The Actuarial Update

VOLUME 20 NUMBER 9 AMERICAN ACADEMY OF ACTUARIES SEPTEMBER 1991

In this issue

Enclosures

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

- Government Relations Watch
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- ASB Hearing Memorandum
- 1992 Enrolled Actuaries Meeting Exhibit Brochure

Close-up on President Harry Garber

Harry D. Garber will assume the post of president at the Academy's Annual Meeting, September 26. He is currently vice chairman for The Equitable, a company he has served in various capacities for more than forty years. From his venerable corporate perch, Garber brings unique and practical perspective to everything from politics to professionalism.

THE UPDATE: Incoming Academy presidents often have something particular in mind that they want to accomplish during their term. Does one project or issue stand out as a key objective for you as you begin your term as president?

GARBER: If you look at the Academy, what you have is an organization that is going forward as a result of the continuing efforts of various people serving its leadership. So, the question for a new president is, "Do I continue these efforts, or do I try to change the momentum of things." Fortunately, I'm coming on as president at a point were the Academy is exceedingly active in many areas. Many of these activities are the result of efforts that I have been involved with and fully supportive of, such as the Actuarial Board for Counseling and Discipline and the common code of professional conduct—ideas that came out of the Joint Task Force on Strengthening the Actuarial Profession.

In other words, I find myself in the fortunate position of carrying forward projects that I have had a hand in starting and have been working on over the past few years. And I firmly believe that efforts to strengthen professional standards and discipline are the way of the future for the profession.

So first, I want to accomplish those things that the task force on strengthening indicated we needed to do. Beyond that, I believe we need to work on strengthening the interface activities of the profession with state and federal legislators and regulators—work that Jim Murphy, Gary Hendricks, Gary Simms, and other Academy staff have worked on over the years.

Third, I want to increase public recognition of membership in the Academy through some form of accredita-

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ASB Public Hearing Announced

The Actuarial Standards Board (ASB) has scheduled a public hearing on the proposed actuarial standard of practice titled, *Discounting of Property and Casualty Loss and Loss Adjustment Expense Reserves.*

Hearing Date: Wednesday, September 25, 1991, 9:00 a.m. to 12:00 noon
Place: Crystal Gateway Marriott Hotel, Arlington, VA
(Site of Casualty Loss Reserve Seminar, September 23–24)

For further information on the ASB hearing, see the hearing announcement enclosed with this copy of *The Actuarial Update.*

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From the President

Harry D. Garber

The Quality Movement and Our Profession

Improvement in the quality and reliability of products has been a key focus for industrial companies in North America over the past few years and will continue to be one in the years ahead. The quality movement is being embraced, as well, by service and financial companies. Although the actuarial profession has undertaken many important initiatives to bolster its public repute in recent years, these steps have lacked an all-encompassing theme and a coherent theory. I believe the quality movement provides such a central focus. It should be adopted by the profession as the organizing approach to increased professionalism.

Quality is a worthy goal. Recognition of the actuarial profession as one that preaches and achieves high quality will be beneficial not only to the profession as it pursues its public interface goals, but also to individual actuaries in their relationships with employers and clients.

What does quality entail in the area of service and professional activity? In the United States, the most prestigious recognition for quality in business is the Malcolm Baldrige National Quality Award. Each year, two or three companies that best meet certain criteria are selected as winners of the award. The same criteria are applied to all companies. To win the award, companies must demonstrate (1) a knowledge of customers' requirements and expectations, (2) a work force that is both knowledgeable and dedicated to improving the quality of its products and/or services, (3) a process for *controlling* the quality of the products and/or services, (4) a system for regularly compiling information on the quality of products and/or services as well as customer satisfaction, and (5) a leadership that creates and sustains a clear vision of quality values and seeks continuing improvement in quality.

Quality Criteria Applied

I believe the Malcolm Baldrige criteria by and large could be used as a basis for establishing and executing a quality-based program for the actuarial profession. Specifically, I would suggest the following elements for such a progra

1. The profession should understand the customers' requirements and expectations for each of the various actuarial services to be performed.
2. For each of these different services, there should be specified qualification standards and standards of practice.
3. Individual actuaries should understand and observe these standards.
4. The profession should have mechanisms in place to ensure that these standards are being observed, to measure customer satisfaction, and to take any needed corrective action.
5. The profession should continually seek to improve its members' quality performance.

Where Are We Today?

Where does the actuarial profession stand with respect to these criteria today? We have well-established standards of professional conduct, and we have made good progress in defining standards of practice for most actuar services. We have well-developed ge eral qualification standards. We are continuing to fine-tune specific qualification standards for particular actuarial services.

We also have a well-established discipline process for handling violations of the professional code of conduct. With respect to the reported failures of some individuals to observe standards of practice or qualification standards, however, our discipline process is less mature. But we are improving as we gain experience. In most cases of professional misconduct, counseling is a better response than punishment. As proposed, the Actuarial Board for Counseling and Discipline would be able to provide this counseling.

Two serious deficiencies remain, however. The first concerns an understanding of our customers, be they employers, clients, regulators, or legislators. In many instances, our profession has established standards for various actuarial services without consulting its customers. For any professional, consulting the customer is a logical and reasonable approach to suring quality. Yet too often it's ov looked, maybe because professionals think that *they* know what's best for their customers.

According to company officials I have talked with, even design engineers from companies that have won the Malcolm Baldrige Award (e.g., IBM, Rochester, and Cadillac) often fail to consult customers—and thereby misjudge their attitudes. The actuarial profession may be guilty of similar arrogance and/or oversight.

We will never know whether, as a profession, we are improving our performance vis-à-vis customers' expectations, unless we work with our customers. Without doubt, this is a difficult task. But, as a profession we must exercise as much imagination in bringing customers into our quality-improvement strategies as we already apply when dealing with new legal and business requirements.

Our second deficiency involves the degree of control our profession has over the quality of work being performed by practicing actuaries. Except for cases submitted through the discipline process, the profession does not know the extent to which its standards are being observed. This is inadequate quality assurance for a profession whose watchword is "quality." In addition to disciplining and counseling individuals as cases come up, we need to monitor, in general, how well actuaries are observing the profession's standards. Then, as problems are uncovered, we will need to develop and implement new ways to improve the profession's system for quality control.

Of course, the actions of knowledgeable, responsible professionals are what ultimately determine the reputation of a profession. The job for the profession is to establish the standards that are to be met and then to educate its members about them, to monitor how the standards are being applied, and, when necessary, to take corrective action.

We are moving in the right direction. If we apply the precepts of the quality movement directly, I believe that the profession will gain greater recognition. Let's become known as a profession that not only preaches, but achieves, high quality. Δ

Letters to the Editor

Hoist by Our Own Petard?

I just read Ed Hustead's comments in the July *Update*, i.e., "Pension Audit Revisited." In my opinion, Ed is right "on the mark." The Internal Revenue Service's criteria may be, in fact, unjustifiable, but much of what is happening is a direct by-product of the inaction of pension actuaries *as a profession*.

Almost six years ago at the annual meeting of the Conference of Actuaries in Public Practice, I commented on, among other things, professional actuaries' responsibilities in measuring funding adequacy.

The ambivalence of the actuarial profession in adopting minimum funding standards has always been a concern to me and many others. Long before ERISA was enacted in 1974, there was an obvious need for minimum funding standards. Pension plan assets clearly were growing rapidly and would soon exceed a trillion dollars, funds supposedly dedicated to provide benefits for employees. It's difficult to accept the fact that many actuaries today retain a laissez-faire attitude about the need for minimum professional and ethical standards more rigorous than those imposed by ERISA.

We keep talking but do little: It's no wonder our profession remains virtually invisible when we have refused to adopt our own minimum standards and principles of practice.

Daniel F. McGinn
Whittier, California

Distinguished Service

The actuarial profession has, at long last, received the ultimate of public recognition! The Internal Revenue Service includes us in its definition of "personal service activity." This term is defined as "an activity that involves performing personal services in the fields of health, law, engineering, architecture, accounting, actuarial science, performing arts, or consulting, or any other trade or business in which capital is not a material income-producing factor." (See page 40, 1990 1040 Forms and Instructions, Package 1040-5, IRS)

One might wonder about the significance of the order in which the professions are listed, or about the notable absence of the fields of economics, social sciences, and statistics!

Robert J. Myers
Silver Spring, Maryland

Colleague Concurs

I was distressed to find in the 1991 annual report of the Board of Trustees of the Federal Hospital Insurance (HI) Trust Fund an attack on the professionalism of the chief actuary of the Health Care Financing Administration (HCFA) by the two public trustees, Stanford G. Ross and David M. Walker. Even though the public trustees have no actuarial credentials, their statement appears to be calculated to pass judgment on the professional judgment of the chief actuary and the actuarial profession.

It takes great courage for the chief actuary to qualify his certification with regard to the methodology and assumptions in the face of this sort of pressure from "big shot" political appointees.

The public trustees alleged that the chief actuary made "an expression of a professional preference outside of the bounds of the legally required actuarial opinion." To the contrary, it is the duty and responsibility of the chief actuary to express any legitimate concerns in the actuarial certification. Indeed, legal counsel for both HCFA and the Treasury Department have ruled that the chief actuary's opinion is proper and within the bounds of the statute.

The public trustees have attempted to trivialize the actuarial certification and its requirement in the statute by stating:

We have taken great care to review this year's HI annual report. We have closely examined and seriously considered the comments noted in the actuarial opinion and concluded that they are not persuasive and should not have resulted in a qualified actuarial opinion, based on the applicable statutory requirement. We respect the right of the HCFA Chief Actuary to express his professional views regarding any significant actuarial matters but regret that he, in our view, has improperly qualified his actuarial opinion.

I consider the public trustees' statement to be an assault on the actuarial profession. It is noteworthy that the majority of the trustees declined to join the two public trustees in their statement. Actuaries must be able to accurately inform the public of the financial status of guaranteed benefits such as Social Security, life insurance, pensions, and health insurance, without pressure and political interference.

Gregory Savord
Baltimore, Maryland

CLOSE-UP ON HARRY GARBER
(continued from page 1)

tion. I view this as an opportunistic activity; that is, the profession must seize opportunities for public recognition or "accreditation" in the form of specific regulations and legislation. As an example, the valuation actuary concept has developed in the life practice area and is now being implemented by state regulation. The National Association of Insurance Commissioners (NAIC) requires that a qualified valuation actuary submit an opinion and now defines "qualified actuary" as a member of the Academy.

In the property/casualty practice area, all states now require loss reserve opinions by qualified actuaries. This development resulted from a public need for greater confidence in insurers' ability to meet their financial responsibilities. I think that additional opportunities for actuaries' formal recognition will arise in other areas as well. I will make sure that we are looking for such opportunities, whether or not any happen to come up during my term of office.

THE UPDATE: What opportunities for greater public recognition do you think might arise?

GARBER: Well, I think one opportunity might develop in the area of insurance company solvency. As a result of a number of insurance company insolvencies, the Congress is now very interested in the issue of insurer solvency regulation. They are endeavoring to find a way to do something positive, whether it's substituting federal regulation for state regulation, undergirding state regulation, or whatever. Some of the models that the Congress, and Representative Dingell's subcommittee in particular, is looking at are the "appointed actuary" approach in the United Kingdom and similar developments in Canada. If Congress decides to follow up with these ideas to any degree, I think that would be an opportunity for us to get further recognition and maybe accreditation for the profession.

THE UPDATE: When you speak about gaining accreditation for the profession, are you specifically thinking in terms of federal recognition?

GARBER: Yes, that's exactly what I'm thinking about. When the Academy was founded, it's original purpose was to gain federal accreditation for the

profession in the United States. We were unable to accomplish that goal back then, and I think it's clear now that we won't accomplish it in the broad sense that we had originally hoped. So we are focusing rather on gaining recognition for specific actuarial duties. The valuation actuary's role is now recognized by state regulators. The enrolled actuary designation, created under the Employee Retirement Income Security Act of 1974, was perhaps the first instance of a kind of accreditation for actuaries.

I do think we will end up accomplishing our goal of gaining federal recognition more on a need-by-need or task-by-task basis, rather than by getting broad, governmental accreditation for the whole profession. We'll simply have to take every opportunity we're given to further institutionalize the role of the actuary.

THE UPDATE: Do you expect that the Actuarial Board for Counseling and Discipline (ABCD) and the common code of professional conduct will help the effort to gain federal recognition for the profession?

GARBER: Yes. Any profession first needs to have a body of knowledge with which it skillfully serves the public. Second, it needs to have a code of professional conduct. Third, it must have standards of practice. The fourth requirement is a discipline process that ensures that members of the profession follow those standards and the code of conduct. These are the four essential elements of any profession.

The task force on strengthening the profession thought that the profession needed to work harder in the areas of professional conduct and discipline. The problems are that the actuarial organizations have had their own professional standards, some have not required their members to follow the standards of practice issued by the Actuarial Standards Board, and ea[illegible] has had its own code of professio[illegible] conduct. Also, discipline cases involving members often have not been coordinated among the organizations, and differences have developed among the various organizations in terms of how specific cases were handled.

An individual who is a member of two organizations and violates a standard of practice may well be disciplined very differently by the actuarial organizations. I've seen situations where one organization concluded that an individual really did nothing wrong, and therefore no discipline was required, while the other organization sent a letter of warning.

It was thought that the profession needed to get its act together in this area. Those of us on the Joint Task Force on Professionalism looked into the problem and concluded that each organization should continue to have the responsibility and the ability to discipline its own members—that should not be taken away by any effort to coordinate the discipline process among the actuarial organizations. W[illegible] didn't want to have a central autho[illegible] that could discipline a member of the Society of Actuaries and tell the Society that it should throw that member out. However, we thought it was very important to establish a uniform code of conduct that would require each organization to discipline its members if they failed to follow the ASB standards of practice or the Academy's qualification standards.

As a practical matter, we thought it important to set up one body to investigate cases where discipline might be required. That's the role of the ABCD as we've conceived it. The ABCD would be a service arm to each of the organizations by investigating cases, providing counseling to individuals, and recommending disciplinary measures as appropriate. However, in the end, any disciplinary action to be taken would be taken by the organizations and their boards.

We consider the counseling role of the ABCD very important. Clearly, when you are dealing with a code of conduct the issue is were you lying, stealing, or cheating. These are basic proble[illegible] one doesn't ordinarily need to do a lo[illegible] counseling in those instances. But when you get to standards of practice, you have more complex issues. For

example, did the individual know that a certain standard of practice existed? If the individual did know about the applicable standard, did he or she understand it? Did the individual think the standard meant one thing, when it really meant something else?

Ultimately, counseling is a much more powerful tool than discipline. Discipline is what you want to apply when all else fails. We wanted to have the ability, when individuals had *unknowingly* violated standards, to make sure that they understood what they *should* be doing. If people who know better continue to violate standards, we can always resort to punitive actions. But when there's a huge body of standards that some members may not know exist, or have never read, or don't realize apply to the specific situation with which they are dealing, it's very important to have a means to counsel them. Such a process may also help us to identify possible ambiguity in a standard that the Actuarial Standards Board could subsequently clarify.

The establishment of the ABCD will give us the ability to do those kinds of things on a professionwide basis. There really are surprisingly few serious discipline cases, and they can be dealt with by the ABCD making a recommendation. The membership organizations would then take care of any disciplinary action themselves.

THE UPDATE: At this time, does it look like all the actuarial organizations will support the ABCD, as proposed? And what is the status of the uniform code of conduct that was exposed to the membership?

GARBER: Each of the other organizations has had a hand in putting the ABCD proposal together. The leaderships of the other organizations are all represented on the Academy's Board of Directors. At this point, there is no reason to believe that there will be any major problem; in fact, there seems to be broad support for the ABCD. Even so, it is not necessary that all of the organizations actually become a part of this process. However, I do think that it's in their interest. I would expect that they would all participate eventually.

Meanwhile, the work on the uniform code of conduct is proceeding as well. Again, the uniform code as drafted does not have to be adopted word-for-word by each organization; but we do want to have each organization adopt a code that follows the uniform code's wording as closely as possible. I believe all the organizations will adopt the common code in principle and thereby require their members to follow the actuarial standards of practice of the ASB and the qualification standards of the Academy.

THE UPDATE: As you mentioned with respect to public recognition, the valuation actuary has now been formally recognized by the NAIC. Do you want to comment a bit on the significance of that?

GARBER: I think it's very important that the states come to understand and respect the profession's ability to discipline its own members. I think there's been a certain amount of skepticism about the Academy's ability to do that. And there seems to have been some reluctance on the part of state regulators to identify, for potential disciplinary action, those individuals who they believe are not living up to the standards of the profession.

Under Jim Murphy's leadership, the Academy has begun informal discussions with state regulators and particularly with actuaries involved in insurance regulation at the state level. At NAIC meetings, Academy representatives regularly meet with actuaries from the state insurance departments. I expect we will be able to cooperate more closely and seek the common objective of having state regulatory authorities rely more on actuaries. This will happen when regulators are more confident that the profession itself can ensure that actuaries will perform in a professional manner.

It's up to the profession to make sure that people who do actuarial work are in fact qualified to undertake that work. We've begun a process of defining what qualifications are necessary for specific tasks. Continuing education requirements are a part of that.

Another very important part is something I talk about in my editorial. (See page 2.) Not only must the profession set professional standards and then counsel and discipline people who are reported as failing to meet those standards, the profession must become much more active in monitoring actuaries to see whether they are meeting the standards.

I think that this more proactive approach to professionalism is necessary if we are going to convince people that members of our profession are truly accountable. The Committee on Professional Responsibility, chaired by Past President James MacGinnitie, is taking this positive approach.

In sum, there is a whole web of things that are being developed to bolster professionalism. All of these efforts, I believe, are designed to help the profession to get greater public recognition. Of course, public recognition in turn gives the profession a greater responsibility for assuring that it's members are living up to professional standards and are therefore worthy of that recognition.

THE UPDATE: Do you think that all the necessary structures are there within the Academy to accomplish what you want to in the year ahead?

GARBER: Well, the practice councils were established to make sure that we were coordinating our response to public issues and continually identifying the issues that the profession should address.

But that alone is not enough. For example, if the Casualty Practice Council identifies particular issues that are important to actuaries in the casualty practice area and such issues require research, it is also important that the council connects with the Casualty Actuarial Society in order to fund and conduct that research. In addition, if there are public issues developing that are apt to be very important to the casualty practitioners, we need to pass that information on to the Casualty Actuarial Society, so that it can plan its educational and communications activities. I would hope that the practice councils will coordinate all of these activities. The profession must prepare its members for whatever they have to do as a result of the public policy issues. And we must be sure that the profession is prepared with the information that it needs to bring to the legislators and regulators as they formulate public policy.

THE UPDATE: So you would underscore the current philosophy behind the Academy's government information program, which is "getting information from those who have it to those who need it."

GARBER: Yes, I want to emphasize that, because some of our members may not understand what we are trying to do. The Society of Actuaries still has, as part of its constitution, a prohibition about expressing opinions on public issues. Some actuaries may think that if we shouldn't express an opinion on public policy, that we ought not to get involved in regulatory or other legislative matters. However, it's clear to me that we must have a role. What is

(continued overleaf)

lacking most in the legislative arena is real information. Too much legislation is based on anecdotal information. People who can bring real information to the process are very valuable. Our role is not to try to persuade policy makers but to inform them so that better decisions can be made.

THE UPDATE: Do you think that the Academy's government information program is working optimally in this respect, or could it be doing more?

GARBER: The challenge for the program, it seems to me, is to be able to determine what is prompting certain legislation. If you're going to provide helpful information to the debate, you need to know what problem prompted the proposed legislation in the first place. It's not always clear at the beginning.

If research is required on a problem, you are really a couple years away from being able to provide the information and technical guidance required. That's why being able to anticipate legislative issues is so important.

The government information program appears, at least for now, to be meeting the needs for information in Washington. I don't have the sense that we are under-resourced. But we'll have to evaluate the program as time goes on. We're still in the development process.

It's very important to establish our credibility and to have policy makers become more reliant on us. That's not something that you can do simply by throwing more people into the job. Government relations is such a people business. Individual people have to build the organization's credibility. It's initially Jim Murphy and Gary Hendricks that policy makers come to view as credible. Only as their personal credibility is established will policy makers see the Academy as credible.

THE UPDATE: You apparently have a good deal of credibility on the Hill yourself. When you testify, members of Congress seem genuinely interested in what you have to say. Could you talk a bit about your own experience in the legislative arena?

GARBER: For about five years, up until the fall of last year, my corporate responsibilities involved government relations. Specific issues I've been involved with on the federal level include tax issues, employee benefits issues, and McCarran-Ferguson. Demutualization was my principle focus at the state level. I've also been involved to some degree with housing issues. And, since my youth, I've always had a great interest in history and politics—some of my family were involved in politics.

As a vice chairman of a company, with a strong technical background, I've been able to work with members of Congress on broad issues as well as with their staffs on more technical matters. I can move back and forth easily between the two levels, whereas most people don't have the opportunity to do that. With my actuarial background, I have a fundamental understanding of businesses, and I am therefore able to provide legislators with information and an understanding that many people involved in lobbying don't have. They know the party line, but they really don't have the ability to talk with fundamental knowledge about how businesses work.

Government relations is interesting. You always have to take into account that the members' main job is to get re-elected. They get re-elected by serving their constituents; if their constituents believe that they are well served, the members are re-elected. So, in every discussion it's important to know not only what it is that *you* want to achieve, but to tie it in with whatever the member is looking to achieve. It's not enough to just go in and give your story; you really have to understand where the member is coming from and what angle is most likely to influence the member. It's like dealing with any sales situation. You have got to know what a client is looking for. And if you're working with congressional staffs, you have to determine what their problems are and how you can help them.

THE UPDATE: You mentioned that members of your family have been in politics. Perhaps that gives you particular sensitivity to how old pols need to satisfy their constituencies! Could you tell us a bit about your family's political side?

GARBER: Family members on my mother's side were very involved in Democratic Party politics. My grandfather was the clerk of the House during the Wilson Administration. In fact, during the 1924 Democratic Convention I think he wielded the gavel. I don't remember the exact title he had; essentially he was parliamentarian. That was the convention that went over 100 ballots to get a nominee.

I also had an uncle who ran for lieutenant governor, and my mother was a Democratic Committeewoman. With this exposure, I inherited a lifelong interest in politics and history.

THE UPDATE: Where did you grow up? And what led you to become an actuary?

GARBER: I'm orginally from Detroit, went to Yale and graduated in 1950. I joined The Equitable in 1950, and I've lived in New York ever since. Strangely enough, I still don't feel part of New York. It's a place where I live, but I don't have a strong association with it.

I came to New York because, when I graduated, we were in the 1949–1950 recession, and there weren't that many jobs available. There were a lot of companies looking for actuaries, though. In fact, The Equitable hired nine people that year.

I had a degree in math, and once I'd begun to work at The Equitable, I started taking the actuarial exams. I served briefly in the Navy from 1952 to 1954, although I never got out of the United States: I served in Rochester, New York, and Lincoln, Nebraska. After that, I came back to The Equitable, and I've been there ever since.

The last time I had a full-time actuarial position was 1963, before I was asked to head up the largest computer project that The Equitable has ever undertaken. I did that for several years and became head of all systems activities. Then I got involved in corporate activities, ran the individual business for The Equitable for a couple of years, and then became The Equitable's first chief financial officer in 1981. Eventually I was elected vice chairman and got involved with government relations work for The Equitable.

THE UPDATE: Does any recent experience or opportunity you've had stand out in your mind as particularly challenging and rewarding?

GARBER: Very much so. One of my personal goals has been to complete a plan for the demutualization of The Equitable. A few years back, a group of New York company people, which included actuaries and lawyers, worked with representatives of the New York Insurance Department to develop a demutualization law. We incorporated into this law many of the ideas developed by the Society of Actuaries' task force on demutualization, which I chaired.

This is an example of how research, in this case research by the Society of Actuaries, was going on at the same time that legislators were examining a problem. We were able to draw on that research and help develop a law that I feel very proud of. It's basically sound

law. The real fun for me now is applying the law to my company as we seek to demutualize.

So taking theoretical findings to the legislative arena, and then to the real world—that's very challenging and very satisfying. The process of developing the demutualization law was ideal—companies working with regulators. It took a long time; there was a lot of give and take, a lot of argumentation. But in the end, we had a law that everyone felt quite comfortable with. As we go through the process of demutualization at The Equitable, the fundamentals written into the law are holding up very well. The whole process will probably take two to three years. We started about this time last year and hope to finish about this time next year.

I think my experience shows that you can take the base of knowledge you have as a professional and build on it by doing new and different things. You want to have a firm knowledge base, but you don't want to be so rooted there that you are limited in what you can do. Being an actuary is a fine career path; however, there's a lot more you can do, just by building on that base of knowledge and being open to opportunities.Δ

September Checklist of Academy Statements

❑ PS-91C-10 Response to Oklahoma Department's Inquiry on Trending Techniques in Ratemaking

❑ PS-91H-6 Comments on Community Rating and Small Group Health Insurance Reform

Check the public statement(s) that you would like to receive and send your request to the Academy's Washington office.

Annual Statement Changes

At its June 1991 meeting, the National Association of Insurance Commissioners (NAIC) Blanks Task Force adopted changes to the 1991 annual statement. Notice of these changes in their detail and supporting documentation is available upon request from the Academy's Washington office. Please reference "NAIC Annual Statement Changes for 1991" when making your request.

Economic Assumptions for Pension Plans

by Silvio Ingui

The Actuarial Standards Board's (ASB) Pension Committee has been hard at work drafting a standard of practice on selecting economic assumptions for pension plans. The committee anticipates that the proposed standard will be approved for exposure at the October 1991 ASB meeting. Once the proposed standard is approved for exposure, all of you will have the opportunity to comment.

Since this standard strikes at the core of what pension actuaries do, the Pension Committee especially urges pension practitioners to review the proposed standard and send their comments to the ASB. The committee needs to hear both what practitioners think is right and what they think is wrong with the proposed standard.

This standard on selecting economic assumptions will be the first in a series of standards dealing with pension assumptions that the ASB Pension Committee hopes to develop. The committee's ultimate goal is to develop a set of standards covering all actuarial assumptions used to perform pension valuations.

The ASB has undertaken this project for several reasons. The first, and probably the most important reason, is that no formal guidelines for setting actuarial assumptions for pension plans currently exist. Other groups, such as the Internal Revenue Service (IRS) and the Financial Accounting Standards Board (FASB), have taken it upon themselves to promulgate requirements. It is thought that if our profession had a formal set of standards, the IRS and the FASB might recognize our standards and be less inclined to impose new regulations and standards on us. Another reason for the proposed standard is to prevent abuse with respect to setting assumptions.

Preview of Proposed Standard

The proposed standard is designed to be flexible. As with all ASB standards of practice, actuaries may deviate from the standard as long as they disclose why they deviated from the standard and what the effect of the deviation is.

The proposed standard provides general guidance for setting economic assumptions. Depending upon the particular valuation being performed, any specific rules concerning setting assumptions for certain types of valuations (e.g., for purposes of Internal Revenue Code Section 412 or *Statement of Financial Accounting Standards (SFAS) No. 87*), would also need to be considered by the actuary.

The standard emphasizes setting assumptions on an explicit rather than implicit basis. The use of select and ultimate assumptions may become more prevalent. This is especially important when interest rates are high and therefore there is a higher risk associated with reinvestment.

The standard discusses economic assumptions such as inflation, investment return, salary increases, and government indexes. The assumptions should be selected in a consistent manner. For example, the same underlying inflation rate should be used for both the interest and salary assumptions.

The standard stresses that while past experience is important, greater emphasis should be placed on the long-term expectations.

The importance of the asset mix in selecting the interest assumption is discussed, as are other considerations, such as the plan's funded status, the asset valuation method, and taxes. The standard describes the methodology for determining economic assumptions from a combination of elements, i.e., the "building-block approach." The standard includes the concept of looking at the rate of return in three components, the pure rate (i.e., net of taxes and inflation), inflation, and the tax premium.

One thing the standard does not attempt to do is set a defined range for what is to be considered reasonable. The committee discussed the issue. It decided that any attempt to define a range of reasonableness could divert the practitioner from going through an analytical process in setting the assumptions, something the committee considers very important. Setting a defined range could also lead to abuses if the range were simply used as a safe harbor.

Finally, the standard has a secondary purpose. Users of actuarial communications such as pension valuations need to understand the views and principles that guide actuaries in setting economic assumptions.

I hope this brief article has piqued your interest and will start the discussion process a little earlier than the actual exposure date. The ASB and its Pension Committee want to hear from you. We want this standard to represent a general consensus within our profession, not just the views of the ASB and the Pension Committee.

Ingui is a member of the Pension Committee of the ASB.

Long-Term Care Insurance—A New Federal Presence?

by Gary D. Hendricks

Up until now, private insurance has come under the states' perview almost exclusively. Medicare supplemental policies (i.e., Medigap) and the determination of what constitutes a life insurance contract are notable exceptions; these are areas where the federal government has the last word. It now seems clear that Congress is going to extend the federal presence into a new area and set consumer-protection standards for private long-term care (LTC) insurance. Several bills introduced this year would set federal standards for LTC policies—what they should cover, how they should be marketed—as well as stipulate how the federal standards should be implemented by the states.

Current Legislation

Last year, several congressional committees, including the House Committee on Energy and Commerce, held hearings on current practices in private LTC insurance. As a result of those hearings, the 102nd Congress is now considering bills that would impose federal standards on long-term care policies.

In February, Representative J. Roy Rowland (D-GA), a member of House Committee on Energy and Commerce, introduced the first of these bills, H.R. 1205. His bill did not actually set forth federal standards, instead it called for the Secretary of Health and Human Services to undertake a study and submit proposed federal standards for congressional consideration. Since February, three other bills have been set before Congress, each of which would, in fact, establish federal standards for LTC policies.

In April, Representative Ron Wyden (D-OR) introduced H.R. 1916. On the same day, Senator David Pryor (D-AR) introduced a companion Senate bill, S. 846. Pryor is an influential member of the Senate Finance Committee and Chairman of Senate Special Committee on Aging. In May, Representative Terry L. Bruce (D-IL) introduced H.R. 2378.

The Wyden, Pryor, and Bruce bills are all serious proposals. When introduced, Wyden's bill had six cosponsors, five Democrats and one Republican—all are important members of the House. Pryor's companion Senate bill has the strong support of a number of his Senate collegues including Majority Leader George Mitchell. Bruce's bill originally had six cosponsors. It is likely that one of these bills, or a compromise bill, will be enacted during the 102nd Congress, which is nearing the end of its first session.

The Wyden/Pryor bill is similar to the more recent Bruce bill, but there are some important differences, both in the means for implementing the standards and in the standards themselves.

Implementing Federal Standards

The Wyden/Pryor bill adopts the approach that the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) took toward implementing federal standards for Medicare supplementary policies. Under the bills, the National Association of Insurance Commissioners (NAIC) is required within twelve months of enactment to promulgate a model law and regulation for the states to implement. If the NAIC fails to meet its deadline, the Secretary of Health and Human Services is charged with developing the model law and regulation within the following twelve months.

The Secretary of Health and Human Services is also charged with determining whether a state has established a program that meets the federal standards. If a state fails to gain the approval of the Department of Health and Human Services, no new LTC policies may be issued in the state, and the state will be denied federal Medicaid funds. In addition, persons who offer a policy for sale in a state that has not complied with the federal standards are subject to a civil penalty not to exceed $25,000 for each violation. The same civil penalty applies to issuers who violate any of the specific standards set forth in the law and regulations.

The Bruce bill's approach to implementation differs from that found in the Wyden/Pryor bill. First, the Secretary of Health and Human Services, not the NAIC, is charged with promulgating a regulation to implement the federal standards. The NAIC is mentioned only as a consultant in the process. Second, the Bruce bill contains tighter implementation deadlines. The Department of Health and Human Services is charged with developing a regulation within six months of any federal standards' enactment; states that do not comply within twelve months may be sanctioned. As under the Wyden bill, the Department of Health and Human Services is charged with determining whether states are in compliance.

Proposed Federal Requirements

Both the Wyden/Pryor and Bruce bills include a long list of federal standards. Most are very similar, even identical. But, here again, there are some important differences.

Consumer Information: Both the Wyden and Bruce bills require consumer access to complaint files on LTC policies and access to the considerable information that companies are required to file periodically with each state insurance department.

The Wyden bill requires state information filings on the number of LTC policies in force, the most recent premium rates, and premium trends for the previous five years. Also required are lapse rates, replacement rates, and rescission rates by agent, and claims denied as a percentage of claims submitted.

The Bruce bill includes an equally extensive but somewhat different list of information. Significantly, the Bruce bill makes no reference to reporting on an agent-by-agent basis.

Policyholder Rights: Under both the Wyden and Bruce bills, new policyholders are guaranteed a thirty-day free trial during which they can cancel the policy. If the applicant returns the policy or coverage is denied during the thirty days, all premiums must be refunded. All policies are guaranteed renewable and cannot be cancelled by the issuer except for nonpayment of premiums or material misrepresentation by the policyholder. The Bruce bill qualifies this, however, stating that the policy is guaranteed renewable "if the policy has not been in effect for 5 years."

Both bills give policyholders greater rights by limiting contestability. Under the Wyden bill, policies cannot be cancelled or benefits denied based on fraud or misrepresentation at the time of issue unless the issuer provides the insured with notice of such fraud or misrepresentation within six months of issue. The Bruce bill would lengthen the notice period to one year.

Both bills also give policyholders the right to an explanation when benefits are denied and require the issuer to provide information on the reasons for denial within sixty days.

Both bills require guaranteed continuation and conversion rights for group policies. Conversions must be made to policies with the same or equivalent benefits and cannot require evidence of insurability. Neither of the bills place restrictions on the premiums that can be charged to those who opt to convert when they terminate coverage under the group policy.

Preexisting conditions: Policies may exclude preexisting conditions from coverage, but only for the first six months of the policy, and replacement policies cannot exclude preexisting conditions at all. Neither can they require any additional waiting period if any waiting periods under the original policy were already satisfied.

Group replacements must take the entire group without exclusions for conditions that were covered under the original policy. However, underwriting is permitted to the extent that a new policy includes coverages that were not included in the original policy.

Benefit Standards: The Wyden bill requires that all policies provide for at least twelve consecutive months of benefits. The Bruce bill takes a stronger position and prohibits a dollar limitation on the maximum amount of benefits that may be paid under the policy.

Both bills place similar restrictions on conditions that can be used to limit benefits. For example, both state that a long-term care policy may not condition or limit eligibility for one benefit to the need for or receipt of any other benefit. Both bills also set minimum standards for home health care and would not allow policies to restrict such benefits to the need for registered nurses, for example. The Bruce bill is somewhat more explicit by defining directly what benefits must include. For example, the bill states that "home health care services shall include homemaker services, assistance with activities of daily living, and respite care services."

Both bills provide that in determining benefits, other than nursing facility benefits, all policies are required to use functional assessments and to specify the level of functional impairment that must be reached before obtaining LTC benefits. Each policy must also provide policyholders who dispute the insurer's assessment a means to appeal.

Inflation protection: Both the Wyden and Bruce bills require limited protection against inflation and include identical provisions. Each policy must include a specified annual percentage increase of at least 5% in dollar payment levels and maximum payment limits.

Under Wyden's proposal, all policies must also specify a limit on the annual percentage increase in premiums. The Bruce bill is silent in this area.

Nonforfeiture: Wyden's bill requires that, if policies lapse after some period of time (to be determined by the NAIC in its model law and regulation), the policies must specify what benefits then become available. Available benefits must be a percentage of the benefits otherwise available at term, or in some other form to be determined by the NAIC.

The Bruce bill is more explicit. If a policy lapses after five or more years, the policy must provide benefits equal to at least 30% of the benefits otherwise available at term. Moreover, the specified percentage is to increase above 30% in a manner to be determined by regulation from the Department of Health and Human Services.

Prior rate approval: Both bills require prior approval of rates by the states. The Wyden bill would require proposed increases in rates to be accompanied by an actuarial memorandum. The Bruce bill does not require an actuarial memorandum but would require that the rate increase be based on sound actuarial standards as recognized in regulations. Both bills would require an opportunity for public comment before rates are approved by the states.

Sales Practices: The Wyden bill includes a general requirement regarding duty of good faith and fair dealing and prohibits a number of sales practices, for example, twisting, high-pressure tactics, cold-lead advertising, sale to Medicaid-eligibles, and sale of duplicate service-benefit policies. Agents who practice illegal sales techniques can get five years in jail and be fined $25,000 for each violation. The Bruce bill is not nearly so specific, except with regard to duplicate coverage.

Under the Wyden bill, insurers must provide an outline of coverage for new issues and for renewals, and they must use standard terminology and uniform format for presenting the outline of coverage. The outline of coverage must include (1) a description of principal benefits; (2) a statement of principal exclusions, reductions, and limitations; (3) a statement of terms under which the policy may be continued or discontinued; (4) terms for conversion or continuation; (5) a reservation of the right to change premiums and a statement of the percentage limit on anuual premium increases; (6) a statement of the value of the policy (to be determined in regulations); (7) information on national average costs for nursing facilities and home health care, and information (in graphic form) on the value of the policy's benefits as compared to such national average costs; and (8) graphic information on the projected effect of inflation on the value of benefits during a twenty-year period.

The Bruce bill, on the other hand, does not outline these details. Rather, the bill states that such an outline of coverage shall be based on the NAIC's LTC Insurance Model Regulation of December 1990. Neither does the Bruce bill require an outline of coverage for policy renewals.

The Wyden bill restricts first-year compensation for newly issued policies to no more than 200% of compensation for the second and subsequent years. The Bruce bill does not restrict compensation.

New Trend in Regulation?

The potential, if not certain, move toward federal standards for LTC policies is itself a significant regulatory development. It is also important because it may signify a new model for the regulation of insurance products. This hybrid model combines federal standards with state enforcement and splits setting standards from setting rates—responsibilities that have traditionally been connected. The Wyden/Pryor and Bruce bills also highlight a more subtle underlying debate on who will develop future regulations. Will the NAIC continue to be the predominant promulgator of model regulations or, as in the Bruce bill, will regulations increasingly come directly from federal agencies? The Bruce bill may well be an indicator of a change in Congress's basic attitude about who should be in the driver's seat regarding insurance regulation.

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

A.M. Best Releases Insolvency Study

by Jeanne Casey

A recent report released by A.M. Best Company is intended to fill what Best calls the "information void" plaguing legislative debates on insurer solvency regulation. *Best's Insolvency Study: Property/Casualty Insurers, 1969–1990*, is billed as "the most comprehensive study to date on the scope, magnitude and characteristics of the 372 property/casualty insolvencies that occurred from 1969 to 1990." It certainly compiles some interesting data.

Scope of Insolvencies

Over the past twenty-two years, the property/casualty industry has gone through two complete underwriting cycles. The Best study compares the number of insolvencies that occurred in 1975, at the end of one underwriting cycle, with the all-time high number of insolvencies in 1985.

In 1975, the industry had twenty-nine insolvencies—this number represents 1.0% of the total number of property/casualty companies. However, these insolvencies constituted only 0.3% of the industry's total premiums written.

In 1985, forty-nine companies became insolvent—an increase of 69% over the earlier peak in 1975. These failed companies represented 1.4% of all companies and accounted for 1.0% of the industry's premium. According to Best, "In each of the last 22 years, with the exception of 1985, the premium volume of insolvencies has been less than 0.5% of industry's premium volume."

Insolvencies by State

Fifty percent of all 372 property/casualty insolvencies for the twenty-two-year period occurred in six states. Forty-seven of these companies were domiciled in Texas; thirty-five in California; thirty-five in Pennsylvania; thirty in New York; twenty-two in Illinois; and eighteen in Florida. These six states combined have regulatory authority over 34% of domestic property/casualty insurers.

The percentage of insolvencies per number of companies domiciled in a state is, on average, 0.7% per year. Florida and California experienced higher than the average failure rate, 1.3% and 1.6% respectively. On the other hand, Illinois, which has the most property/casualty companies, has had a relatively low failure rate—0.3%.

State Regulatory Resources

In 1990, the five states with the largest budgets overall (California, New York, Texas, Florida, and North Carolina) spent 52% of all regulatory dollars, although these states only had regulatory authority for a bit more than 20% of all life/health and property/casualty insurers.

Budget dollars per domiciled company spent on insurance regulation ranged from $3,000 to $343,000 in 1990. A.M. Best observed that "large state budgets, relative to the number of domiciled companies, did not necessarily correlate with lower failure frequency experience."

Company Characteristics

"Small companies (policyholders' surplus of $5 million or less) have accounted for 63% of the insolvencies over the past 22 years," reports Best. Middle-sized companies (policyholders surplus of $5 to $50 million) accounted for 34% of the insolvencies; large companies, 3%.

However, when the number of insolvencies is taken as a percentage of total companies within each of these sectors, medium-sized companies have experienced the highest failure frequency, 0.7%. Small and large companies average failure frequencies were 0.6% and 0.1% respectively.

"Although the industry's companies are almost evenly divided between stock and mutual ownership, stock companies have experienced an average failure frequency more than four times greater than that of mutual companies," Best reports.

Companies that experienced premium growth greater than the industry norm of 5% to 25% accounted for 81% of all insolvencies.

The report also discussed economic factors such as inflation and interest rates and their effects on the industry and its underwriting cycle.

Causes of Insolvencies

Together, deficient loss reserves, linked with inadequate product pricing, and rapid growth accounted for 50% of the insolvencies for which Best was able to identify primary causes. Alleged fraud was identified as the cause of insolvency in 10% of the cases, as were overstated assets. Other causes included significant change in business (9%), reinsurance failure (7%), catastrophe losses (6%).

Best concluded that, "with the possible exception of catastrophe losses, all the causes of insolvencies involved some form of company mismanagement."

On the basis of its study, A.M. Best makes some general recommendations for improving solvency regulation, including:

- Regulators should target high-risk companies for more frequent reviews.
- Regulators should focus attention on companies that A.M. Best and other qualified rating agencies have identified as high-risk companies.
- Companies that are not rated by qualified rating agencies should be closely monitored.
- Licensing should require risk-adjusted capitalization in order to reflect the degrees of risk associated with different lines of business.
- Stiffer fines and penalties should be levied in cases of fraudulent financial reporting.

Best said it did not "expect the industry's current underwriting downturn which began in 1988 to be as prolonged nor as severe as the 1978 through 1984 soft cycle." Rather, Best expects the property/casualty industry's annual failure frequency to peak at 1.1% of all companies—that's a total of 45 insolvencies—in 1992-1993. The percentage of insolvencies to industry premium volume will remain well below 1.0%, Best said.

If you would like to receive a copy of the report, please contact A.M. Best's customer service department at (908) 439-2200, ext. 5552.

Look for a story on the changes in store for the A.M. Best rating system in an upcoming Update.

Name Change for CAPP Approved

As of September 1, the Conference of Actuaries in Public Practice (CAPP) will be called the Conference of Consulting Actuaries (CCA). The organization's leadership recommended the change because it believed that the new name would better reflect the organization's focus on the consulting actuary's perspective. The proposed change was approved by a membership vote in May.

Medicaid Task Force Releases Report

John Klemm

Medicaid costs in the aggregate are currently growing at an annual rate of over 25%, with rates in some states exceeding 50%. These extraordinary rates of growth have considerably exceeded federal and state budget projections. If this trend continues, by the mid-1990s, combined federal and state Medicaid spending may surpass Medicare spending.

As mentioned in the July *Update*, last April the Bush Administration appointed a "swat team" to examine the substantial and unexpected increases in recent spending under the federal-state Medicaid program, which finances health care for 27 million low-income Americans. The swat team comprised a joint task force of officials from the Department of Health and Human Services (HHS), Office of Management and Budget (OMB), and Congressional Budget Office.

The work of the joint task force, which included on-site visits to nine states and an independent actuary's review of the Medicaid budget process, culminated in the report *Better Management for Better Medicaid Estimates*, issued by HHS and OMB on July 10.

The report concludes that about two-thirds of the shortfall in recent Medicaid budget estimates is attributable to changes in federal and state legislation and policies that were not anticipated by budget estimators, for example, the use of refundable donations and provider-specific taxes to leverage federal funds. The report asserts that greater attention to Medicaid estimating at both federal and state levels could provide earlier warning of Medicaid trends and minimize the budget "shocks" that have recently plagued the system.

The report specifically recommends consolidating responsibility for federal Medicaid functions within the Medicaid Bureau of the Health Care Financing Administration (HCFA). It also calls for an expanded role for HCFA, particularly the Medicaid actuaries, in monitoring and reviewing state Medicaid budget activities and developments—including tracking Medicaid policy proposals in each state and developing independent state-by-state federal Medicaid forecasts as a check on states' own estimates. Thirdly, it recommends enhancing the federal-state Medicaid partnership by providing feedback on the accuracy of states' estimates as well as sharing ideas for improving the estimates.

The task force's recommendations are now being implemented at HCFA under very tight time constraints. The task force asks that improved data collection and systems for monitoring state activities be developed by the end of the year.

The current effort is not the first one to be directed at improving federal oversight of the Medicaid program, but it is the first to have the force of an official "swat team" behind it.

Klemm is a supervisory actuary with the Health Care Financing Administration and was himself a member of the Medicaid swat team. Klemm was interviewed in the June 1991 Update.

Academy Speaks Out

FASB Gets Comments on Present-Value Accounting

In December 1990, the Financial Accounting Standards Board (FASB) released its discussion memorandum *Present Value-Based Measurements in Accounting*. Now under consideration by FASB is *how* and *when* present-value-based measurements should be used instead of undiscounted measurements for accounting purposes. (See related article in the February 1991 *Update*.) The Academy's Committee on Property and Liability Financial Reporting, chaired by David G. Hartman, formally commented on the discussion memorandum in a July 9 letter to the FASB. The committee also plans to testify at the FASB hearings in late August.

Much of the Academy committee's eight pages of comments focus on the aspect of risk and how best to recognize risk in discounted measurements. Currently, property/casualty insurance companies usually present their claim liabilities on an undiscounted basis. This practice is recognized under generally accepted accounting principles (GAAP), presumably because there is too much uncertainty in the timing and amount of loss payments for property/casualty insurers to use present-value-based measurements appropriately.

"As actuaries, we regularly deal with the practical aspects of decision-making based on the valuation of 'risky' cash flows or forecasted earning streams," the committee said. Any change in the current practice should require risk to be taken into account. "Adopting a present-value technique for the claim liability, without consideration of the risk associated with claim reserves, results in less reliable financial statements," the committee asserted.

The committee referred to the Actuarial Standards Board's proposed actuarial standard of practice titled *Discounting of Property and Casualty Loss and Loss Adjustment Expense Reserves*, which would require that the actuary "consider the degree of uncertainty inherent in loss reserve projections." (See announcement on page 1.) The committee stated that present-value-based calculations are possible to do, but as the ASB proposed standard on discounting indicates, "risk must be considered when those calculations are made." In sum, "present-value-based measurement of claim liabilities is an incomplete adjustment to GAAP financial reporting. Consideration of uncertainty is also required."

"There are practical ways to include risk in present-value-based measurements and to handle the theoretical and implementation issues raised in the discussion memorandum," the committee said. "Assuming that assets are valued at market value, liabilities should be discounted at a risk-adjusted interest rate, which is a risk-free rate adjusted downward. The risk-free rate should consider the term structure of the liabilities and the risk adjustment should consider the risks in management's best estimate of that structure."

If the risk question is resolved properly," the committee said, it believes that present-value-based measurements can be used when marketplace values are unavailable and present value best serves the measurement objective. The committee will be working with the FASB to ensure that the risk question is properly resolved.

The committee's full statement is available from the Academy's Washington office. Please request PS-91C-9.

Standards Outlook

by Christine Nickerson

The Actuarial Standards Board's (ASB) agenda for its July meeting illustrates well the variety of ASB projects. What follows is a report on the board's recent actions.

LTC Standard Adopted

The first order of business was a review of the proposed final version of a standard for long-term care insurance. Bartley Munson, chair of the Task Force on Long-Term Care, reviewed the draft with the ASB. The board noted that the proposed standard contains more background and educational material than some other standards, but decided that such material is appropriate because long-term care is a newly emerging area of actuarial practice.

The board spent some time discussing the section dealing with actuarial assumptions and premiums. Munson noted that it is an important issue for consumers. The board emphasized that the standard should make clear that assumptions must be consistent with any guarantees in the terms and provisions of the policy.

Minor changes to the proposed standard were suggested, mostly for purposes of clarification. The board voted unanimously in favor of adopting the proposal as a standard of practice.

Cash Flow Testing

Douglas Collins, Joint Casualty/Life Cash Flow Testing Task Force chairperson, presented the proposed final version of the standard, *Performing Cash Flow Testing for Insurers.*

Development of actuarial standards of practice in the area of how to perform cash flow testing was originally undertaken separately for the life and health and the property/casualty specialites. The first to be published was *Actuarial Standard of Practice No.7, Concerning Cash Flow Testing for Life and Health Insurance Companies.* When the Casualty Committee of the ASB undertook development of a parallel standard, the board decided there should be a single standard on performing cash flow testing that would apply both to life and health insurers and to property/casualty insurers. The board therefore appointed a joint casualty/life task force to draft a new standard applicable to both practice areas.

Upon reviewing the draft of the proposed standard, *Performing Cash Flow Testing for Insurers,* at the July meeting, the board voiced concern about the standard's use of the term "hypothetical assets." The board asked the task force to have the standard specify that it is not appropriate for a company to use the same asset more than once to support different liabilities. Other clarifications were also suggested.

The board voted to adopt the proposed standard, which, when published, will replace the current version of *Actuarial Standard of Practice No. 7.*

Economic Assumptions for Pensions

Also under review at the meeting was an exposure draft of a proposed standard on selecting economic assumptions for pension plans. The previously promulgated *Actuarial Standard of Practice No. 4, Measuring Pension Obligations,* contains some general principles for selecting demographic and economic assumptions. However, in recent years, regulatory and other changes in the pension environment have created a need for more specific and detailed guidance, especially in the selection of economic assumptions. (See article on page 7.)

Silvio Ingui, a member of the ASB Pension Committee, presented the draft standard on economic assumptions to the board. The ASB reviewed the proposal and decided that, while it contained a great deal of good material, it was not ready for exposure. The board asked the committee to rework the document and bring it to the October ASB meeting.

Financial Reporting Standards

When the ASB was established in 1988, it undertook to reformat existing standards of practice into a uniform format. Currently, the Life Committee of the ASB is working on revising and reformatting the various Financial Reporting Recommendations and Interpretations related to life insurance. At the July meeting, Life Committee Chairperson Harold Ingraham presented revised versions of *Recommendation 2, Relations with the Auditor,* and *Recommendation 7, Statement of Actuarial Opinion for Life Insurance Company Annual Statements.*

Recommendation 2 was first published by the Academy in 1974 and was updated in 1983. In addition to replacing *Recommendation 2,* the currently proposed revision would also incorporate some language from *Recommendation 3, Actuarial Report and Statement of Actuarial Opinion.* The board reviewed the Life Committee's revision of *Recommendation 2* and voted to release it as an exposure draft because of significant revisions.

The board also reviewed *Recommendation 7, Statement of Actuarial Opinion for Life Insurance Company Annual Statements. Recommendation 7* was originally promulgated by the Academy in 1975, in response to the National Association of Insurance Commissioners' (NAIC) requirement that a statement of actuarial opinion on reserves and other actuarial items accompany the submission of life and accident and health annual statements to state regulatory authorities.

The board's consideration of the newly revised *Recommendation 7* was complicated by the fact that the NAIC recently adopted a new Standard Valuation Law and model regulation for the actuarial opinion and memorandum. Because of these changes in the law and regulation, the board expressed concern that the revised version would be of declining value when released. Therefore, the ASB took no action on the revised standard and asked the Life Committee to consider further how best to address the situation.

SFAS 106 Compliance Guideline

The board also reviewed a preliminary draft of an actuarial compliance guideline for *Statement of Financial Accounting Standards (SFAS) No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions.* The compliance guideline would provide guidance on the actuarial calculations required by SFAS 106.

Retiree Health Care Committee Chairperson Robert Haver discussed this project with the board. He explained the difficulty in drafting such a guideline. Retiree welfare benefit valuations for the purpose of the accruals required by SFAS 106 are a new area of practice for actuaries, requiring experience and skill usually found in two different areas of practice, pensions and group health benefits. Haver said the that the guideline would be aimed at actuaries who are familiar either with pension or group health benefits and who are starting to do SFAS 106 calculations. The guideline would point out areas that could cause problems for a practitioner new to this work as well as give general guidance. The board supported the committee's approach. The committee will continue to work on drafting the guideline.

Loss Reserve Discounting

The board decided to hold a public hearing on the proposed loss reserve discounting standard on September 25, in conjunction with this year's Casualty Loss Reserve Seminar. (See announcement enclosed with this *Update* mailing.)

The proposed standard, *Discounting of Property and Casualty Loss and Loss Adjustment Expense Reserves,* was released as a second exposure draft in January 1991, with a comment deadline of April 30, 1991. The proposed standard would define the issues and considerations that an actuary should take into account in determining discounted property or casualty loss and or loss adjustment expense reserves.

Nickerson is director of the standards program.