Standards notebooks	8,737	1,577	—	10,314
Membership awareness study	44,000	—	—	44,000
Other	30,174	1,583	1,560	33,317
	$2,647,479	$ 399,228	$ 112,411	$3,159,118

BALANCE SHEET DECEMBER 31, 1992

Assets

Current assets:	
Cash	$ 219,150
Certificates of deposit	296,000
Money market funds	1,947,399
Accounts receivable	172,935
Accrued interest receivable	10,644
Prepaid expenses	77,952
Total current assets	$ 2,724,080
Certificates of deposit —long-term	888,968
Furniture, equipment & leasehold improvement, net	225,021
	$ 3,838,069

Liabilities and Fund Balances

Current liabilities:	
Accounts payable	$ 247,927
Deferred membership dues revenue	1,735,637
Deferred revenue—other	50,766
Accrued expenses	18,031
Deferred rent credit	2,145
Total current liabilities	$2,054,506
Deferred rent credit —long-term	3,755
Fund balance	1,779,808
	$3,838,069

capitol VIEWS

Minnesota will allow for the creation of large health care networks under legislation recently signed by Governor Arne Carlson. The networks can be established after July 1, 1994 and will be regulated by the state to control health care costs. The legislation, HF 1178, provides broad guidelines for the networks, but each will be required to provide a full array of health care services. The Minnesota Health Care Commission is developing detailed specifications for the network, which the legislature is expected to adopt next session.

Colorado mandates the development of a medical assistance program as an alternative to Medicaid. Under Senate Bill 93-122, which was signed into law by Governor Roy Romer, the state Medicaid program will be able to ...ce competitive bids for services to help control health care costs. The law also authorizes the implementation of an automated system to aid in the administration of the state's program. The plan is to be established once federal waivers are granted.

A special session of the Kentucky legislature rejected a health care plan. Governor Brereton Jones called the special session after proposing a bill that would provide universal coverage and a statewide system of cost controls. A compromise could not be reached between the governor, who wanted to insure every Kentuckian, and legislators who questioned the state's ability to pay for the proposal. Legislators have agreed to examine the state's health care needs and work toward passage of a comprehensive plan later this year.

The California Assembly ...roved a bill to limit preexisting condition exclusions and waiting periods in health insurance coverage for all groups and individuals. Under the bill, AB 1768, health insurers and health care service plans may not exclude any person from coverage based on a medical condition that had existed for more than 6 months. Insurers and plans that do not utilize preexisting condition limitations may impose a waiting period of no more than 60 days before providing coverage. The bill is currently before the state senate and has support from the California Insurance Department and the California Association of HMOs.

Maine lawmakers killed a universal health care plan that would have provided health insurance coverage under a state-sponsored plan, but the legislature is now looking at a bill that would extend community rating to individual policies and expand liability limitations for doctors who follow voluntary guidelines. The bill, LD 1548, which has passed the House and awaits final passage in the Senate, would prevent insurers from denying coverage to people who change jobs or become self-employed by requiring community rating of individual policies. The state already has extended community rating to group policies covering twenty-five or fewer employees.

Worker's compensation reform is pending before legislative conference committees in both California and Nevada. California's proposal is expected to contain anti-fraud provisions for lawyers and medical clinics, and limits on vocational rehabilitation and counseling services. The plan also would include some form of managed care health services selected by employers, a modest increase in disability benefits, tighter stress thresholds, and limits on post-termination claims. The proposal in Nevada would permit self-insured employers to introduce managed care for workers comp coverage. The final proposal is expected to include a freeze on the average monthly wage for 2 years, reduce compensation for permanent partial disabilities, establish an employer-paid deductible of up to $200, and authorize groups of five or more employers to form associations for self-insurance beginning in July 1995.

An amendment to reverse the Supreme Court's decision in *Mertens v. Hewitt* has been introduced by Sen. Howard Metzenbaum (D-Ohio). The amendment, which would be attached to the budget reconciliation bill, would significantly restructure ERISA's civil enforcement scheme, expanding the liability of fiduciaries as well as nonfiduciary service providers. Although Metzenbaum purports that his proposal merely reverses the Supreme Court's *decision*, in fact its provisions go well beyond the Court's decision. *(See Legal Lines, page 5.)* The Academy's Pension Committee has sent a letter to the appropriate senators urging them to oppose the Metzenbaum amendment and has issued a statement on the proposal. *(Copies of the public statement are available from the Academy. Please request PS-93P-5.)* ■

STANDARD BENEFIT PACKAGE DESIGN

The Clinton administration has decided to design a federal standard health benefit package that will offer Americans a choice from among three basic types of health plans: a standard indemnity insurance plan, a health maintenance organization, or a preferred provider organization. Coverage under the three plans will have "common actuarial value," indicating that the main difference will be in the out-of-pocket costs incurred by individuals.

The indemnity option would resemble a standard Blue Cross/Blue Shield plan, with a $200 annual deductible for individual coverage and a $400 annual deductible for family coverage. The premium cost would be split between employers, who would pay 75%, and individual workers, who would pay 25%. It is not yet clear whether copayments for services would be required under the indemnity option. However, if copayments are required, annual $2,000 out-of-pocket maximums for individual coverage and $3,000 maximums for family coverage have been decided upon.

The HMO option would be modeled on plans offered by Kaiser Foundation Health Plan or the Harvard Community Health Plan, with no individual deductibles or co-payments but the same level of premium cost-sharing. Under the PPO option, the deductible is expected to be lower for patients who use doctors approved by the plan and higher for those opting to obtain care from providers outside the plan.

The administration has not made final decisions on financing, short-term cost controls, or the size of the state-based health alliances.

MCCROSSAN

continued from page 1

an organization comprising fifteen EC actuarial associations. The issue of possible harmonization of the basic actuarial mathematical examination content was to be discussed in Dublin in September 1992, a meeting to which representatives of both the Society of Actuaries and the Casualty Actuarial Society were invited. The UK organizations also expressed interest in including the Society of Actuaries of Ireland in future discussions.

Three Key Questions

At meeting's end, the group summarized its discussion in the form of three questions of principle:

Was each organization willing to have its member actuaries bound by the standards of practice in the jurisdiction in which the professional services were rendered with respect to the countries represented?

If so, was each organization willing to establish multilateral or bilateral arrangements to conduct disciplinary investigations and tribunals in the jurisdiction of the incident, regardless of the affiliation or residence of the alleged offender?

Was each organization willing to consider establishing accreditation guidelines and procedures for recognizing fellowship in other actuarial bodies toward obtaining authority to sign reports?

All representative organizations agreed to take these three questions to their governing bodies and to meet 12 months later in Dallas .

Finally, the issue of a name for the group conducting the talks had to be selected. The British suggested the McCrossan Group as a nonthreatening, neutral name under which to hold the discussions, and so it was adopted.

Events moved quickly during the year. The *Groupe Consultatif* produced Common Principles for a Code of Professional Conduct for actuaries in EC countries. Presidents Walt Rugland of the Society of Actuaries, David Flynn of the Casualty Actuarial Society, and Mo Chambers of the CIA traveled to Europe to conduct talks with the actuarial bodies of the United Kingdom and to open discussions with the International Actuarial Association, an association of individual actuaries, in Brussels.

In September, 1992, NA[redacted] was signed by Presidents B[redacted]sh and Salinas and Prime Minister Mulroney. The head of the Mexican actuarial organization was invited to join the Council of Presidents.

An International Association

On May 13 the McCrossan Group met in Dallas.

In the year since the Montréal meeting, a consensus had emerged that the establishment of an international association of professional actuarial organizations could be desirable and should be explored. Such an organization would promote high professional educational standards, codes of conduct, and standards of practice in all member countries.

Our discussion in Dallas centered on developing a framework for such an international association. There was agreement that the member organizations m[redacted] well subscribe to the first [redacted] questions of principle discussed in Montréal, those involving discipline and standards of practice. The third question, dealing with accreditation guidelines and recognizing Fellowship across national boundaries, was found to need more work.

A working party of Walter Rugland, John Martin, President of the British Institute of Actuaries, and myself was appointed to develop a possible framework for such an association. The working party accepted the offer of the Institute of Actuaries of Australia to meet in that country in August, coincident with the Institute's biennial general meeting.

The Institute of Actuaries of the U.K. will host the next meeting of the McCrossan Group in London in November. Other national actuarial organizations interested in discussing the issues of international cooperation among actuaries are also ex[redacted]ed to attend.

PBGC TASK FORCE HEARS ACADEMY PENSION COMMITTEE

On May 12 Academy Pension Committee Chairperson Sam Kikla testified before an interagency task force established by Secretary of Labor Robert Reich to recommend solutions to the problems of the Pension Benefit Guaranty Board (PBGC). The task force is headed by PBGC Executive Director Martin Slate and includes representatives of the Department of Labor, the Treasury department, and the Office of Management and Budget.

The Academy Pension Committee was invited to present its views on PBGC reform as part of a series of hearings the task force held to listen to regulators, business groups, and pension professionals. The task force will recommend legislative remedies for the PBGC's problems to the Clinton administration in September.

ACTUARIES TAKE INSURANCE HELMS

Academy members Robert E. Wilcox and Dwight K. Bartlett III have been appointed insurance commissioners of their respective states.

Wilcox began his term as Utah Insurance Commissioner on January 5. A consulting actuary in Salt Lake City, Wilcox owned his own firm from 1973 to 1991, when he sold his business and joined Milliman & Robertson. Wilcox worked for many years for the Utah Insurance Department on a consulting basis, and as a member of a state recodification committee helped draft the 1986 Utah Insurance Code.

In Maryland, Bartlett's appointment to lead that state's insurance commission was announced by Gov. William Donald Schaefer on May 27. Most recently, Bartlett has headed his own insurance management and actuarial consulting firm and been visiting executive professor at the Wharton School of the University of Pennsylvania. From 1984 to 1989, Bartlett was president of Mutual Life Insurance Company of America. Bartlett served as chief actuary of the U.S. Social Security Administration from 1979 to 1981.