PBGC Focus of Capitol Hill Hearing
By Jeffrey Speicher

The proposed solvency maintenance requirement for the Pension Benefit Guaranty Corporation (PBGC) is "too broad a solution for a narrowly focused problem," Academy Pension Committee member Gregg Richter told the Subcommittee on Labor-Management Relations of the House Education and Labor Committee. Richter represented the Academy at an April 29 oversight hearing that focused on the PBGC.

The solvency maintenance requirement is a provision of H.R. 298, a pension funding reform bill introduced by Rep. Jake Pickle (D-Tex.). It would require all private pension plans that are less than 100% funded to contribute the value of benefits earned every year and the total amount of benefit disbursements for that year. The requirement is intended to prevent failing pension plans from dissipating plan assets by paying lump sum benefits, leaving too few assets for vested active participants.

Richter called the requirement an undue burden on employers who pose little risk to the PBGC. As an alternative, he recommended that such a requirement apply only to employers with underfunded retiree liabilities, rather than underfunded total liabilities.

Citing fairness to participants, Richter also recommended that no reduction of guaranteed benefits be made. However, he did call for reducing or eliminating benefits paid to workers at the time of a plant shutdown, saying such benefits were closer to unemployment benefits than pensions.

In his written testimony, Richter presented three steps that the Academy Pension Committee recommends be taken to put the PBGC on a sounder financial basis:

- Require the retroactive cost of negotiated increases in flat dollar plans to be amortized over the life of the contract. Current tax law allows plan sponsors 30 years to fully fund such plan amendments.
- Revise the Pension Protection Act of the Omnibus Budget Reconciliation Act of 1987 to require that funding of all underfunded liabilities be phased in on an accelerated timetable. Currently, unfunded liabilities that existed at the time of the bill's adoption are exempt from the accelerated funding requirement.
- Require the PBGC to be funded at a statutory rate that is actuarially sound.
FROM A

guest president

Mobilizing Our Talent

By David P. Flynn

I am almost always surprised by actuaries! I have been in the actuarial business now for almost 30 years. During this time, the image of the actuary as the person with the green eyeshade, ever vigilant lest one small digit go astray, but completely oblivious to the larger world has persisted. Yet almost never have I encountered this stereotypical actuary. In fact, I can’t imagine any other group in which I would meet the well-rounded, intelligent people I’ve worked with in the actuarial field.

Now a pessimist (or an underwriter—by definition, a pessimist) might say that, like an ostrich, I have my head stuck deep in the sand. But I truly believe that our profession is the finest, most dedicated group of business people that you’ll find anywhere. Actuaries have the talent and the business acumen to accomplish just about anything to which we set our minds.

We have much to do in the years ahead. Actuaries face the challenge of change in all areas of our practice. The nature of the insurance business has changed dramatically in the last 10 years. I suspect that it, like most things in the world about us, will change at an even faster pace in the next decade. Soon we should know exactly what the Clinton administration will propose to meet health care needs in the United States. But no matter what solution is finally enacted, the actuarial profession will play a key role in its implementation. The federal government now seems to be awakening to the fact that it has damaged the defined benefit pension plan system with its onerous and convoluted requirements. Some think that defined benefit plans will once again take a significant place in retirement planning. Likewise, at the state level, risk-based capital requirements are now in place for life and health companies and will be soon for property/casualty companies. These formulas, designed to measure required surplus levels based upon economic and actuarial concepts, will involve the actuary even more deeply in the day-to-day operations of the insurance business. Risk-based capital formulas are linked closely to the concept of the appointed actuary.

I’ve recently finished browsing through a report released by the U.S. Advisory Commission on Intergovernmental Relations (ACIR) titled, State Solvency Regulation of Property/Casualty and Life Insurance Companies. The ACIR is a twenty-six-member, bipartisan organization created by Congress in 1959 to monitor the operations of the American federal system and to recommend improvements. The ACIR report focuses on state and federal government roles in the solvency regulation of property/casualty and life insurance companies. It recommends that the federal role be limited to General Accounting Office studies and the exemption of state insurance liquidations from the effects of federal priority and arbitration statutes.

Unfortunately, the commission does not recommend a specific role for the actuary, and by omission leaves that matter up to the individual states and the National Association of Insurance Commissioners (NAIC). What a tremendous political opportunity we’ve missed! It is unfortunate that the actuarial profession didn’t have the influence with the commission to underscore the beneficial role that the profession could play in the solvency of insurance companies.

In the property/casualty field, the report fails entirely to address the impact of self-insurance pools on the marketplace and the virtual absence of effective regulation of these pools. Technically not insurance companies, these pools were made possible by earlier federal law, and state regulators have limited control of their activities. Municipalities and companies throughout the U.S. are now questioning the wisdom of their participation in these pools at their initial attractive and, in my opinion, artificially low rates, now that claims have emerged and payments are due.

In recent years, the Academy has done tremendous work with federal legislators and staff, the NAIC, and state regulators. However, we must do still more to bring the resources and capabilities of the actuarial profession to the attention of the proper authorities. Forecast 2000 is an excellent start, but we need to mobilize the talent of the profession more effectively if we are to accomplish our goals in the period ahead. The Academy is the ideal vehicle to carry out this mission.

Finally, I want to note that the Casualty Actuarial Society is well and continues to grow. At our 1993 Spring Meeting, we introduced 100 new Associates to our Society, bringing total membership to more than 2,000. The high caliber of our new members guarantees that the future of the CAS will be in good hands. Among the many projects the CAS is pursuing today, let me single out our joint effort with the other North American actuarial bodies to establish common understanding concerning education, accreditation, and discipline matters with other actuarial organizations around the world. In the years ahead, we look forward to working closely with the Academy and the other organizations to advance the interests of the entire actuarial profession.

Flynn is president of the Casualty Actuarial Society.
Academy and NAIC Collaborate on Risk-Based Capital Formula

A joint effort of the Academy and the National Association of Insurance Commissioners (NAIC) to develop a risk-based capital formula for property/casualty insurers has led to a modification of Academy procedure on open meetings.

In March, the Academy established a task force on property/casualty risk-based capital under the leadership of Academy President-Elect David Hartman. The task force was established at the request of the NAIC Property/Casualty Risk-Based Capital Working Group, which is developing the formula for property/casualty insurers. The Academy task force will provide the NAIC group with actuarial analyses of risk measurement techniques and will examine the potential impact of the formula on insurer behavior.

The work of the Academy task force requires close collaboration with the NAIC working group at all stages of the formula’s development. The task force has access to all preliminary drafts of the formula and to the results of tests done on various models. The NAIC has requested that such sensitive material be kept confidential until the public release of a draft formula.

All members of the task force have agreed to honor the NAIC’s desire for confidentiality. Consequently, the task force has been conducting its meetings in closed session. However, the task force’s deliberations will not be secret, and minutes of its meetings will be published.

This departure from normal practice in no way implies that the Academy encourages secrecy in committee business. In order to allay any concerns members might have, the Academy Board of Directors, meeting in Dallas on May 14, ratified a resolution of the Executive Committee designed to clarify the Academy’s position on open meetings.

The resolution states that portions of meetings of certain committees may be closed only for the limited purpose of considering confidential material and only with the prior consent of the chairperson of an Academy Practice Council or Council on professionalism, or the president of the Academy. Guidelines for determining appropriate grounds for closing meetings to consider confidential material are being developed. 

The Editors welcome 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.

Harry Sutton
Minneapolis, Minnesota

Lectures and Loot

Academy member Truman Breithaupt of TAB Actuarial Services in New Orleans recently passed on a most interesting letter to the editors of The Update. The letter invited Breithaupt to Nigeria to give a series of public lectures on actuarial science on behalf of the Fejic Actuarial Institute of Lagos. On the face of it, a prestigious invitation. And lucrative too. The letter went on to promise Breithaupt a tour of “government establishments where business deals of some millions of dollars will be struck.”

As visions of plum contracts danced in his head, Breithaupt reread the sentence that asked for “a little sum of about US $2000 to complement our efforts of arranging for your hotel bills and other huge expenses.” Plums turned to prunes.

Through the good offices of the Nigerian embassy, The Update has attempted to trace the Fejic Actuarial Institute. To date the embassy has been unable to confirm that such an organization even exists. However, to our eyes, it looks like an ambitious transatlantic con game in the works.

Have any other members received similarly intriguing business propositions?

The Editors
Workers’ Comp: An Actuarial Rx

By Jan Alan Lommele

Casualty actuaries and risk managers should seize their unique opportunity to control workers’ compensation medical costs. Casualty professionals can employ cost control techniques in all insurance environments. Such techniques can be applied to insurance company policyholders, self-insureds, or employers who use other risk-financing alternatives.

To the skeptic who says, So what? it should be noted that workers’ compensation medical costs are a staggering burden to business in this country: The increase in such costs during the past 10 years has been at about twice the rate of inflation on the U.S. medical consumer price index.

Risk managers can apply medical care cost control strategies that have been used for years by benefits managers. There are some traditional risk management strategies that ought to be used more often, such as claim policies and procedure reviews.

Actuaries can provide the analytical ability to price specific strategies, as well as to evaluate and monitor the overall cost of workers’ compensation. Using current cost as a benchmark, the actuary can demonstrate to senior management that cost control strategies are working.

Repricing Claims

From the risk manager’s standpoint, an obvious approach is to work with the benefits manager to reprice every workers’ compensation medical claim before it is paid. For example, even in states that have no medical fee schedule, an employer can retain a service provider to review medical claims for usual and customary charges.

Usual and customary charges are based on charges for specific procedures, regardless of whether the injury or disease is employment-related. Employers who pay for medical benefit plans have negotiated discounts from standard fees. Without a formal preferred provider agreement, physicians, hospitals, and other medical care providers may charge 100% of standard fees.

However, there is no medical reason that it should cost more to treat an employment-related sprained back, for example, than to treat an identical injury suffered off the job.

In fact, though, workers’ compensation claims have been shown to cost twice as much as their nonemployment-related counterparts.

A provider who reprices these claims must have access to a broad base of medical care cost information. Workers’ compensation claim costs are generally not available by type of procedure performed, except in states with medical fee schedules.

Thus, in selecting bill review providers, be sure that the provider has the capability to reprice claims using procedure costs. If possible, these costs should be related to nonemployment-related injuries and diseases, as well as those related to employment. The services of such providers could also be adapted to guarantee that bills are in compliance with medical fee schedules in states that use such schedules.

Obtaining Key Data

For casualty actuaries, the challenge is to obtain data. The National Council on Compensation Insurance’s expanded DCI (detailed claim information) database has medical cost information on items such as the ZIP Code where the injury occurred, the part of the body, the nature of the injury, the injury’s cause, hospital costs, physicians’ costs, and other information. However, since reimbursement of medical costs not related to workers’ compensation is based on the ICD-9 code that details the diagnosis and the procedure taken in each case, obtaining these costs provides the risk manager the ability to corre-
NAIC and Hill Focus on Solvency

By David Bryant

A growing chorus of legislators and regulators is clamoring for insurer solvency preservation, and one notorious felon has even offered his expertise to bring about new industry safeguards. In the midst of the excitement, the Academy continues to advocate an enhanced role for the actuarial profession.

Academy Solvency Plan

Academy Executive Vice President Jim Murphy presented the position statement of the Academy's Solvency Task Force to the National Association of Insurance Commissioners (NAIC) Life & Health Actuarial Task Force (LHATF) at its April 28 meeting in Los Angeles. The Academy proposal recommends that insurance company actuaries perform a continuing review of solvency and report annually to company management and board of directors on the insurer's total financial condition.

NAIC leadership has been quite receptive to the general recommendations made in the position statement. Murphy gave assurance to task force members that working groups of both the Society of Actuaries (SOA) and the Casualty Actuarial Society (CAS) were fine-tuning the details of the Academy's proposal and considering methods for its implementation. (Preliminary reports are available from both the SOA and the CAS.)

The LHATF agreed to submit a letter to the Examination Oversight (EX4) Task Force commending the Academy's position statement and requesting that it be considered at the OCI Summer National Meeting in June.

In March, after a presentation by Academy President-Elect David Hartman, the NAIC Casu-
Managed Care: The Actuary’s Role

By Charles W. Edwards III

As the nation moves toward comprehensive health care reform, it seems ever more likely that some form of managed care will be the fundamental unit of care in this country. What will the actuary’s role be in a system designed to maximize the efficiency and cost effectiveness of health care delivery?

Managed care is an environment ripe for the type of actuary defined by Society of Actuaries President Walter Rugland. In an October 1992 address, Rugland called for actuaries who “provide expert, relevant solutions to financial and business issues, especially those requiring analysis of uncertain future events.” The political, regulatory and social issues surrounding the delivery and finance of health care make managed care as dynamic as any field in which actuaries practice. Contingencies apply not only to individual risks but, on a macro level, to entire lines of business, as we anticipate the actions of state and federal government.

In discussing its actuarial aspects, managed care can be broadly defined as any product that attempts to influence use of health care via contractual or financial mechanisms. This may be through the use of exclusive or preferred physician networks, physician discount or shared risk agreements, claim management and review techniques ( precertification, concurrent review, second opinion, case management, etc.), or cost sharing with the insured member.

The actuary’s role is to analyze the effect of managed care strategies on rating, trending, reserving, and profitability. In a more general sense, a managed care actuary must anticipate the reaction of providers and insureds to various managed care stimuli. If successful, this will give the company the advantage of knowing which managed care techniques are worth pursuing from a sales and profitability standpoint.

In the work of a managed care company, the actuary is the traffic cop at the intersection who directs the flow of new ideas, quantifying their impact before they are transformed into health care products. The actuary is also the individual most capable of measuring the potential for success of new managed care approaches. This means getting behind the loss ratios to isolate the effects of individual changes on utilization and cost.

The competitive market for health care coverage demands that managed care companies be alert for the need to fine-tune premium rates and trend assumptions. Changes in managed care strategies can have an impact on this need and must be monitored carefully.

For example, some argue that managed care strategies that use employee cost sharing, claim management, and claim review affect rating only through a one-time savings. This argument holds that these strategies affect rating but not long-term trending. However, these strategies have been pursued only half heartedly up to now and do not have lasting impact if applied more vigorously. Also, the degree of cost sharing has not kept pace with overall inflation or the medical cost component of the consumer price index. This could explain its lackluster performance. All these factors must be considered as the actuary accounts for the implementation and execution of cost sharing.

Actuaries have a unique set of skills to offer. Their expertise should be called upon to help develop and set goals for the managed care company, not merely to manage strategies once they are in place. Managed care actuaries must take the initiative to recognize and analyze all sources of impact on the managed care company.

Edwards is associate actuary with Humana, Inc. in Louisville.

Academy Meets with Accountants

By Stephen Meskin

A single accounting standard for insurance companies was at the top of the agenda when the Academy Committee on Relations with Accountants met with the Committee on Relations with Actuaries of the American Institute of Certified Public Accountants (AICPA) on April 30 in Orlando.

The two groups focused on the desirability of such a single standard, the merits of statutory accounting versus accounting that adheres to GAAP (generally accepted accounting principles), and the difficulty of making a regulatory accounting change.

In other business, the accountants detailed an aspect of their profession’s peer review process, explaining to the actuarial committee how an accounting firm audits the work of a competitor. The distribution of work papers to regulators was also discussed.

Other items discussed were: an AICPA exposure draft on the disclosure of “risks, uncertainties, and financial flexibility;” an accounting project studying present value measurements; the status of actuarial opinions in accounting statements; the role of risk transfer in the proper accounting of funded catastrophic reinsurance; and the implementation of Statement of Financial Accounting Standard (SFAS) 112 on postemployment benefits, SFAS 113 on reinsurance, and Standard of Practice 92-6 on health and welfare plans.

Representatives of the two professions met twice a year to exchange ideas, discuss common issues, and, when appropriate, coordinate actions of their professional organizations.

Meskin is vice president of the Segal Co. in Washington, D. C.
The Pension Portability Act, introduced by Rep. Sam Gibbons (D-Fla.), would amend ERISA to reduce pension vesting requirements and increase pension benefit portability. H.R. 1784 would compute the value of accrued benefits and permit terminating employers to transfer their earned benefits to IRAs or other qualified plans. The goal of the bill’s sponsor is to reduce substantially the loss in value of earned pension benefits.

An IRS hearing on proposed nondiscrimination regulations for qualified plans was held on April 23. The proposed regulations (EE-62-92) seek to bar employers from discriminating in favor of highly compensated employees when making contributions or providing benefits under tax-qualified retirement plans. In comments at the hearing, the Academy’s Pension Committee called the proposed regulations an improvement over current regulations, but still too long and complex. The committee criticized the regulations as having a damaging effect on small plans. The Academy supports additional changes to the regulations that would reduce administrative complexity and simplify the establishment of plans for small employers.

Iowa approved legislation to permit the establishment of model HIPCs (health insurance purchasing cooperatives). The bill, passed unanimously by both houses of the legislature, directs the insurance commissioner to adopt rules and a licensing procedure for the model projects. The rules are to be drafted by a fifty-four-member council appointed by the governor. The bill allows voluntary agreements between competitors that otherwise would be in violation of antitrust laws. The insurance commissioner must agree that each cooperative would improve health care quality, access, or affordability in the region it serves. The governor is expected to sign the bill into law.

Kansas announced a health insurance program to help residents who have had difficulty obtaining health insurance in the voluntary market. Such residents may obtain coverage from the Kansas Health Insurance Association, a new legal entity created by state authorities to function like a private sector, third party provider. Premiums are expected to cover program benefits and administrative costs during the first 2 years. There will be no waiting period for coverage of preexisting conditions. Persons who have lived in Kansas at least 6 months will be eligible to participate in the program if their health insurance was involuntarily terminated or if they have been rejected by at least two insurers because of health conditions.

The South Carolina Senate approved guaranteed access to health insurance for small businesses. The bill would require all insurance companies that write policies for small businesses to provide basic and standard health insurance packages for any employer of fifty or fewer employees. The small business insurers could write the policies through their regular group mechanism or participate in a reinsurance program set up by the state. Basic and standard packages would be developed by the Governor’s Committee on Basic Health Services. If the House does not pass the bill in the remaining weeks of the session, the bill likely will be taken up next year.

Arizona Gov. Fife Symington signed a bill to establish and regulate accountable health plans for small employers. Beginning July 1, 1994, health insurers will be required to offer a basic health benefit plan to small employers as a condition for doing business in the state. Employers of twenty-five to forty workers that have not offered health benefits for the past 90 days will qualify for the plan. Health benefit packages will be offered without regard to health status or claims experience. The law also sets up a small-employer reinsurance board to establish a method to determine premium rates.

Hawaii is seeking federal waivers for a proposed 5-year Medicaid program. Governor John Waihee’s program, “Hawaii’s Health Quest” would provide medical and mental health benefits to about 88,200 people now being served by three separate public health financing programs: Medicaid’s AID to Families with Dependent Children, state general assistance, and the state health insurance program that provides coverage for “gap group” citizens not covered by their employer or through public aid. The program would create a purchasing pool coupled with a basic benefit plan intended to achieve quality services at more affordable prices by focusing on preventive care and managed care. The strategy is to provide medical services through existing health maintenance organizations, thus providing an opportunity for all HMOs to expand their market.

California is the first state to license companies that provide living benefits for the terminally ill. Three such companies have obtained licenses and another sixteen await governmental approval. California law allows terminally ill people to cash in their life insurance policies, without paying taxes, to provide funds while they are still alive. Companies that specialize in viatical settlements are intended to achieve quality services at more affordable prices by focusing on preventive care and managed care. The strategy is to provide medical services through existing health maintenance organizations, thus providing an opportunity for all HMOs to expand their market.
PBGC, continued from page 1

- Amend Section 401(a)(29) of the Internal Revenue Code which requires an employer to provide security if a benefit increase with a value of more than $10 million causes the plan to become less than 60% funded. H.R. 298 changes the 60% threshold to 90%, with a $1 million floor instead of $10 million. The Academy Pension Committee supports an adjustment closer to the original 60%/10 million provision; too drastic a change would adversely affect long-service employees and retirees.

PBGC Executive Director Martin Slate also testified at the oversight hearing, his first appearance before the subcommittee since his March 21 appointment. Slate stated that he wished to communicate a balanced message to lawmakers and the general public: The PBGC faces problems that must be addressed, but there is no cause for panic.

Slate also reported on the work of an interagency task force on PBGC reform established by Secretary of Labor Robert Reich. The task force has held a series of meetings with congressional and regulatory staff, and is currently hearing the views of representatives of public groups. The task force will recommend legislative remedies for the PBGC’s problems based on the hearings’ findings.

Slate’s appearance triggered an exchange between subcommittee chairman Pat Williams (D-Mont.) and Rep. Marge Roukema (R-N.J.), the ranking minority member. Roukema, a cosponsor of H.R. 298, urged the task force to complete its work and make its recommendations before the September deadline set by the administration. “I don’t want to be accused of fiddling while the PBGC burns,” she said. Roukema, pointing to new pension promises that might be made to workers during auto industry labor contract negotiations this summer, warned of “the potentially enormous consequences of delay” in reforming the nation’s pension insurance system.

For his part, Williams stated that the pension system is troubled but far from a state of crisis, and that Congress, as it approaches PBGC reform, should “take its time and do it right.” He called suggestions that lawmakers tack on a PBGC reform proposal to the pending budget reconciliation bill “highly inappropriate at this time.”

Health Care Reform, continued from page 1

Working groups of the Clinton administration’s Health Care Task Force have used the Academy’s papers in their deliberations. Committee members of both the U.S. House and Senate also have requested copies to use in preparing for hearings on the administration’s proposal this autumn. The work groups’ papers have also been requested by lawmakers and regulators in several states.

The Standard Benefits Work Group include Chairperson Alice Rosenblatt, John Bertko, Ned Crocker, Anthony Hammond, David Helwig, Bruce Pyenson, and Geoffrey Sandler. Also serving on the work group were health economists Bruce Bowen of Kaiser Foundation Health Plan and Susan Palsbo of the Group Health Association of America, and Michael Moore, a physician with the influential health policy think tank, the Jackson Hole Group.


Gregg Richter (standing, right) speaks with subcommittee chairman Rep. Pat Williams (standing, left) and ranking minority member Rep. Marge Roukema (seated, left). Phyllis Borzi, counsel to the subcommittee, is seated at right.