NUMBER 10

AMERICAN ACADEMY OF ACTUARIES

1984 JOURNAL

ANNUAL MEETING—NOVEMBER 12–13, 1984
STATEMENTS RELEASED IN 1984

AMERICAN ACADEMY OF ACTUARIES

HEADQUARTERS
1835 K Street, N.W.
Suite 515
Washington, D.C. 20006
(202) 223-8196
(202) 223-8316

MEMBERSHIP ADMINISTRATION
500 Park Boulevard
Itasca, Illinois 60143
(312) 773-4204

CONTENTS

BUSINESS SESSION page

Annual Meeting of the American Academy of Actuaries
November 12-13, 1984

WORKSHOPS

1984 ACADEMY STATEMENTS

BUSINESS SESSION

The American Academy of Actuaries
is not responsible for statements made or opinions expressed
in the record of the annual meeting which appears in this publication.

OPENING REMARKS OF PRESIDENT A. NORMAN CROWDER, III

I want to welcome all of you to the annual meeting of the American Academy of Actuaries. I am particularly pleased that so many of my colleagues on the Council of Presidents have taken the time to attend this meeting; it is a mark of the high level of cooperation and respect that exists among the various actuarial organizations. Most especially, I would like to thank the Casualty Actuarial Society for making us so welcome to its sessions.

REPORT OF SECRETARY CARL R. OHMAN

The Board of Directors of the American Academy of Actuaries has held four meetings since our last annual meeting: December 13, 1983 in Chicago, March 23, 1984 in Key West, June 12, 1984 in New York, and October 8, 1984 in Atlanta.

Major concerns addressed by the board at these meetings included implementation of changes in the organization of standards of professional practice, revisions to the Guides to Professional Conduct and Interpretative Opinions, development of health actuarial qualification standards and standards of practice, the role of the valuation actuary in the United States, relations between actuaries and accountants, federal and state government relations, and other public relations activities for the actuarial profession. The board also received the report of the Planning Committee, adopted the goals stated in the report and approved, in principle, recommendations by the Executive Committee as to priorities and proposed actions regarding the report.

Specific non-routine actions taken at the board's first three meetings have been previously reported to you in The Actuarial Update. A report on non-routine actions at the October 8 meeting will appear in a future issue.

In addition, the Academy's Executive Committee has held four meetings since our last annual meeting: November 21, 1983, February 28, 1984, May 10, 1984, and September 6, 1984 - all in the Washington area. All actions of the Executive Committee are reported to the Board of Directors on a continuing basis, non-routine actions being incorporated in the periodic reports of non-routine board actions in The Actuarial Update.

From November 1, 1983 through September 7, 1984, 427 applications for membership in the Academy were received, 452 new members were added and 9 former members were reinstated. At the end of this period there were 50 applications pending in the Admissions Committee and 46 pending in the Academy's office. The Academy's admissions process operated efficiently throughout the year in terms of average time to process applications for membership, while the quality of professional review of individual applications

has been maintained throughout. The continued success of the admissions process reflects the very fine work of the Admissions Committee, chaired by Cecil Bykerk, and of the Academy's staff.

During the year, Academy members approved an amendment to the bylaws changing the minimum age for waiver of dues because of retirement, which had been approved by the board on June 10, 1983. Rules for implementing the amendment were adopted by the board. Also, the Executive Committee adopted certain changes in the Academy's admissions procedure to clarify the respective roles of the Executive Committee and Admissions Committee and these changes have been implemented by the Admissions Committee.

REPORT OF TREASURER BURTON D. JAY

The Budget and Finance Committee received the Academy's 1983 Financial Statement along with the Report of the Certified Public Accountants, Main Hurdman, on May 9 of this year. Total assets as of last year-end were $1,081,910; total current liabilities were $451,419 and fund balances were $630,491. Total revenue was $1,157,954 and expenses were $1,058,690. Excess of revenue over expenses was $99,264. Several points were raised in the management letter prepared by the auditor to improve the financial administration of the Academy's office. These points have been acted upon by Academy staff.

At its October 8 meeting, the Academy Board of Directors reviewed the statement of income and expenses for the first six months of 1984, along with a full-year projection for this year and a preliminary budget for 1985. Based on these reports, the board approved that membership dues be set at $135, a $10 increase over 1984 dues. The need for the increase in Academy revenues reflects primarily the projected increase in Academy programs in the coming year, the most significant of which is the standards development program, which will likely continue to grow in 1986 and beyond. Future office space needs are being evaluated with expansion probable.

Membership in the Academy increased from 7,316 as of October 1983 to 7,684 as of October this year. Part of the increase during the past year is attributable to the enrollment of the health service corporation actuaries who successfully completed the exam in this field sponsored by the Academy.

NOMINATION AND ELECTION OF MEMBERS OF THE BOARD OF DIRECTORS

We will now elect the new members of the Board of Directors. The nominees of the Nominating Committee in alphabetic order are: Robert A. Anker, Linda L. Bell, Thomas M. Malloy, Daniel J. McCarthy, Stewart G. Nagler, and Leroy B. Parks, Jr. Are there other nominations? There being none, I hear a motion that the nominations be closed and that the secretary be instructed to cast a unanimous ballot in favor of these nominees. All in favor indicate by saying -aye; opposed -no. These people are elected as directors of the Academy.

BUSINESS SESSION

REPORT OF VICE PRESIDENT JOHN A. FIBIGER

The committees that I have been charged with overseeing are the committees on financial reporting and standards of practice. There have been a lot of interesting developments over the past year, much of it resulting from pressure both within and outside the actuarial profession. Two major items that have forced a response from the actuarial profession are the pension project of the Financial Accounting Standards Board (FASB), and the real concern over the viability of insurers arising out of the Baldwin United insolvency and allegations about some other companies, particularly in the single premium annuity area. As a member of the Financial Standards Advisory Committee, I have found it very interesting to deal with FASB, talking about some of the practical, real-world impacts of FASB tentative decisions in exposure draft. It has been fascinating to watch the reaction of non-actuaries to the actuarial profession. It is very hard to tell the FASB members who are proposing a single-cost method for accounting for pensions that the actuarial profession has developed standards in that area, because there is no single standards that is appropriate under all circumstances. Happily, they are willing to wait for the completion of the study of the Committee on Pension Actuarial Principles and Practices, under Tom Malloy's direction. That committee has also been very active restating their present recommendations in the pension plan recommendations A and B in the pension plan, recommendations and interpretations. The Committee on Dividend Principles and Practices, has been working on extending principles of surplus distribution from participating life issued by mutual companies to include participating life insurance issued both by stocks and mutuals. In addition, they are working on Recommendations and Interpretations for non-guaranteed, non-participating policies issued by stock companies. Obviously, with all the activity relating to the FASB in relating to insolvencies in relating to standards there has been a lot of activity among the accounting, the auditing, and the actuarial profession, so that the Committee on Relations with Accountants, there is a regular liaison maintained with the American Institute of Certified Public Accountants (AICPA). The Subcommittees on Actuary/Auditor Relations have been active working out long-term strategy involving statutory evaluations for state insurance departments, reserve illustrations in those states which require a CPA audit, property and casualty reserve evaluations, and dealing with GAAP financial statements. They have worked on a revision of Recommendation 7 relative to the statement of actuarial opinion for life insurance company statutory annual statements, and there will be an expansion of that, which will be made in connection with the expectant move toward requiring companies to appoint a valuation actuary. I think this move to the valuation actuary reflects the feeling that statutory valuation principles are beginning to break down. The Committee on Life Insurance Financial Reporting Principles has been working on the statement of actuarial opinion and also very heavily on accounting for non-guaranteed premium products. The Committee on Property and Liability Insurance Financial Reporting Principles has made comments to the Securities and Exchange Commission (SEC) on proposed regulations on loss reserve disclosure, has monitored the NAIC's discounting disclosure proposal, and has prepared a revision of Interpretation 8b on adequacy of reserves for exposure to Academy membership. In general, I think that all of these committees really do reflect the increasing move toward treating actuaries as professionals, requiring professional certification of solvency and developing

professional standards of practice. The profession owes all of the committee chairpersons and the people who have worked so hard on these committees a great debt of thanks.

REPORT OF VICE PRESIDENT DAVID G. HARTMAN

There are now five Academy committees we designate as Public Service Committees - Insurance. The general purpose of four of these committees is to 1) monitor legislative and regulatory activities, 2) develop and present statements of Academy positions where appropriate, and 3) communicate developments to the Academy membership. All five committees have been quite active, as indicated below by their most significant accomplishments in the past year.

The Committee on Health - Robert H. Dobson, Chairperson.

1. An open forum for successful candidates on the health service corporation actuarial examination was given by the committee on June 6 in Boston.

2. Worked with the Committee on Social Insurance of the Academy to prepare testimony on the December 15, 1983 recommendations of the Social Security Advisory Council regarding Medicare. This testimony was presented September 13, 1984 to a subcomittee of the House Ways and Means Committee by Bob Dobson.

3. Subcommittee on Liaison with the NAIC Accident and Health (B) Committee has undertaken an extensive project on reserve standards for health insurance contracts, in addition to ongoing liaison work (Paul Barnhart, Subcommittee Chairperson).

4. Subcommittee on Health and Welfare Plans has assumed responsibility for a project on other post-employment health benefits in conjunction with FASB. It is also working with the IRS in developing a training program for their actuaries (Stephen D. Brink, Subcommittee Chairperson).

5. Subcommittee on Health Maintenance Organizations is preparing comments on latest AICPA proposal on accounting for HMO's (Lloyd F. Mathwick, Subcommittee Chairperson).

6. Subcommittee on Federal Role of Health Actuaries was eliminated since there were no projects pending.

7. Subcommittee on Principles and Practices was up-graded to a full committee (see below).

Bob Dobson has been elected secretary of the Academy, and Paul Barnhart is now the chairperson of the Committee on Health.

BUSINESS SESSION

Committee on Health Actuarial Principles and Practices - Ronald M. Wolf, Chairperson.

This committee formerly was a subcommittee of the Committee on Health until the summer of 1984. As the name of the committee implies, it is to identify and write standards of practice for health actuaries. It is responsible for having formulated and finalized Recommendation 10 - Statement of Actuarial Opinion for Health Service Corporation Statutory Annual Statements.

Committee on Life Insurance - Richard S. Robertson, Chairperson.

The committee worked with the following regulatory bodies during the past year.

1. IRS - Revised table of uniform premium rates for group term life insurance.

2. FTC - Study of life insurance consumer information (cost disclosure).

3. NAIC Technical Staff Actuarial Group (TSAG) - specifications for 1980 CSO Tables.

4. NAIC Standing Technical Actuarial Task Force (TSAG's successor) - application of the CRVM to policies with cash values in excess of the reserve.

5. Washington State Insurance Department - Universal Life Model Regulation.

6. Colorado Insurance Department - reinsurance regulation and annuity regulation.

7. Monitor development of the Life Insurance Tax Act of 1984.

Dick Robertson has completed three years as chairperson of the Committee on Life Insurance. Gary Dahlman is now the chairperson of the Committee on Life Insurance.

Committee on Property and Liability Insurance - Jerome A. Scheibl, Chairperson.

1. Property and Casualty Loss Reserve Certification - recommended to the Academy Executive Committee that the present policy, not to actively promote the certification of loss reserves in all states, should be reaffirmed. This report was accompanied by a survey of the characteristics of loss reserve certifiers in the states with such requirements.

2. Advised NAIC Committee on language inserted in Model Workers' Compensation Group Self-Insurance Bill to require loss reserve certification by qualified loss reserve specialists (provides automatic qualification for members of the Academy).

3. Advised Minnesota hearing examiner on need to assure professional qualification in administrative rule for those providing actuarial services for group self-insurers.

4. Testified before NAIC Investment Income Task Force regarding the actuarial implications of requirements that investment income be explicitly recognized in the making of rates.

5. Reviewed General Accounting Office (GAO) study on taxation of Property - Casualty Insurers and referred it to the Committee on Property and Liability Insurance Financial Reporting Principles.

Jerry Scheibl is continuing as chairperson.

Committee on Risk Classification - Robert L. Knowles, Chairperson.

1. General Accounting Office (GAO) reports on the economic implications of enacting unisex legislation - detailed response prepared by committee.

2. Worked with Academy Committee on Government Relations to develop resources for Academy members who wish to participate in risk classification legislative or regulatory activity at the state level.

3. Blindness Discrimination - the committee submitted a written statement to the House Subcommittee on Commerce, Transportation and Tourism concerning HR4642. This bill would prohibit insurers from treating blind people differently from others unless justified by "sound actuarial evidence" - a vague standard.

Bob Knowles is retiring as chairperson; Claire Wolkoff is now the chairperson of the Committee on Risk Classification.

More detailed reports on the activities of the various committees can be found by reading articles about them in The Actuarial Update each month. In addition, each chairperson welcomes comments or inquiries regarding the work of their committees from interested Academy members.

I wish to thank all the members of these five committees for their numerous contributions in the areas in which these committees have been active. The committee chairpersons join me in thanking the Academy staff for their fine support during the past year.

REPORT OF VICE PRESIDENT DAVID M. READE

We have been asked to make our remarks brief and related to topics of interest to casualty actuaries. For me, with four out of five committees being pension oriented, these requirements become very compatible.

However, it would be unfair to the fifty-five members of those committees who, though not members of your society, work almost as hard as if they were, to omit their activities from my report.

BUSINESS SESSION

Using the order they appear in our yearbook, the first committee is the Pension Committee, which together with its four subcommittees, is basically responsible for researching pension issues in pending legislation and regulations. During the past year they filed eight separate position papers with various congressional committees. The Pension Committee acts as a coordinator on all pension matters of an actuarial nature that come to the profession. To this end, its membership includes the chairman or other senior representative of each pertinent committee of the Society of Actuaries and the Conference of Actuaries in Public Practice. The Pension Committee has no members in the Casualty Actuarial Society.

The Committee on Services to Enrolled Actuaries continues to research the needs of all enrolled actuaries, whether or not they are members of the Academy. It is now exploring various avenues toward implementing or expanding services identified by a survey taken during the past year. This committee does not have any casualty actuaries on it either.

The Committee on Social Insurance, one of whose members is both an FSA and an FCAS, reviewed a report issued by the General Accounting Office dealing with Social Security actuarial projections. Upon its recommendation, President Crowder wrote to GAO, emphasizing the need for independence of the Social Security Actuary in selecting actuarial assumptions. This committee worked closely with the Committee on Health in preparing testimony on the recommendations of the Social Security Advisory Council regarding Medicare. The testimony was presented in September to the Subcommittee on Health of the House Ways and Means Committee.

The Committee on Pension Terminology continues its mission to obtain wide acceptance of standard pension terminology. It does so without the assistance of a casualty actuary.

Last but certainly not least, the Committee on Guides to Professional Conduct (casualty to non-casualty: five to eight) completed the comprehensive review and revision of the Guides and Opinions that was started a few years ago. These Guides and Opinions have been (or hopefully soon will be) adopted by the Boards of the Academy, the Casualty, Society and the Conference in virtually identical forms. As one who has been personally involved in this project, including a term as chairperson of the committee, I can assure you that it would not have been possible without the unceasing efforts of those casualty actuaries who have served on the committee over the last four years.

REPORT OF VICE PRESIDENT WALTER S. RUGLAND

As Vice President of the Academy for the last two years, I have had responsibility for what I describe as miscellaneous committees.

These include the Committee on Publications, chaired by Mavis Walters, and the Public Relations Committee, chaired by Jay Ripps. Both have been superbly staffed by Erich Parker, Director of Public Information, and his staff in the Academy office.

Additionally, I have had responsibility for the Committee on Government Relations, chaired by Fred Kilbourne, and supported by Gary Simms, Academy General Counsel.

I have also had responsibility for committees in the area of qualifications standards. The Committee on Qualifications has been chaired by Bob Miller. We have also had two special committees on qualification, one with regard to health, chaired by Bob Schuler, and the other is with regard to pensions, chaired by Joe Stahl.

As you can see, some of my committees are the most visible to Academy members. Others struggle for recognition of any type.

With regard to the Committee on Publications, we need to give special thanks this year to Mary Adams, who leaves her position as editor of The Actuarial Update. She will be ably succeeded by Barry Watson, who I am pleased to welcome to the masthead.

Equal thanks must go to Joe Brownlee, who has served as editor of the Enrolled Actuaries Report. Joe, by becoming a vice president of the Academy, has made good on his long-time threat not to continue as editor of EAR. As of last week, we were still looking for his replacement. Any of you casualty actuaries in the room who think you might like to lend a little spice to the Enrolled Actuaries Report by being its editor, be sure to let Mavis Walters know.

In the past we have asked Academy members (most recently Harold Wiebke and George Morison) to serve as editors of our yearbook and journal, respectively. Those days are over. From now on preparation of those two publications will be the responsibility of the staff in the Academy office; the efforts of volunteerism will not be subject to those particular tasks.

A few years ago, the Academy realized that trends were developing among regulators -- both state and federal -- that indicated the need for some type of professional opinion with regard to health service providers. It was acknowledged that there was a significant group of specialists within health service plans who were doing actuarial work, essentially, and who probably would need credentials of some form if this trend continued.

We created a special Committee on Health Standards of Qualification; and Bob Dobson was appointed its chairperson, and Bob Schuler succeeded him in midstream. I won't go through all the activities that committee has pursued, but the net effect of it is that about seventy-five individuals are now members of the Academy, who were not even anticipating being such back when the initial issue was defined. The committee prepared a qualificiation exam, handled its administration and grading, and then worked with the Academy's Board of Directors and Executive Committee to structure arrangements so that individuals within these health service corporations could be members of the Academy and subject to all the professional requirements of membership. In addition, the committee recommended to the board minimum standards of qualification for actuaries who provide opinions on health service corporations -- an opinion which is now required by the National Association of Insurance Commissioners (NAIC) to go along with an annual statement.

The work of this committee is now complete. Its designation "special" means that it was special, and the committee itself will no longer exist.

The special Committee on Pension Qualifications will continue its work with regard to review of qualifications required under ERISA to determine whether it would be appropriate to recommend any changes in those qualifications.

The Committee on Qualifications has done substantial work this year with regard to the concept of valuation actuary. This entailed a revision of the qualification standard for the life company blank which has been in place for several years. A proposed revision will be presented to the board in December for exposure to the membership.

The Public Relations Committee's mode of operation is to support the Academy office staff with regard to policy decisions and ongoing monitoring of results. This it has done in good stead over the past year. Jay Ripps is retiring as committee chairperson, and we owe our thanks to him.

We have a committee that is structured to improve relations with legislators and regulators at the state level of government. It works with actuarial clubs to achieve this goal. This is Kilbourne's committee, and this year it has achieved measurable results. They targeted some states and established relationships with those states. They also targeted an issue -- unisex -- and provided material to legislative and regulatory bodies as soon as it appeared appropriate. In addition, they have made progress involving local actuaries in specific local issues.

This is my last duty as Academy vice president, and I wish to thank the memberhip for giving me the opportunity to serve. It has been a rewarding experience!

REPORT OF EXECUTIVE DIRECTOR STEPHEN G. KELLISON

I am pleased to be able to present this annual report. The scope and volume of Academy activities has grown substantially during the past year, both internally within the actuarial profession and externally with the Academy's public interface activities. It has been an exciting year for me to have been involved in as many important professional issues facing our profession as there were during the past year. Moreover, next year promises more of the same.

Let me begin by recognizing the dedicated staff in my office who are working on your behalf. We currently have a staff of twelve employees in the Washington office. Our three department heads are here today and I would like to introduce them to you. First is Erich Parker, who is our Director of Public Information. Erich splits his time between the external public relations program of the Academy and overseeing Academy publications. Second is Cyndy Sharp, who is our Director of Administration. Cyndy's responsibilities include financial management, convention management, membership data base management, and a number of other administrative activities needed to keep our office running smoothly. Third is Gary Simms, who is our General Counsel. Gary provides legal advice throughout all Academy activities and also is heavily involved in our government relations program. Just by these

job titles and brief descriptions of functions, I think you can get some sense of the great breadth of activities in which our office is involved. I hope all of you who have not had the opportunity to do so will introduce yourself to these people and express your appreciation to them."

I would also like to mention another member of my staff who has been quite visible at the registration desk at this meeting - Sue Hendrickson. Sue has helped run CAS meetings for the past two years. We are pleased to provide this service for the CAS and always welcome your comments and suggestions.

While I am on the subject of meetings, I would be remiss if I did not mention that the Academy and the CAS have just completed their fourth jointly-sponsored Casualty Loss Reserve Seminar which was held in New York in September. This meeting was quite successful drawing over 525 attendees. From the CAS vantage point, the Casualty Loss Reserve Seminar represents a commitment to continuing education - to improve the skills of actuaries and other loss reserve specialists in this most important area. From the Academy vantage point, this continuing program of annual seminars reflects our commitment to professionalism in loss reserving which we made to the NAIC in 1980 when statements of actuarial opinion were first added to the NAIC Fire and Casualty Annual Statement Blank and recognized Academy membership in the qualifications section.

One of the highlights of the past year on our staff has been the inauguration of a formalized staff planning process. Last winter for the first time we prepared a staff plan for calendar year 1984, which was approved by the Academy Board of Directors. This was followed by regular quarterly progress reports. We are now in the process of finalizing our staff plan for 1985. This staff planning process has achieved its intended purposes of ensuring that staff functions reflect the organizational priorities of the Academy leadership and that accountability and performance levels are being met. However, it has also achieved another, somewhat unexpected, beneficial result. It has brought the multifarious activities in our office closer together and helped create more teamwork in our approach to problem solving. The result has been to broaden everyone's perspective on the Academy and the role of our staff in serving it.

The lifeblood of any professional association such as the Academy is the work of its volunteer committees. The other reports which you have just heard this morning give you some sense of just how extensive Academy committee activity has become. As you might imagine, staff support for committees is a major part of what we do in the Washington office. Another highlight of the past year for our staff has been the completion of a Committee Chairperson's Manual. This manual has been helpful in increasing the productivity of committee chairpersons in carrying out their mission.

I notice that the theme for this CAS meeting is the one word: regulation. It is most appropriate that the Academy would hold its annual meeting at an actuarial meeting with this as its theme, given the Academy's public interface role. This brings me to a topic on which I personally devote considerable effort --- namely, government relations. I would like to spend a few brief moments on what the Academy has accomplished during the past year and what we see on the horizon over the next year.

First, some numbers to give you a sense of the extent of this activity. I have gone back and tabulated the Academy statements made over the twelve-month period October 1, 1983 through September 30, 1984. There have been forty-six such statements in total. The breakdown is a follows:

15	U.S. Congress
14	Federal Agencies
9	NAIC
8	FASB/AICPA

Although the Financial Accounting Standards Board (FASB) and the American Institute of Certified Public Accountants (AICPA) are not governmental agencies, we do deal extensively with them a basis similar to government, given their quasi-regulatory powers in establishing accounting and auditing standards. Also, statements to individual states are not included in this head count.

For those in the audience who wish to become more familiar with this area of activity, I would commend to your attention the Academy publication, Government Relations Watch. This is a regular insert in our monthly newsletter mailings containing a full run-down on governmental activity in which the Academy is involved. Also, Academy statements are listed after the fact each month in The Actuarial Update, itself, and are available upon request.

Now that the elections are over, what can we expect at the federal level? The following three issues are certain to be on the front burner in 1985, although they are not in any way an exhaustive list of issues with actuarial content.

- Risk Classification

  Insurance industry lobbyists were successful in 1984 in preventing passage of the unisex legislation that has been around Congress for several years. However, it will be back again next year. To the proponents of this legislation the issue is one of civil rights, not economics, and they have no intention of giving up the fight. Look for this issue to surface in state legislatures in 1985 as the insurance industry attempts to reverse the omnibus unisex law now on the books in Montana, while the proponents attempt to extend such legislation into other states.

  However, the battleground for the unisex debate seems to be shifting from the legislative arena to the judicial arena. Within the past few months three major lawsuits have surfaced.

  1. First, the Pennsylvania Supreme Court has ruled in favor of an action by the Insurance Commissioner to eliminate sex-based rates for automobile insurance as "unfairly discriminatory" under the state's ERA.

  2. Second, promising more of the same in other jurisdictions, the National Organization of Women has filed a lawsuit against Mutual of Omaha involving sex-based rates for individual health insurance in the District of Columbia under a public accomodation statute.

3. Third, TIAA-CREF has lost a lawsuit and will be required to provide unisex annuities retrospectively prior to the August 1, 1983 date specified in the Norris decision all the way back to 1980.

Unisex is not the only risk classification issue to watch. Late in the 1984 Congress a bill began to move which would prevent insurance rating for blindness unless it could be justified on the basis of "sound actuarial evidence." This bill will probably be back in 1985 and could pass. If such a bill were to ever become law, it raises some important questions. First, it presents a challenge to the actuarial profession to define "sound actuarial evidence," a new term not appearing in any previous law. Second, if this is done for blindness, why not for a number of other physical impairments?

- Taxes

With persistent and intractable deficits in the federal budget, tax issues are guaranteed to be on center stage. With the life insurance tax issue resolved, Congress will turn to the taxation of casualty companies. This debate will have a significant actuarial flavor, since discounting of loss reserves is high on the Treasury Department shopping list.

Another tax issue that is certain to receive close scrutiny is the taxation of employee benefit plans. Congress made major changes in the taxation of employee benefit plans in 1982 and 1984 and every sign indicates that they are not done yet.

- Medicare

Medicare has serious short and long-term financial difficulties. Short-term, the Medicare trust fund will run out of money in this decade if changes are not made. Long-term, the deficit as a percentage of future payroll is three times as large as the long-term deficit facing Social Security in 1983.

Solutions are not easy to find and are painful. There really are only four ways to address the problem: (1) increase taxes (2) reduce benefits (3) raise the eligibility age and (4) lower the rate of inflation in health care costs.

It is obvious that all of these are difficult to achieve politically. Congress has a "tiger by the tail" on this one.

In discussing government relations we should not forget state and local matters. At the National Association of Insurance Commissioners (NAIC) level efforts are underway to structure a high-level liaison committee on the Academy to deal with the NAIC in an attempt to strengthen actuarial input into NAIC deliberations. As part of the effort, an NAIC casualty actuarial task force to parallel the existing life and health actuarial task force is likely to be created. You would also be interested in knowing that the NAIC has added an actuarial position in the Kansas City office in its 1985 budget.

At the individual state level, the Academy's Government Relations Committee is making significant strides in finding avenues to deal with such issues. This effort is being spearheaded by Fred Kilbourne, a past president of the CAS.

Although I am out of time, I would be remiss if I did not mention the major project on standards of practice. I have deliberately avoided discussing this important project, since it is being so thoroughly addressed by other speakers here today. However, our staff does anticipate that this project will require considerable attention during the next year, and we are excited at the prospect of helping to move this project forward.

In closing, I would like to express the gratitude of the staff and myself to the officers and directors of the Academy, to the committees and task forces, and to the general membership for the outstanding support which we have been afforded during the past year. The staff always welcomes your comments and thoughts as to how we can better serve the needs of the membership in the years ahead.

Thank you.

PRESIDENT'S ADDRESS - A. NORMAN CROWDER, III

A TRADITION OF SERVICE

Today I would like to reflect briefly on a growing tradition of service that I hope we can all nurture and continue. The Academy is a volunteer-run organization like the Casualty Actuarial Society and the other groups. Nowhere is it so clear as when one is president of one of these groups that you come to realize how dependent we are on the work and cooperation of others. The Academy now has some forty-seven committees and task forces, involving over 400 of its members, and there are numerous others who participate in special events. Obviously, the Academy is a major undertaking when looked at in its collective whole. And then, when you multiply these numbers across three other large actuarial organizations, one can understand the extent of the commitment that we, as members, are making to our profession. Moreover, this time is spent largely on a volunteer, part-time basis.

As you know, the Academy is a public interface group. It was founded in 1965 by the constituent actuarial bodies to act for the collective good of the profession - to act primarily as its public interface arm. The Academy needs to be sensitive to trends and concerns in our industry and profession. These days issues often emerge rapidly and require quick action. The Academy staff and its committees act as coordinators. They attempt to mobilize actuaries to respond and speak to public issues. They work for the collective good of the profession, not merely the Academy, the CAS, the Society of Actuaries, or the Conference.

We want actuaries who can act, who are practical and articulate, and who are credible, capable, and decisive. Otherwise, the Academy and its interface activities cannot be effective for the actuarial profession.

We have a growing tradition of service in the Academy. On reflection, I recall that the Casualty Actuarial Society has systematically encouraged its members to get involved in the Academy. It has sent their best, and not merely on property and liability matters. Just let me name a few - some from the past - Dan McNamara, Ron Bornhuetter, both of whom are past presidents

of the Academy; Jim MacGinnitie, who is one of your recent presidents, is in semi-retirement in Academy activities. But, we hope soon to bring him back. Adger Williams, who was my predecessor as the Academy president, has served long and hard in both the Casualty Society and the Academy. And, some of our current leaders come from the ranks of the Casualty Society; e.g., Stan Hughey, who is to be my successor. Stan Khury, who is your incoming president, has been a board member of the Academy as has been Phil Ben-Zvi, your president-elect. Not to be forgotten are the two Walters - Mavis and Mike - both of whom have served as board members of the Academy and in a number of other roles. Dave Hartman is a current vice president of the Academy and one of our most able contributors.

It's the old story, "If you want a job done, ask a busy man." When we in the profession were concerned about our discipline activities a year ago, we asked Charlie Hewitt to step in and help us with the situation. It wasn't as if he had nothing to do as the president of Metropolitan Reinsurance. But, he gladly volunteered to undertake this complex, confidential, and difficult task. One year later, I can tell you he has done a magnificent job. Walt Rugland, who is retiring as an Academy vice president, has been starting a consulting practice from scratch in Hartford. He doesn't have much free time, and yet he has been one of the most prolific contributors to Academy activities over the last eight or ten years. I'd also remind you, in the tradition of service, that Walt's father was president of the Fraternal Actuarial Association and an early president of the Academy - that is a real tradition of service. And John Fibiger, who is chief operating officer of New England Life (certainly a challenge in itself), has been willing and able to find time to be active in the Academy as vice president and with several different committees. So here are three busy men who are able to find a little extra time to give to their profession.

The other actuarial groups have also sent good people. Walt Rugland has simultaneously been active in the Society of Actuaries. Pres Bassett, who is here this morning, has chaired a number of Academy committees and is still very interested in our work, even as he assumes the presidency of the Society of Actuaries. Dick Robertson, president-elect of the Society of Actuaries, has served as chairman of several committees amd recently has been a vice president in the Academy. The Academy appreciates the time that these individuals have been willing to devote. The difference between these involvements and the Casualty Actuarial Society efforts are that the CAS has attempted systematically to provide help from their leaders in the Academy. I would ask that the leadership of <u>all</u> actuarial groups undertake this level of commitment and involve their best in the Academy.

I believe that the Academy is steadily increasing in its effectiveness. It has been gaining stature and momentum in the last eight to ten years. We have established our presence in Washington over the last eight years with Steve Kellison and his staff. We are making some real contributions for the profession and the public. We are speaking out on matters of actuarial concern, trying to strike a real balance as a public voice and yet present a professional stance. We exist to serve the profession, our constituent bodies, and our member actuaries. The Academy is <u>not</u> an entity in itself. We have no desire to duplicate the work of others. We will supplement the activities of other bodies only as needed. And, we will attempt to coordinate our collective efforts where it is useful. The Academy wants only to play its unique role, not to duplicate the work of others.

There is still much to be done. New issues and concerns are emerging daily. Are they more serious and threatening than in the past? It is hard to tell, but in the poignancy of the moment, some of these issues certainly look rather ominous. The profession must be prepared to respond. The public wants and needs our help in areas where we are uniquely qualified to assist. We actuaries cannot operate merely from selfish interest; we need to help protect the public and to advise on actuarial matters. Our members, whether from the Casualty Society, Society of Actuaries, or wherever, need to give that help.

In the vice presidents' reports this morning, you heard about a number of issues which are emerging or current. Let me tick off a few of them. The valuation actuary, standards of practice, relations with accountants (where discounting reserves continues to be a major issue), risk classification, and last (but by no means least), Medicare and the whole question of national health. This is a large agenda of major issues that touch on various segments of the actuarial profession. In particular, each of these matters has some direct bearing on casualty actuaries.

So the Academy needs your help, your time, effort, and concern. As the Marines would say, "We need a few good men (and women)." Actually, we need many people, because there are dozens of issues of concern and interest to our profession.

Looking back on my year as president in 1984, there have been many challenges. Some we have met and solved; many are still left to be done. In fact, I've only accomplished a fraction of what I had hoped to do. There are practical limits. I must in some degree attempt to earn my paycheck at TPF&C.

But, there are two things that stand out during this year. The Standards of Practice effort under Stan Hughey's able leadership is moving toward a reasoned and practical approach. Comprehensive standards are a necessary step whose moment is beginning to arrive. The second major event is the valuation actuary activity. Concern over financial failures, such as Baldwin United and several casualty insurance companies, has hit the public and regulators hard. The need for an independent actuary, who can help to safeguard the financial security of an insurance company and the interests of the public, has become a pressing need. Particularly on the life insurance side, we have made rapid progress in defining the concept of a valuation actuary. In the next year we will be looking closely at a comparable approach for the casualty actuary.

On a personal note, I feel that I have given back, in small measure, some portion of what the profession has so richly given to me. I believe that this is a debt which most of us come to honor over our years as actuaries. But also, I have developed some real personal relationships with a number of bright, capable people. This has been a source of real, personal satisfaction and fun for me.

Without a moment of hesitation, I am happy and proud to turn over the Academy leadership to Stan Hughey and Bart Munson. They are two capable and industrious people. Stan is one of those who has been raised in the tradition of service; first in the Casualty Actuarial Society and now in the

Academy - and Bart is a man who, in his prior role as President of the Fraternal Actuarial Society, had the courage to close down that organization when its time had ended. That kind of practical, capable mind can serve the Academy and the profession very well.

A final comment - I would hope for the eventual consolidation of the profession. Four separate groups can't be as efficient as one. Our time is precious, especially since we are all volunteers taking time from active business careers. I recognize that many people worked long and hard on the process of consolidating the profession five to ten years ago. I would like to see the profession renew these efforts, if only for efficiency. I would gladly help in this proces of unification, if others think it may be time to reopen such discussions.

I hope for and expect the continued success and effectiveness of the Academy. After a few months' rest, I would intend to continue to work for its activities. In closing, I would like to thank you for your confidence in me. I hope that my year of leadership will stand the test of time; that some will say we have made some real contributions in 1983-84. I was pleased to serve as president, and I stand ready to do more. Thank you.

REMARKS OF NEWLY-ELECTED PRESIDENT M. STANLEY HUGHEY

I am honored to serve as president of the American Academy of Actuaries in this its 20th year. Looking ahead, we seem to be on the verge of achieving some important progress on problems and issues that have been bubbling for some time in the cauldron of actuaries as professionals.

During the early years of the Academy's life, and particularly during its more recent teen years, many people have worked creatively and thoughtfully to put together the ingredients, fill the cauldron, and light the fires. Full credit is due previous Academy boards and officers for bringing this cauldron to what just may a boiling point. Now, today, your new officers have the exciting opportunity and somewhat awesome responsibility to draw off some of this mix and create some of the finely tempered achievements which our predecessors have visualized. Tackle the job we must, and with full dedication, because there is strong evidence that the time is right to take the concept of actuaries as professional several important steps forward.

Lest you think I am being a bit over-dramatic about the potential for finally achieving some long-term goals, let me list just a few activities and issues which are being worked on:

- Actuarial Standards - a cornerstone of our profession, has a program being considered.
- Education - particularly in the field of research, panel discussions, and various kinds of special seminars, there is an increase in activity.
- Public Relations - actuarial issues are getting increasing attention and actuaries are being noted and quoted in the public press.

- Interface with Federal and State Governments - long efforts to have actuaries recognized as important sources of information seem to be coming to fruition. Substantial cooperation efforts are taking place, as in the case of the very important valuation actuary concept.

- Discipline - administration working well and improved procedures are being established.

- Liaison with Other Professions - good contacts and communication are being developed.

- Academy Tools - the Academy committee and control structure is functioning well, as witnessed by the fine set of 1984 committee reports. Staff goals and structure have been strengthened. Importantly, the role of the Academy is being clarified as various projects go forward.

All of these Academy activities, directly or indirectly, contribute to the advancement of actuaries as professionals. As your new officers take over the reins for the coming year, we salute Bill, Adger, Norm, and all the other leaders who have contributed so much to bringing the Academy to its present state of readiness. We pledge our full effort toward moving a step or two closer to achieving that ultimate goal of recognition and acceptance of actuaries as highly regarded professionals.

REMARKS OF NEWLY-ELECTED PRESIDENT-ELECT BARTLEY L. MUNSON

During these couple moments I want to leave with you a theme that I personally take into these next couple years, as I look forward to working with Stan, Norm, the Academy staff and Board of Directors, and for the many volunteers and members that are the Academy.

I was impressed long ago with a distinction that can be used to classify an organization. It has stuck with me, as a useful test in considering the worth of an organization, any organization. It's this. In evaluating an organization one should consider whether it is an instrument or an institution.

Cyclical historians who have considered the matter observe that human organizations are created as instruments for achieving some practical end. They are purposeful. But as instruments age and increase in power, they devote less and less of their energies to satisfying needs for which they were created. They become concerned with perpetuating themselves. In short, they become institutions.

Instruments are aggressive, flexible, innovative, often efficient.

Institutions tend to react slowly and be wasteful, needing more resources to accomplish less. They are characterized by bureaucracies that are fearful of change. Thus they are enamored with consistency as an operating principle, since consistency greatly reduces both the necessity for being ingenious and the element of risk.

BUSINESS SESSION

As I believe is clear from the three panel discussions here at this meeting, and the highlighted reports given this morning, the Academy is indeed an instrument, not an institution. We are serving a purpose, being aggressive and innovative. We are helping the profession meet and serve the needs of the many publics whose lives, both individual and corporate, our expertise does or should touch. And we are doing much to ensure that we can deliver what we say we can -- a professional expertise and quality of performance and product.

The goal, clearly, is for the entire profession to be an instrument, not an institution. I believe it is. And I believe it is becoming more an instrument and less an institution. I believe the Academy is having a lot to do with that.

This distinction of institution or instrument is one I will attempt to hold before us these next couple years. Without using those two words, clearly leaders like Norm and Stan have been doing exactly that, as have those before them. Though the leadership necessarily and properly changes regularly in an essentially voluntary professional organization such as ours, the real theme doesn't. We're here to serve. And with the help and input and support from its members, I'll do my best to continue and enhance the role of the profession as an instrument for service.

AMERICAN ACADEMY OF ACTUARIES
WORKSHOPS

MONDAY, NOVEMBER 12, 1984
1:30 - 3:00 P.M.

#8 - STANDARDS OF PRACTICE

MODERATOR: BARTLEY L. MUNSON
Vice President and Actuary
Aid Association for Lutherans

PANEL: DOUGLAS C. BORTON
Chief Actuary - Office of the President
G.B. Buck Consulting Actuaries

JOHN H. HARDING
Executive Vice President
National Life Insurance Company

C.K. KHURY
Vice President and Actuary
Prudential Property & Casualty

(THIS TRANSCRIPT WAS PREPARED FROM A TAPE RECORDING.)

WORKSHOP - STANDARDS OF PRACTICE

MR. MUNSON:
It is the first of three American Academy of Actuaries Workshops. One follows this, and the third is tomorrow morning.

This one, as your program says, is on Standards of Practice. I will be the moderator because I am following in Stan Hughey's shoes, as best I can, as Chairman of the Academy's Standards Implementation Committee, as Stan moves to President of the Academy.

I will introduce the panel only to the extent of calling your attention to page eight in your program. Doug Borton has the pension subject as background; John Harding, life insurance; and Stan Khury, the property and casualty.

And as your program says, this workshop will review the need for and the current status of the American Academy of Actuaries' standards of practice.

Many of you probably have seen the Academy's slide/tape show, "Standards: Who Needs 'Em?" It has been shown to something over two-thirds of the actuarial clubs around the country, more than that by membership. We chose not to show it again here this afternoon, both because some of you have seen it and because we would rather take the time talking with three members of that Standards Implementation Committee. They are board members of the Academy and have been very involved in the standards subject, as well as others, helping to lead the profession.

We thought for starters we might call on each of the fellows just briefly to say where they are coming from and some of their perhaps personal experiences or business experiences, and to offer their observations as to why we need standards and why we are into this whole big subject as a profession. John said he would be willing to go first and offer some lead observations from his perspective on standards.

MR. HARDING:
Thank you, Bart. What I would like to talk about at this point is how I got into the standards business myself.

In the 1970s, the subject of life insurance dividends emerged as a relatively hot topic. In the '50s and '60s, we all thought we knew about what the standards for dividend determination might be. As the '70s arrived, technology changed substantially how much we could do, and competitive pressures also changed.

Bart Munson led the committee in the mid-'70s, which verified that in fact what was really happening in the real world was quite different from what everybody assumed. At the same time the regulators had come to a point where they were adopting competitive disclosure regulations which relied upon the existence of a fairly coherent set of standards as they existed in the '50s and '60s.

So the purpose of the Academy and the Society of Actuaries (SOA) groups dealing with this issue were to get a handle on it fairly rapidly and put us back in some reasonable plan of attack.

The SOA worked for several years in developing some overall principles. Then the Academy took over, redid some of that work, and eventually on Halloween of 1980 the Academy board adopted the Dividend Principles and Practices.

As I look back on it, there are three things that bother me.

The first was it was a very inefficient process. The Society and Academy committees were in each other's way and probably extended the

work of both groups by perhaps eighteen months because nobody quite knew who should do what.

Secondly, the Academy board is not really a good group to promulgate standards. I can speak now as also an Academy board member at a later time. It is a group that is really representing a very wide range of interests, and you have to do an awful lot of studying to really know what you are doing when you are approving standards for another discipline.

And the third thing--and this one probably bothers me more prospectively--is that there has been no provision for systematic update and elimination of old standards: and I think that probably for anybody working with any kind of standards, the fear of rigidity is something that almost forces some kind of systematic process. If you are going to have standards, you better manage them.

MR. KHURY:

The reason for my interest in standards of practice can be summed up in a comment I heard a week ago. It was really frightening. I was in a meeting with a state official, an appointed position, and he made what I thought was a gratuitous remark. There were others in the room. He said: "Actuarial science is not really a science. When two people can come so far apart in answers to the same problem, this can't be a science."

Now, this happens to be a regulator of our business, a commissioner type or equivalent.

This is my problem, and this is where I perceive there is a need for standards. If the actuary is, in fact, going to be a professional, the buyer of our service has a right to predicatable quality of performance. When we create that kind of perceived gap in the answers for the customer or, if you will, the buyer of our services, I don't know how good a job we are doing. There should be no reason for such wide diversions of answers to the same problem as sometimes confront us.

I can understand judgements being different by different people, but when you come 180 degrees opposite something is wrong. I think standards of practice will help us narrow that gap, at least to a gap of judgement, not that of method or assumptions or things of that sort.

About two years ago I was asked by Adger Williams to serve on the second task force. The first task force was headed by Walter Rugland; the second task force was chaired by Norm Crowder. I agreed to do so, and it has been two of the best years of activity I have had in connection with the actuarial profession. It has provided a chance to put some flesh on some fundamental personal principles that our work, as we give it to the buyers of our services, should be of predictable quality.

I was asked at the outset here to present some of the reasons why I got interested in standards. Actually it goes back to the late '70s, at the time when I was serving on the Pension Actuarial Principles and Practices Committee of the Academy, and, lo and behold, along about that time the Financial Accounting Standards Board (FASB) was very involved in its studies of pensions. As we are generally aware, FASB periodically seems to get around to the study of pensions.

But this was their first cut since Opinion 8, and there were all sorts of problems involved, particularly in coordination between the types of information which FASB was going to require and the information which the federal agencies -- the Internal Revenue Service (IRS) and the Department of Labor (DOL), in particular -- were going to require on Schedule B.

We at the Academy and others in the actuarial profession had been making the point for a great period of time that there was no one single number that represented actuarial liabilities under a pension plan under all conditions, but FASB kept pushing and DOL and the IRS kept pushing, and eventually, as a result of this, the Academy did produce Interpretation 2. This was picked up by FASB directly as an addendum to FASB Statement 35 regarding financial disclosure under pension plans. It also was picked up in general by the IRS and DOL under Schedule B, and this method of computing accrued liabilities has been in effect since that time.

So that was really where I first got involved in standards. This was rather perhaps a narrow area, but it did point out to me the fact that although in the actuarial literature we had more information and recommendations and interpretations in the pension area than in the other areas, we were still somewhat deficient. Some of this material was getting out of date and the whole subject should be looked into.

So I was very pleased when Adger Williams, at the same time he spoke to Stan Khury, also asked me to serve on the Standards Implementation Committee. As we go along this afternoon we will be talking further about the work which this committee has been doing.

MR. MUNSON:
Perhaps the experience of these three fellows gives you a smattering of why we got into standards. I suspect you can add your own experiences as you have observed the need for better managing this process.

You are not alone. And they weren't alone in their observations (and perhaps at time frustrations) in the last several years, for the Academy Board of Directors and Executive Committee have moved in several steps to get us where we are today. And we thought it might be worth just taking two minutes to review a couple of those steps for you, so you see where we are.

We face a long future with this subject, and we didn't just get here overnight.

From the beginning, I think it has been realized by the profession's leadership that we need to go slowly enough to be responsible as we get into the standard setting process, but to move resolutely ahead.

The task is as big as it is essential. One of my favorite management textbooks is the book titled Murphy's Law. I commend it to your attention. One of the laws in there is the Law of Evolving Systems Dynamics, which says that once you open a can of worms the only way to recan them is to get a bigger can. And we wanted to make sure what size can of worms we have as we get into this big subject of standards. I think that explains why we have gone through one step at a time, and a couple of those steps have already been alluded to.

In the late '70s, the Academy board first formed the Committee to Study Requirements of Professionalism. That was led by Walt Rugland, and his committee reported to the Academy board in February of 1980.

In '81, the board commissioned staff to further develop the exposure draft procedures related to standards, and that was approved and distributed to the membership in November of '81.

In June of '82, a little over two years ago, the Executive Committee formed the Task Force on Organizing Professional Standards, led by Norm Crowder, and their report was adopted by the board in June of '83, one year later.

At that same time, the board formed the current committee, the Standards Implementation Committee. These three gentlemen have been on that. That committee issued an interim report last March.

In June of this year, the Academy board authorized liaison members from the SOA, the Casualty Actuarial Society (CAS), and the Conference of Actuaries in Public Practice (CAPP). We thus have three more members on that committee, as of last June.

And in October, last month, the committee reported to the Academy board and is in the process of receiving reports on discussions of the boards of these other organizations.

That is where we are at today.

We will close later by observing the future time line a little bit, but know that we are looking over the next six months or so to adopt the committee's report at the Academy board level.

We have gone through these several steps. They have been deliberate. They have been resolutely moving us ahead, and we hope and believe that it has been responsibly moved ahead.

Stan Khury feels pretty deeply, I know, about the question of why we need standards and some of the hallmarks of our profession. Stan, perhaps you should next cover some of those points.

MR. KHURY:

I guess I had occasion to review that subject way before I had heard of standards of practice. This is going back maybe about eight years. I was doing some research for an article in The Actuarial Review. And I was doing some work on professional societies -- lawyers, doctors, and the like -- and I was trying to juxtapose the actuarial profession next to those professions. Well, in that research I turned up some requirements, if you will: how can a group of practitioners of anything call itself a profession? What are the steps? What are the criteria it must meet? The research that I did at that time turned up a number of criteria. There is no uniformity on the labels or the number, but four broad ingredients emerged.

One is the entry requirements. The group of practitioners must have established some entry requirements.

Two, there have to be some maintencance requirements if you will, requirements that will keep the skills sharp of those who have met the entry requirements.

Thirdly, you have the standards of performance that the group will hold its members accountable to.

And, fourthly, you have to have a "hook", which is the ability to enforce those standards.

Now, if a group of practitioners can meet all four criteria, then that group can call itself a profession.

Reflecting on the actuarial experience takes on different dimensions with respect to different pieces. Let me deal with each one very briefly.

Entry requirements. I think of all the four legs this is the most prominent one. We have somehow developed a reputation for having erected such difficult barriers for entry into this profession through the examination process. Our process is a very difficult one; it is very rigorous; and in fact the subject mater is so heavy that we have acquired that reputation, I think, deservedly. We have very good entry requirements.

Now, whether they are valid or not to executing as an actuary in the future, that is not quite as clear. But we certainly have entry requirements. As to the validity, I think we are still working on that subject matter.

The maintenance requirements. You can begin to see some divergence among the learned societies. The maintenance, if you will the continuing education process, is basically carried out through programs of the various societies such as seminars, special interest sections, the development or having papers available, and research. All of those subjects tend to be described as maintenance opportunities.

We do not have any recertification requirements. I imagine this as like a house or a piece of territory that is surrounded by a high fence. In order to get in, you have to be able to jump that fence. But you have to be able to maintain the ability to jump that fence: "See, that fence I jumped once, and I can do it any time I want." But we never have to demonstrate that again.

So we have the opportunity, but we do not have the recertification requirement. Some day we may have to face that music.

And here the societies, I think, have different track records. The CAS, through our meetings, is beginning to expand with the Special Interest Seminar, with the Casualty Loss Reserve Seminar. We are moving in that direction.

I believe the SOA is much farther along in that sphere, with far more numerous types of workshops, seminars, courses, with a staff to support it.

CAPP, I believe, draws on both kinds because of the sort of complex nature of the organization. They are both a learned and a membership society, so they are somewhere in between the CAS and SOA.

The third aspect, which is the standards of practice. The Academy has a collection of Guides and Opinions which we can call standards. We do not have an extensive or an exhaustive treatment of the actuarial science there. I think that is recognized, but we have something along those lines.

Now, are those binding on members of the various societies? It is not clear. Some societies have adopted various versions of these and put them into their own yearbooks. I know the CAS has. We have made some progress along the lines of the standards of practice.

In terms of discipline? Well, of course, if you don't have the standards, you really can't have very much discipline.

I know on the CAS side I am aware of very, very light discipline activity over the past fifteen years, or ten years for sure. In the Academy, I know until recently there was a backlog of maybe twelve, fifteen cases, I have no information on the Society of Actuaries. But I think one can safely say we have not had a great deal of activity on the discipline front.

So you can see the thing cascade. We are very good at the starting blocks. Then it sort of diminishes on the continuing education or recertification. It is less on standards, even less on the actual enforcement of the discipline.

Now, if we really aspire to become a true profession, I think we have to treat each of these subjects. I think we are doing better, relatively better, on the first and the second, and this effort on the standards implementation that is going on -- I think if we ever deliver that the discipline will follow.

Then we -- if you will, this guild aspiring to become a union -- can probably go up front again and see if we can get a charter or governmental sanction, that in order to call yourself an actuary you have to meet the standards. Then we have a chance maybe to achieve the original Academy goal, which is to charter this profession in some way, federally or on a state-by-state basis.

MR. BORTON:
Stan, I guess I would like to ask in whose eyes do you want to demonstrate that the actuarial profession is in fact a profession?

MR. KHURY:
I think it is the buyer of our services.

Who is the ultimate buyer of our services? Well, if you are in the ratemaking business, it is probably the regulator. You have got to convince them.

I think in the case of the ratemaking it is the regulator who is the ultimate customer. If you are doing reserves, it has got to be really the stockholder. You know, we are providing a statement about the financial condition of the enterprise. How good is that opinion?

What happens is in a buyer-seller situation the buyer and the seller, may go out and each get their own actuary. In a recent case in Canada, I think the selling company had their actuary saying this small company is worth over $20 million, and the buyer produced his own actuary, who is a member of the Academy and who said the thing is broke. Now, these things are just too far apart, and if you knew the size of the company, you realize just the enormity of this statement of being from $20 million to being broke.

So I think the buyer of our services, whoever pays the fee for us, has to be assured he is getting one opinion, maybe two should be sufficient, and they should not be worlds apart.

MR. BORTON:
Certainly, in the benefits area, I think you have at least two situations that exist. One is in the pension area where the government in effect took over the responsibility for saying who can practice in the pension consulting area for plans which are subject to ERISA, which is about 90 percent of the plans, and in effect established standards and guidelines for the way in which these people will work plus setting up educational requirements.

Some people would review these requirements as minimal. Others would feel that they are appropriate. There are various points of view on that point.

But at least in the pension area you do have a certificate on the wall, if you are an enrolled actuary, which says that presumably you are entitled to make calculations for the basis of government reports and any evaluations of retirement plans which are subject to ERISA.

But then we get into other areas. We have a wide number of pension plans which are not subject to ERISA. We have some unfunded plans, and we have the state and municipal plans throughout the country which involve many billions of dollars of assets and where there really are no requirements.

Now, I would have to say that the work on certainly most of these larger plans is being done very well and by people who are very professional and who have the qualifications: but there may be situations where this is not the case, and particularly in the case of smaller plans.

And then we get into other areas in the employee benefit arena where one of the big dangers is that people may have an expertise in a particular area but not be well qualified in the particular area in which they are being asked the question. It is awfully difficult if you are approached by someone and asked to review something which might be in an area where you, who may be very well qualified in another area, have no experience. It is quite difficult to say: "Well, I really don't think I can handle that job; you should go see my competitor across the street."

So you do have practical problems there. You also have in a dynamic area like the employee benefits area situations which come along that nobody is familiar with because they just haven't existed before.

So those, as I see it, are some of the things which we are approaching in the benefits area. What we really are hoping is that standards of practice within the Academy, in the pension area particularly, be expanded to cover some more of these situations which are not covered and also that they be updated to meet current conditions, because this is a very fast-moving and active field at the present time.

MR. HARDING:

Well, I have just got to go back to that same question. In the life side we do have a number of areas where the designation of "actuary" is clearly beyond our control. The certification of reserves on the life insurance blank is to be done by a Member of the Academy or anybody else the commissioner deems qualified.

Let's go on to the question of the form of standards. The actuarial profession in its standard-setting process has to recognize that we are dealing mostly with future events, so that we can't use a cookbook, as the accountants almost are forced to do. The general framework of our standards -- and I assume you have all read them, so I am kind of restating the obvious -- is to start off with essentially a set of generally accepted practices. The actuary, in doing his job, will write a report indicating which of the practices he has in fact employed and the assumptions used and, perhaps most important, those areas where he has deviated from the standard practices.

The explanation of the deviation is probably the most important. It is saying where there is good and sufficient reason in the actuary's judgement to deviate, that actuary can and in fact should do so, but be prepared to defend why.

And I think that this is the type of standard that we are all looking toward in the development of the standard setting process for the actuarial profession.

Stan, how about talking about the roles of the various players in the game?

MR. KHURY:

In connection with standards, I guess I have singled out three separate entities that I would like to deal with at this session. One is the individual actuary; second is the learned societies; and thirdly is the Academy. That does not mean the Academy is not a learned society, but I have to draw a distinction. The Academy is more a membership society in my mind as opposed to a learned society. There are other players in this, but these are the three I will focus on here.

In terms of the development and the managing of standards, the individual actuary can play almost any degree of role he chooses. A person can in fact initiate ideas of areas that require implementation of standards. Those can be nominated to this interim actuarial standards board that is proposed. A person can serve on the committees that are in fact drafting the standards. A person can serve as a board member. What particular role you might find for yourself, I think, is a function of where you are, what you would like to do and what is in fact available.

The learned societies get a little heavier. They don't have as much discretion. The learned societies are the societies that erect the standards, if you will, that must be met for entry and for maintenance subsequent to

entry. The learned societies are in fact going to be the societies that develop the standards, whatever the ultimate form of the actuarial standards board may be.

The learned societies have to see to it, for example, that the work that is done in developing standards relating to casualty work are done by casualty actuaries who are intimately familiar with the subject matter for ultimate adoption by the actuarial standards board. So that role I don't believe is discretionary at all for the learned societies.

And, thirdly, there is the Academy role, which is somewhat gray at this point, and let me explain why I say that.

The present effort in terms of dealing with the standards and their future is done under Academy sponsorship. The Academy has taken the leadership on this to see the effort through.

The interim actuarial standards board that is proposed, that is on the table, is a pilot project, if you will, to develop actuarial standards under this interim actuarial standards board, which is connected to the Academy. Its standards are not subject to review by the Academy board, but it draws its funding and life and quarters and rations from the Academy through this pilot period.

If the actuarial standards board in fact is adopted as the way to go, now at that point a decision must be made. Should it be, in fact continue to be, under the aegis and the direction and control of the Academy, or should it be entirely a different organization?

That question has not been answered at this point, and it was deemed that it is not intelligent to try to answer that now until we get some experience under our belt through the pilot operation. Then experience will help us determine what the Academy role will be.

These are the three broad roles that are envisioned.

MR. BORTON:

I would just like to back up a minute and put a few things into perspective.

I think everybody in this room is aware of the fact that we do have over a 100 pages of standards right now in the Academy yearbook, the Guides, Opinions, Recommendations, and Interpretations.

We also have an exposure process for changing these standards, which is spelled out in the yearbook, and which involves in most cases going to the members of the Academy for their comments before a final or interpretation or recommendation is issued.

So we do have a lot of things in place. So what are we talking about here now when we talk about standards implementation?

Basically, we are not talking about mechanics. We are talking about management. We do have a lot of things in the book, and some of them are very good, but we do have some problems with them.

There are whole areas of practice which are covered very loosely or not at all. The selection of what is going to be put into the standards and what is going to be removed currently is a very "catch as catch can" basis.

Virtually all of the standards are developed as a reaction rather than a proaction. The quality of the presentations is uneven to some extent.

And certainly nobody has the job of looking at these standards periodically and saying this one is no longer applicable because times have changed, or that this should be replaced or this one should be updated to get more recent developments into the picture, even more recent references.

One of the major standards for the pension field has cost of living

references in it that are about ten years old, which it would be better to have updated.

So that is what we are talking about. We are really talking about management of standards. We are not talking about the mechanism. We are talking about actually getting our house in order in the standards area.

If we do that, what will happen? What will be the positive results?

We have talked about some of these as bases for discipline, and I think even for the non-Academy members or people who are not members of any actuarial body would perhaps feel the pressure of standards which had been issued. If they were the only ones available, certainly they would be looked to by the courts or outsiders in deciding whether certain action should be taken from time to time.

I think it would give credibility to the actuarial profession, would help us to be evaluated by our peers and our clients, and certainly would help with the outside observers.

As has been mentioned here, certainly anybody can call themselves an actuary in most of these fields, with the possible exception of pension valuations, and to the people outside of this room the distinction between a Fellow of the SOA or a Member of the Academy or just a member of an actuarial club or just somebody who puts "Actuary" after his name is kind of fuzzy at best. You are pretty lucky sometimes if — when you are talking to somebody who doesn't work closely with actuaries -- they know what an actuary is.

I just would like to spend a moment on the fact that although we do have this body of standards, there are a lot of other people in the standards-making game, particularly in the pension field.

We have the IRS issuing rules for how certain actuarial methods should be used, how assets should be allocated in certain situations.

Congress, in ERISA, set forth rules for valuing assets in the valuation of a pension plan. Congress, because of revenue reasons and other reasons, has advocated something which is probably actuarially unsound in most cases.

In funding a pension plan you can take into account the current maximum benefits but you can't anticipate increases in these maximum benefits, even though, according to the statutes, they are scheduled to occur.

We have had, as I mentioned before, FASB taking a very active role in financial reporting. They are now trying to take a much more active role in how pensions are expensed and actually setting up a formula which defies the imagination on how to compute pension expense.

The Joint Board for the Enrollment of Actuaries has just received an assignment from the General Accounting Office (GAO) to facilitate a study by the actuarial profession on what are the criteria for determining whether multi-employer plan data is sufficient as a basis for an actuarial valuation.

There is a lot of competition in this area, and if the actuary — the profession itself -- is not willing to take on the burden of actually setting its own standards, they are going to be set elsewhere. They are going to be set in the halls of Congress or in the regulatory agencies or in the courts or in the pseudo-governmental agencies like FASB or the SEC, and I think that is why it is important for us to move ahead in this area.

MR. HARDING:

I think what Doug was saying means a lot to me. What we need to do is to control the standards, to gain and retain those standards under which we work. I am less concerned, for example, about whether we have everybody

who isn't a member of our particular professional body covered by our standards as much as I am that we have a good hold on the rules of the game.

The purpose of these next remarks will just be to offer a very brief summary of some of the structural ideas raised in the Standards Implementation Committee report; namely, to look at the actuarial standards board and also the interim board that Stan mentioned a moment ago.

The actuarial standards board would be the ultimate organization, and some of the trappings of it are still very much open. We are talking about rotating members who clearly represent all of the major actuarial bodies -- the CAS, SOA, CAPP, and the Academy -- or at least all of the actuarial fields of practice (perhaps that's most important) and that this board would take full responsibility for managing the standards process.

It would do the mechanical things like setting budgets and getting funding, from somewhere. It would coordinate with disciplinary committees, as desirable. It would appoint and direct the actions of what are called operating committees, those committees that will actually do the standards writing. It will oversee the exposure process and the comment process, with particular interest in consistency and form throughout the standards process and also the general results. It will promulgate the standards, finally, and clearly, to me, as I indicated earlier, not only promulgate them but change them and terminate them as is appropriate in the future.

There have been a number of suggestions as to how the membership of the actuarial standards board should be composed. I will give you the two that are in the report, and you can see that there can be many variations from them. One would simply say let's have twelve members of the board and have each of the four professional bodies appoint three of them and have them rotate, so that you have a reasonable continuum of people on the board. The other would say let's only have one each from each of those bodies, and let the five operating committees (that I will describe in a little bit more detail in a minute) be the people responsible for appointing the other five.

We have also entertained the possibility in the future of public members, those who aren't actuaries but who may well have an interest in our standard-setting process.

We would have five operating committees, each of which would direct the standards writing in specific areas -- life, health, casualty, pension, and then one that I fancifully called none of the above, but we will have to have a better name, probably specialty or something of that sort.

These groups would in turn probably appoint task forces to write specific standards or to change existing ones, but they would be the ones who really focused in on the specific disciplines.

The interim actuarial standards board is a transitional thing. By the time we get to a actuarial standards board, I think we will have to have a good idea of how that structure should hang together and exactly what its relationship with the Academy and the other bodies should be.

The interim board is a way to buy some time and help us learn those things by doing them. The interim board would be sponsored by the Academy and would operate in as many ways as possible in the same manner that the actuarial standards board would operate.

We think that probably the interim board should exist for something like eighteen to thirty months after it is formed before the actuarial standards board comes into play.

MR. MUNSON:

I would like to real quickly hit something that I found was informative to the clubs when we chatted about this. It attempts to address this issue from a little different perspective of "Why Standards?"

And I will hit four things real quickly. I bring them up only because these are four items that have been thrown to the actuarial profession and were on the Academy board agenda last month. They represent areas where people are involved with the profession and are expecting the profession to come up with standards.

One is the valuation actuary issue, for which the SOA and the Academy jointly have a task force. It was in part internally initiated but also by the regulatory process on the state level, looking for a better way for us to perform as actuaries.

A second was the Deficit Reduction Act of 1984, DEFRA, which has specific language in it about qualified actuary, about assumptions in actuarial calculations, and requires that there be a study submitted to Congress by February of 1985 which will include consideration of the need for participation in vesting and funding standards for welfare benefit plan reserves.

A third would be the Blindness Risk Classification bill before Congress now, which would permit, if passed, classification for insurance by blindness only if supported by "sound actuarial evidence." It seems to suggest we ought to have some voice in what that means.

And the fourth one was the one that Doug alluded to, the GAO study on multi-employer pension plans. The Joint Board for the Enrollment of Actuaries, in a letter to the actuarial profession, says that the GAO has recommended that the Secretaries of Labor and Treasury direct the Joint Board to work with the actuarial profession to, among other things, work up multi-employer pension plan standards relative to participant data.

So the government in these four very real items right before the profession at the moment is using the word "standards" and asking us to help them and participate with them. I think it is a very real, active subject at the moment, very alive.

Now, to the implementation schedule. As John alluded to and I suggested earlier, the report has gone to the various boards, and I think, in closing here in a second, we will have a couple of reports on where that stands on a couple of the boards.

The Academy board will discuss it again at our meeting next month but will not take action on the committee's report until our March '85 board meeting, to give adequate time for digestion, discussion at clubs, here and other places, and particularly the boards of the founding organizations.

We would hope by next fall -- the schedule says -- to have an interim actuarial standards board formed, and since there is no such thing as instant experience, that would run for maybe up to twenty-four to thirty months, during which time we will evaluate the process and would hope and intend at that time to move to the actuarial standards board. However, similar or dissimilar the actuarial standards board would be from the interim board we can't predict.

I would make one other comment about the reaction from clubs that you might be interested in. At the five clubs that I have discussed this subject with, I have simply, on my own and informally, asked for a straw vote, a show of hands. I gave them three choices: we are right on, keep moving; I don't know, I want to think about the subject; or stop, this is crazy.

I can report that I did count hands roughly -- and I don't have that with me -- but there were maybe a handful of people in total at the five clubs that said, whoa, this just isn't the way our profession ought to be going.

There was a fairly good percent, ten to twenty percent, who said they want to think about this further: of course, I was pleased with that, because that is why we are putting the subject before each other and talking about it.

But the vast majority said, let's get on with it. And in that we take some comfort, because it is going to take a lot of work and a lot of support from actuaries around the country.

For just a few closing thoughts, I would like each of the panelists to make a closing observation.

MR. BORTON:

Well, they always say you should end positively. Actually, I guess I am going to end positively by talking about a negative, because in the actuarial clubs that I spoke to there was one negative which came up occasionally. I don't think it was even a very strong minority, but the people who did voice a concern about it were quite vocal and quite concerned.

And that was the question of whether we were building a monster here, a bureaucracy that was going to regulate every detail of an actuary's working day. And certainly that is not the intention.

I think part of this comes from the similarity between an actuarial standards board, and the Financial Accounting Standards Board.

As many of you are aware, FASB is a multi-million dollar operation. I believe their budget for the past year was something like $10 million. They have paid members, seven I believe, and they have a very large staff operating out of their offices in Stamford.

Certainly, we are not thinking of anything of that magnitude, and even if we could afford it, which we can't, I don't think it would be the right way for our profession to go.

But what we are really talking about here, as I see it, is a board to manage practices within the actuarial profession. Perhaps, in retrospect, it would have been a little better if we had referred to the new body by that name, something along those lines, rather than the actuarial standards board which does quite possibly create some sort of confusion as to what we are actually aiming at.

MR. KHURY:

Well, I will also try to end on a positive note, with a positive note this time.

The CAS Board of Directors at its meeting on Sunday had before us the report that John summarized for you, and a motion was put before the board to seek endorsement, to endorse this effort and encourage the Academy to continue with the development of an interim actuarial standards board.

I should add, this is the third time this matter has come before the CAS board. The first time it was like an indication of sense of the board. Should we support the Academy in this effort? And the answer was in the affirmative.

Later on, as we progressed through the Norm Crowder task force, a motion was put before the board. We have made some progress; here is what the thing looks like. Now, do you still like it? And the answer was again in the affirmative.

And I am very pleased to be able to tell you that the motion this past Sunday was passed, that the CAS continues to support this direction, and it was a unanimous vote by the Board of Directors.

I believe that this is a long journey, a very long journey. In fact, as long as we are a profession, I think this will be part of our life. I don't think we can say we do this for five years and we stop. As Walter Rugland has taught me, standards are living things. You have got to stay with it. You can't say we are done at any given point.

I have a vision in the future that either we act and implement standards before problems are delivered at our doorstep or we are going to have to react to problems delivered to our doorstep and develop standards. So pay me now or pay me later.

I also have a vision that in the future we will have standards that will have equal application in the independent practitioner ranks, the consultants if you will, as well as company people. I don't think working for a company provides any special umbrella for people not to have to observe the standards of the profession.

And I believe in one other vision I have. That is at first I think the standards we come up with will be very broad, like the Ten Commandments, and then as our level of comfort and experience develops we are going to get to the body and get more detailed: but I hope we never get to where in fact they are merely a cookbook exercise.

MR. HARDING:
I think that there are some of us here who probably buy the need for standards on a defensive basis; let's do it so somebody else doesn't do it. I think there are others here who feel more comfortable with the type of thing that Stan put in front of you, which is for the good of the profession let's really build these other parts that we have not done as much with in the past.

But from my view, the thing that we must do is to make sure we manage that process so that it is not any kind of a restriction on the proper pursuit of our business.

MR. MUNSON:
I would observe that both the SOA and the CAPP have the report, have discussed it, I understand, and they are in the process of discussing it further.

Is that right, Pres Bassett for the SOA and Mary Adams for the CAPP?

VOICE:
That is correct.

MR. MUNSON:
So that is in active stages at the moment in both of those bodies, and we appreciate their active deliberation of that report.

Any further thoughts that any of you have are always welcome on this subject, as the fellows have said here, at the meeting and through the Academy office. Drop us a note. We will see that the committee receives those pieces of input.

Just one other closing comment. If any of you would like a copy of this report and don't have one, give your card to me or drop me a note or call the Academy office, and we will be happy to distribute it to anyone on request.

The fellows, I think, have made it clear that this is both a large task and perhaps an unending one, but an important one and one we are committed to. With your help and participation, we will -- I won't say get the job done -- we will get on with the job and proceed.

AMERICAN ACADEMY OF ACTUARIES
WORKSHOPS

MONDAY, NOVEMBER 12, 1984
3:30 - 5:00 P.M.

#9 - FINANCIAL REPORTING DEVELOPMENTS

MODERATOR: RICHARD H. SNADER
Vice President and Corporate Actuary
USF & G

PANEL: ROBERT H. DOBSON
Consulting Actuary
Tillinghast, Nelson & Warren

WALTER S. RUGLAND
Consulting Actuary
Milliman & Robertson

JAMES F. A. BIGGS
Principal
Peat, Marwick, Mitchell & Company

WORKSHOP - FINANCIAL REPORTING DEVELOPMENTS

MR. SNADER:

Welcome to the Workshop on Financial Reporting Developments. My name is Dick Snader.

Let me begin by telling you a little bit about myself and my fellow panelists.

I am chairman of the Academy's Committee on Property and Liability Insurance Financial Reporting Principles. In addition to serving as moderator I will make a brief presentation concerning recent developments in the property-casualty field. Our next speaker, is Mr. James F. A. Biggs. Jim will discuss developments in the field of employee benefits. After Jim, the next speaker will be Mr. Robert H. Dobson who will discuss statements of opinion required in the health insurance industry.

Our anchor man is Walter S. Rugland, who will cover developments in the life insurance field and tell us about a new-fangled kind of actuary called the valuation actuary. I'm sure you will be tantilized by what Walt has to tell you.

My presentation covers some of the past year's activities of the Property & Liability Financial Reporting Committee and other developments that affect the property-casualty field.

The first item I want to mention is the Securities and Exchange Commission (SEC) proposal for loss reserve disclosures. As most of you are aware, the SEC made a proposal calling for extensive disclosure of loss reserve information as part of the financial information filed with the SEC. These disclosures would be required for 1984. The SEC proposal focuses on the disclosure of reserving practices, reporting data on past reserving experience, and publishing a considerable amount of additional data pertaining to GAAP reserves by statutory annual statement line.

The proposal would also require additional discussion of reserving methodology, with emphasis on changes in practices and assumptions, especially as they relate to inflation and discounting.

These new requirements could be onerous in view of the fact that the degree of detail might result in mountains of paper. Moreover, it is doubtful that the information could be provided within the required time frames. The GAAP reserve information is not readily available and the reconciliation between GAAP and statutory in the proposed detail is far more easily said than done.

Finally, there is an underlying presumption, which seems to be the hallmark of all such proposals, that judgements about current reserve adequacy can be made solely by reviewing a company's track record.

In May of 1984, our committee submitted comments on the SEC proposal. In addition to voicing our concern with the proposal as it stands, we offered a counterproposal that we believe would attain the desired objectives in a simple, straightforward, useful, yet less detailed format than called for by the SEC. Our proposal provides for a compact and understandable display of what we regard to be the most important and helpful information, and which can be compiled at a reasonable cost on a timely basis.

Our comments were submitted in May, along with the comments of several trade associations, the AICPA, the big eight accounting firms, financial analysts, and several individual property-casualty insurance companies.

At this time there has been no disposition or response of any kind from the SEC that I know of, but we are watching the situation very closely.

Another topic of interest involves Interpretation 8-B of the Academy's Guides, Opinions, Recommendations and Interpretations. Very shortly you will be receiving from the Academy an exposure draft of a revised Interpretation

8-B. Recommendation 8 delineates the responsibilities of an actuary when signing a statement of actuarial opinion relating to loss and loss expense reserves in the statutory fire and casualty statements. That is, the "Yellow Book." Interpretation 8-B deals with the adequacy of such reserves. However, Interpretation 8-B is very brief and offers little in the way of guidance.

Many actuaries have asked for additional guidance as to when an unqualified opinion could be rendered with respect to the "good and sufficient" provisions. Questions have also been raised regarding the conditions under which discounted loss reserves could be deemed to be good and sufficient.

In response, a project was undertaken by the Casualty Actuarial Society (CAS) Committee on Reserves to develop an appropriate document. The committee completed its work in June, 1983 and presented to the CAS Board of Directors a paper aimed primarily at interpreting the words "good and sufficient".

The CAS board endorsed the general concepts presented in the paper and voted to submit it to the Academy for eventual inclusion with the Academy's financial reporting guidelines. The result is an expansion of Interpretation 8-B prepared by the Financial Reporting Committee and based on the work of the CAS Committee on Reserves. The proposal has been reviewed by both the Academy's Executive Committee and Board of Directors, who voted to expose it to the general membership for comment.

The expansion of Interpretation 8-B was undertaken to fill a gap in existing actuarial standards and meet a need of actuarial reserving practitioners. It places equal emphasis on actuarial methodology and judgement. It provides flexibility for the exercise of professional skill by avoiding a rigid, "cookbook" approach.

Liberal references to actuarial judgement are intended to emphasize the qualities which make the actuary uniquely qualified to undertake reserving assignments. The concept of conservatism in making reserve estimates is discussed at some length. It is pointed out that conservatism is tied directly to the insurer's responsibilities to policyholders and claimants and to the inherent variability of reserve estimates. The wording does not automatically call for explicit quantification of a provision for adverse development. It notes that nothing more may be involved than the selection of conservative assumptions.

Moreover, the wording does not preclude an unqualified opinion on reserves without such in those cases where the actuary has a high degree of confidence in the estimate.

A section on discounting is included in recognition of the situation of an actuary who renders an opinion on a discounted reserve. The employment of a discounted reserve introduces additional uncertainties which should be considered in judging the appropriate degree of conservatism required for the discounted reserve to constitute a good and sufficient opinion. Attention was also given to the concept of asset-liability matching. The proposed Interpretation 8-B expands the actuary's responsibility when dealing with discounted loss reserves by requiring consideration of both rates of return on assets and expected cash flows from assets.

Closely related to the preceeding topic is the question of whether there are enough casualty actuaries to render loss reserve opinions. The CAS Board of Directors is concerned about a perceived shortage of actuaries. They fear there are not enough actuaries to do all the opinions that would be needed if more states required them.

On one hand they might like to advocate certification requirements for all states. But to do so would seem foolish if not enough casualty actuaries could be found to meet the resulting demand.

An ad hoc committee has been appointed by the board to investigate this apparent problem. They have been asked to address the question of whether there is, in fact, a shortage of actuaries, to determine if there is a need for identifying non-actuaries who are qualified loss reserve specialists, and to determine alternative means of identification. The committee is expected to report to the CAS board at its February meeting.

The committee must wrestle with any fundamental questions, including the following:

1. Should there be a special membership class of the CAS or of the Academy?
2. Should exisiting practitioners be grandfathered into the CAS or Academy?
3. Should there be a special examination or should the CAS change its syllabus to incorporate all topics relative to reserving in one or more of its examinations?
4. Should the qualifying examinations be a permanent fixture or be phased out after a specified period?
5. Should the CAS and Academy stand pat?

We can all look forward to their report with anticipation.

The last item I want to tell you about concerns a very recent development. A proposal initiated by the California Insurance Department was recently presented to the NAIC Annual Statement Blanks Task Force. This revoluntionary proposal calls for the elimination of separate life and property-casualty blanks.

The balance sheet, income statement, and capital and surplus account would be common for all types of insurance. Supporting exhibits and schedules would vary with the line of business.

We are fortunate to have with us in the audience today Mr. Steven Gapp of the California Insurance Department. Steve has some hand-out material he wants to distribute. He would also like to make a few brief comments at the close of our session. We will end the question and answer period a few minutes early to allow Steve a chance to make his presentation.

I'd like to turn the podium over to the next speaker, now, Mr. James F. A. Biggs. Jim is a consulting actuary in the New York office of Peat, Marwick, Mitchell, and Company. He is a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, a Fellow of the Conference of Actuaries in Public Practice, and an enrolled actuary. He serves the Academy as a member of the Board of Directors. He currently serves as Chairman of the Academy's Committee on Pension Accounting Matters and as a member of the Academy's Committee on Relations with Accountants.

MR. BIGGS:

I'm going to be talking about the financial reporting developments, with respect to the employee benefit area, and first I'm going to turn to the developments with respect to the setting of accounting standards.

Now that, as you know, is the responsibility of an organization called the Financial Accounting Standards Board (FASB). A little more than a decade ago, FASB undertook a pension accounting project designed to address

accounting issues, both with respect to reporting by pension plans and reporting in the financial statements of pension plan sponsors.

We decided to tackle the plan reporting problem first, and they delivered their product in 1980 in the form of two statements: Statement 35 and 36. Statement 35 is actually the plans reporting, and Statement 36 is a translation of that information into the notes to the sponsor's financial statement. Since the issuance of those two statements, there has been some concern expressed over the wide range of investment return assumptions being used by the actuarial profession for determining the present values required by those statements. Other than that, though, I would say there has been very little controversy over the implementation.

Since the issuance of those statements, FASB has been dealing with the issue of employer accounting, including issues relating to the determination of pension cost and the disclosure of pension costs and liabilities in the employer's financial statement. They issued a Discussion Memorandum a few years ago, followed by a statement of what might be termed their tentative conclusions, termed Preliminary Views, which was followed by a second discussion memorandum dealing with specific issues, transitional problems, and so on. Public hearings last January originally scheduled for three days extended to five.

Preliminary Views proposed very fundamental changes in employer's accounting for pension. FASB, in its recent hearings, has tentatively reaffirmed some aspect of preliminary views, but appears to be moving away from others.

Let me briefly review the tentative conclusions FASB seems to have reached. First, with respect to the amortization of past service liabilities arising either from the origination of a pension plan or the amendment of a pension plan. There FASB seems to have concluded that the period for the amortization of those liabilities should be related to the average remaining worklife of the participant group -- no more broad spread from ten to forty years.

Second, concerning the pattern of amortization of those liabilities, the FASB's tentative conclusion is that the principal amount of those liabilities should be amortized in a declining manner; that is, that the first year principal charge should be the largest and gradually dwindle out over what was expected to be the remaining worklife of the participant group.

Now, you combine this with the fact that the interest on declining balance will also be a declining amount, and you will get an amortization pattern that is very different from the level annual total installment pattern that we're accustomed to both with respect to accounting and the IRS requirements, as far as funding of those liabilities is concerned.

Another major issue relates to the selection of an actuarial cost method. One of FASB's principal objectives is to maximize the comparability of the information presented in the financial statements of various employers at the same time. And for that purpose, FASB has tentatively concluded that a single actuarial cost method should be used by all plan sponsors for purposes of financial reporting. Remember now that I'm talking about financial reporting, not necessarily funding, although to some extent funding may well follow. But FASB has tentatively decided that a single actuarial cost method should be used, and the actuarial cost method they have tentatively chosen is what is referred to as the projected unit credit method.

With respect to the amortization or the treatment of actuarial gains and losses in actuarial valuation, FASB has tentatively concluded that there should be an amortization period and an amortization pattern, with respect to these

gains and losses. FASB is currently developing a position with respect to perhaps establishing a corridor. Roughly speaking, they would say that until the cumulative actuarial gains or actuarial losses exceed 20% of the liability number otherwise being measured, that there would be no amortization of gains and losses. In effect, this would be treated as the normal swing and thre would be no special treatment of those amounts until and unless you get outside that corridor.

With respect to asset valuation, FASB has consistently taken the position tha the only appropriate asset value to be used for actuarial valuations is the fair market value of assets.

With respect to the issue of actuarial assumptions, one of the questions that FASB raised in its Discussion Memorandum was the question of how assumptions should be set, and whether there should be uniform assumption. We understand that FASB has really not addressed that issue in its deliberation since the public hearings in January.

One of the major controversial issues in the Preliminary Views was the issue of information to be disclosed on the balance sheet of the employer. Under present accounting requirements, the only amount that has to be disclosed on the employer's balance sheet, is the amount, if any, by which the pension cost that has been recorded exceeds or falls short of the amounts that the employer has actually contributed to the pension fund.

Preliminary Views would have made a dramatic change in that. Preliminary Views proposed that the entire excess of the actuarial accrued liability determined under the projected unit credit method over the plan's assets would be recorded as a liability on the employer's financial statement. Now, at the time that that liability is first recorded or at the time an additional liability is recorded as a result of an amendment, a corresponding asset would be set up so that there wouldn't be any immediate impact on the employer's net worth but, nonetheless, that great big liability number in many employer's cases would appear directly on the balance sheet, instead of having a portion of it showing up in the notes to the financial statement. FASB, to some extent, seems to be backing away from this position, perhaps because not only actuaries but planned sponsors objected very strongly.

At this point FASB is tentatively moving down a track whereby normally the only amount that would be recorded directly in the balance sheet would be the same amount that's recorded under APB-8 now. That is, the difference between pension cost and amounts funded. However, they are proposing what might be termed a mini-max limitation with respect to these amounts. At one end they're suggesting that if the present value of vested benefits exceeds the plan assets, that that amount would be recorded as a liability in the employer financial statement and that they, too, would charge that amount directly to employer net worth, directly to corporate equity.

At the other extreme, if the assets were greater than the actuarial accrued liability under the projected unit credit method -- which, of course, reflects future salary growth as well -- that that excess asset would be shown as an asset in the employer's financial statement, and the excess would be credited to the employer's net worth. As I say, they haven't even reached tentative conclusions yet on this issue but these are the possibilities that they're discussing.

The Academy has been very busy with respect to this project. A comprehensive written statement was filed in December of 1983, which was prepared by the Committee on Pension Accounting Matters. At the public hearings in January 1984, the Academy committee testified jointly with representatives of the Conference of Actuaries in Public Practice (CAPP).

At that time was made two offers of cooperation and assistance to FASB. The first offer related to the question of selection of an actuarial cost method and whether there ought to be just one actuarial cost method decreed. As a result, the Academy has now undertaken a cost method study, which will examine the degree of variation of annual cost resulting from the choice of different actuarial cost methods and analyze the circumstances that contribute to those variations. This study is being conducted by the Academy Committee on Pension Actuarial Principles and Practices. FASB is aware of this study, they are interested in this study, but they are not waiting for the results.

The second offer was an offer to cooperate in the effort to improve disclosure of pension and information. As I indicated before, plan sponsors were generally quite unhappy with Preliminary Views, particularly with the idea of recording assets and liabilities on the balance sheet. The Financial Executives Institute, for example, made specific proposals for enhanced disclosure, and they have recently reaffirmed those proposals in encouraging their own membership voluntarily to increase their disclosure of pension information.

At this point a joint effort by CAPP and the Academy is just getting underway, the idea being to establish a task force working with plan sponsors, working with the users of financial statements, to see if we can't come up with a better answer as far as pension disclosure is concerned. Again, FASB is interested, but they are making no commitment.

Let me turn now to the subject of other post-employment benefit by which, basically, I mean life and health insurance for pensioners and their dependents. This subject was part of the original pension project. When disclosure was proposed in 1979, which eventually led to Statement 36, there was a specific proposal that there be disclosure with respect to these other benefits. That did not make it through to Statement 36.

An exposure draft was issued in July 1984. FASB has decided to issue a standard as a result of that exposure draft, and it's our understanding that that standard is supposed to be coming from the printers this week. It will be applicable with respect to information to be disclosed in the note to 1984 financial statements. This is purely a disclosure requirement. FASB is proposing that an employer will disclose (1) a description of the benefits provided for his retired employees, (2) the cost of retiree benefits included in net income for the period under report, (3) a description of the accounting and funding policies presently followed with respect to those benefits, and (4) the effect of significant matters such as plan amendments affecting the comparability of the cost recognized for all of the periods being presented in the statement.

The major issue which is yet to come is the question of whether the employers should be required to accrue the cost of these benefits during the working lifetime of his employees. Right now, most employers report the cost of these benefits on a pay-as-you-go or a one-year term basis. The difference in costs and in reported liabilities can be quite dramatic. In fact, from many indications, it seems that the impact on employer's financial statements of requiring accrual accounting and pension-type reporting for these benefits would be far greater than the financial impact of the proposed pension changes.

Let me just turn, for a couple of minutes now, from the subject of accounting standards to the subject of auditing standards. And here I'm going to be dealing, really, with matters that not only affect employee benefits but insurance companies as well. And, of course, when you deal with auditing

standards you're no longer dealing with FASB; you're dealing with the American Institute of Certified Public Accountants (AICPA).

There has been dialogue between the two professions for a long period of time, largely seeking to define their respected spheres of responsibility. It gets into the question of whether the auditor should -- or should be required to -- state reliance on the work of the actuary in his opinion. This was fairly common at one time, at least with respect to insurance company financial statements, but it's no longer common.

In Canada, a joint task force was formed by the Canadian Institute of Actuaries (CIA) and the Canadian Institute of Chartered Accountants (CICA) to define the working relationship between the two professions there. A report was issued recently. The proposals in the report would require substantial documentation largely in the form of what you might term "mutual comfort letters" being exchanged between the two professions.

The Academy and the AICPA have agreed to appoint a joint task force to examine this CIA-CICA report and consider the ways in which their conclusions should affect practice in the United States.

These financial reporting problems are important. To some extent they go to the whole question of what our profession will be doing in many areas, and even more importantly, who will govern what our profession will be doing. There are a number of Academy committees pursuing solutions. Those committees would welcome your input.

MR. SNADER:
Thank you very much, Jim.

As promised, our next speaker is Bob Dobson. It should be no surprise that Bob is a member of the Academy. He is also a Fellow of the Society of Actuaries. He serves the Academy in the position of secretary, as a member of the Board of Directors, and a member of its Executive Committee.

He is currently employed as a Vice President of Tillinghast, Nelson & Warren, and he is a frequent speaker on the subject of health care.

MR. DOBSON:
Thank you, Dick.

The theme of our meeting is regulation. The title of this session is financial reporting developments. My topic is health statements of opinion. Putting these three themes together, it seems like a reasonable place to start is with the convention blanks, otherwise known as statutory annual statement forms.

Health business can be filed on any one of four forms, all of which now require a statement of actuarial opinion. First is the blue form. This is for life, accident, and health. The blue form was the first to require a statement of actuarial opinion. It was followed closely by the yellow form, of course, which all of you are familiar with, the fire and casualty blank. The latter were the most recent to add statements of actuarial opinion. The white form is for hospital, medical, and dental service or indemnity corporations. This is the form that is generally designed for Blue Cross plans or other similar prepayment plans. In many states, though, the Blue plans are required to file a blue or yellow form, depending on how they are organized in that state. The final blank is the form for health maintenance organizations. This one was developed separately and is not really a part of the series. Statements of actuarial opinion are required on each of these four forms, any one of which could have health insurance filed on it.

The requirement is included in the instructions to all forms. The wording for the instructions for the most recent two was drafted by the American Academy of Actuaries, to be consistent with the wording of the first two. As if health didn't have enough problems being on four different forms, however, there can also be differing state requirements, as I'm sure you are all aware.

Now, what has the American Academy of Actuaries been doing in this area? As you know, there is lots of talk concerning standards of practice. The Academy has three separate standards of practice that affect the statements of actuarial opinion, and, therefore, could affect health insurance. The first is Recommendation 7, which relates to life, accident, and health insurance statutory annual statements. Second, Recommendation 8 applies to fire and casualty insurance companies. Finally, Recommendation 10 applies to health service corporations. Here, the term health service corporations is defined to encompass Blue Cross and Blue Shield plans, other similar type pre-payment plans, and health maintenance organizations.

Recommendation 10 was patterned after Recommendation 8 which applies to fire and casualty companies. There are three key differences, however. In the Recommendation, itself, the key difference is that the opinion must encompass all actuarial items. This is from the life statement of opinion and must not have been deemed appropriate for fire and casualty companies. The accompanying Interpretations contain a couple of differences. Interpretation 10-A includes wording on the reliance on an accounting firm. Again, this is from the life statement and must not have been deemed appropriate for fire and casualty. Finally, Interpretation 10-C includes some sample wording for qualified opinions. Again, this is from the life and does not appear in the casualty Interpretation. That's where we are right now.

Let's look at some issues facing health care that will impact future financial regulation. The biggest issue involves changes in the relationship between the financing and the delivery of health care. Here, new models present new problems. If you'll bear with me for a moment while I digress, I'd like to show a separate set of slides relating to this issue. The first shows what I call the independent or traditional system, where the financing of medical care is provided entirely by an insurance carrier, and where the delivery is provided by physicians who are paid on a fee-for-service basis and hospitals which are reimbursed on the basis of billed charges. At the other extreme would be a closed system. The closest I know to this is the Kaiser system, where financing is provided by a health maintenance organization and delivery is provided by physicians who are employees of the HMO and by hospitals which are owned and operated by the HMO.

Now, in between these two extremes, there are many shades. As we go down the spectrum, the amount of control over the delivery system increases. These slides show that we start with the traditional group carrier, then move to the health care financing administration, which is responsible for medicare, to Blue Cross and Blue Shield plans, which traditionally have some relationship to the delivery system, to preferred provider organizations, of which there are many different shades that could fall anywhere in this spectrum. Proceeding down the spectrum, we see exclusive provider organizations, where the delivery is restricted to certain providers, and individual practice-type HMOs, which typically have many physicians that are already practicing in the community, group model HMOs, hospital chain insurance plans, where the hospitals are owned by the insurance carrier, and staff model HMOs. Depending on the particular model involved, the order of these on the list could be changed significantly.

The point is that even health maintenance organizations, which have a fairly clear definition in the spectrum, have presented regulatory problems between insurance departments and health departments in state government. If you remember, we mentioned earlier that the annual statement form for HMOs is a completely separate form; it's not part of the series that applies to other insurance type entities. So, inevitably, we can expect these current developments to complicate this issue even further.

Finally, one of my Academy associates may of made up the word ERISAfication that you see on the slide, or maybe someone on Capitol Hill did. It describes the essence of recent and proposed federal legislation designed to protect health plan participants. These are the two major issues that will affect the future financial regulation of health business.

MR. SNADER:
Thank you, Bob.

Our next speaker will be Walter Rugland. Walt is employed as a principal in the firm of Milliman & Robertson. He is also a member of the Academy, a Fellow of the Society of Actuaries and a Fellow of the Conference of Actuaries in Public Practice.

He has been a member of the boards of both the Academy and the Society of Actuaries.

MR. RUGLAND:
I have two comments with regard to financial reporting committee activities as I see them for the life insurance side. It's my observation in the last year that they've been working on two critical issues. In an effort to staff and perhaps influence FASB and the AICPA groups that are essentially funneling information into FASB, the Academy's committee has been dealing with how universal life should be reported on a GAAP basis.

I'm not sure where that project is. The Academy's project was completed this summer and the AICPA, at various levels of its committees, has been vascillating from rejecting it to accepting it to overwhelming it with definitions, and I believe that the AICPA's position currently is fairly consistent with the Academy committee's approach.

The second thing that the Academy committee has been working on is statutory reporting with regard to the future role of the valuation actuary which I will spend most of my time discussing.

However, I think it's important to note that the thrust of the Financial Reporting Committee in this regard has come again from universal life. Several years ago some companies introduced a universal life product that had the interest rate credited, be tied in with an index. And the NAIC, in trying to figure out how to establish reserves for this, developed the concept of an actuary's opinion with regard to the underlying asset management strategy of that particular product.

The Academy developed Recommendation 11, which has been promulgated to use for valuing universal life products which are based on an index asset account.

The important part of that whole discussion is that many of the people involved said, "Why shouldn't this type of recommendation or this type of analysis be required for the entire statement. And, in fact, it serves to some extent as a prototype for the review which is ongoing now with regard to Recommendation 7, which deals with what the valuation actuary does in preparing statutory statements for a life and health company."

Now, I'd like to spend the rest of my time talking to you as a member of the Joint Committee on the Role of the Valuation Actuary in the United States, where the term valuation actuary does not deal with pension issues, does not deal with casualty companies, but essentially deals with the valuation actuary for life and health companies. The two sponsoring organizations are the Society of Actuaries (SOA) and the American Academy of Actuaries. The committee was put together about a year ago with the idea of trying to coordinate and to activate the necessary working groups within the Academy and the SOA to deal with developments as they happened on the emerging role of the person, the actuary signing the annual statement.

The joint committee met often during the last year and in June issued a report that has been discussed at both Academy and SOA board meetings and accepted.

And I want to summarize for you the thrust of the deliberations of the Joint Committee. Of particular importance is the idea that we perhaps are creating something here that goes beyond the life and health blank and there has been a working group within both the CAS and the Academy to deal with the question of what aspects of this particular recommendation from the Joint Committee report should be considered from a casualty point of view.

It's really a new era for the actuarial opinion as it is used within the life and health insurance area. And some of you have heard me talk about this before. This is the title that I like to use for it: "Getting control of the game called 'You Bet Your Company.' " What we realize is that there are some aspects of our valuation process and opinion making that are not particularly well covered in our current approach, and this is an effort to do a better job of the game called "You Bet Your Company."

The joint committee was organized to determine the appropriate role of the valuation actuary and to suggest ways that the Academy and the SOA can affect and support that role. And it became apparent that we were not just talking about valuation questions. The whole concept of the valuation actuary needed to deal with all aspects of the life insurance companies operations -- from pricing to reserving to ongoing maintenance.

There were five starting points we decided. First of all was agreement that the standard valuation law does not do the job with regard to three things: measuring the economic health of the company at a particular time, assuring that benefit payments will be paid as promised, and that it really doesn't do what it was intended to do when it was written nearly 50 years ago. Remember, it was written in the late 1930s and early 40s when the environment was very much different than it is today.

A second point that we had to agree on was that insolvency of a life insurance company is the result of a court action. And that court action is based on a current status measure. In other words, the court's not really dealing with how healthy it is economically, the court action is basically a reflection of an arbitrary measure which is established by someone else and if the company is above the line, it's good; if it's below the line, it's insolvent. So we had to deal with two questions: How healthy is the company? Is it solvent or insolvent?

The third point that we needed to agree on as a basic premise was that managements of life insurance companies want those companies to be strong, to survive and be healthy. The real issue here is must we develop a valulation approach that will essentially uncover a management that does not want its company to survive. And we really determined that that could not be within the scope of the valuation actuary's work.

And the last premise that we began working with was that we must work within the current framework of the standard valuation law.

So the joint committee, after reviewing the work of a lot of different groups within both the Academy and the Society of Actuaries, put two recommendations in its report. The first one had to do with the concept of the valuation actuary and this really had five points.

First of all, that a valuation actuary be required by statute. Second, that every state required a valuation actuary to be identified by every company licensed to do business in that state. Third, that that valuation actuary be appointed by Board of Directors. Fourth, that the state be notified on a timely basis whenever that appointment is changed. Fifth, that the valuation actuary be qualified. That's the stickler. The question is, okay, what's a qualified valuation actuary?

Well, if the state were to say that a valuation actuary must be a member of the Academy of Actuaries, then it's the Academy's problem to determine what qualifies a person as a valuation actuary. The Academy has a mechanism set up to do that. In fact, the Academy is currently working on redefining the standards for a valuation actuary qualifications.

The other half of the issue, though, is that in the past decade many states have given credentials -- if you want to call it that -- to non-Academy members to be valuation actuaries. And so the states are saying to us, what about all these people that are signing statements who are not Academy members. The real problem here is that the profession has to help the regulators get past that particular problem. And we're working at trying to do that. But the qualification question is a real one and a part of the whole concept.

The second part of the recommendation was the valuation process. In an ideal world, we agreed, we would have an annual statement, but we wouldn't have any laws, and that the best that the regulators could get a handle on this would be to trust the actuary and ask the actuary to give them an opinion and a report that showed how they got to that opinion. We recognize that that perhaps is never going to happen, but as an ultimate goal we felt that that was an appropriate starting point.

The question then becomes what's the interim approach. And our suggestion is that we essentially say that the standard valuation law, as it is, is appropriate for defining when a company is solvent and when it is not.

Additionally, we are recommending that the actuary's opinion on a life insurance company, be -- I guess I'd use the word -- upgraded so that it can speak to the assurance that benefit payments will be made to all those existing policyholders. In other words, the actuaries opinion becomes one of economic health of the company.

And, we would require there be a report submitted by the actuary giving that opinion and that report would be given to the Board of Directors of the company, that it would not be required that it be submitted to the insurance regulators, but that it would be understood that in the process of examination, insurance regulators could ask for that report.

So there are really two main things here. Today we have an opinion and we are suggesting that that opinion be changed, and that our report be required and be essentially positioned so that regulators could use it.

Now, what about the actuary's opinion. The report recommends that the actuary's opinion be broken into two pieces. That there be "reasonable deviations" provided for in the reserve. And, that "plausible deviations" be provided for in the total of reserves and surplus.

Now, the other major change that we made is one that's consistent with what's in Recommendation 11, which has just been promulgated by the Academy. That is that the opinion deal with the cash flows from insurance and investment rather than just a best estimate gross premium valuation.

The question here is when to go to an ultimate status. We'll know when we should go there when we're there. To suggest that we should go to it before we're ready to do it is not a realistic position to take.

This represents a major effort for the profession in the United States and a major opportunity to establish ourselves as professionals. The real question we're trying to deal with is how can the public be assured that benefits which are promised will be realized. And we're saying that no one can do that better than the practicing actuary who has the responsibility to give his opinion as to whether the company he's looking at is, in fact, positioned enough to provide those benefits.

Who is driving this whole effort? I think some of the impetus is really coming from the NAIC.

The NAIC, sitting there with the hammer, is the one that eventually has to drive it and it's been my feeling that all along the staff people within the departments have been saying, we're not satisfied with what we're getting, we're going to try to figure out how to do it, but we'd like to have you come in with an approach that would meet our needs. And that, I believe, is where we are today.

If we revert to the traditional approach, I think what the regulators must do -- this is my feeling, not the committee's -- what the regulators must do is adopt more conservative valuation approaches and for an industry that is essentially undercapitalized, all that means is that we're going to end up not being able to take advantage of opportunities of the current marketplace.

On the other hand, by adopting this approach, which is really a new approach to professionalism for the actuaries, we potentially position the life insurance industry to deal with the current environment. The NAIC has told us they have a concern with actuarial professional credibility, and that's going to be one of the big issues that needs to be addressed in the next six months as to whether they're willing to give the profession this much latitude in terms of its role in reporting the economic health of the life insurance companies.

That's the current status with regard to the concept of the valuation actuary.

MR. SNADER:

Thank you very much, Walt.

We don't have very much time left and I do want to give Steven Gapp a chance to make his presentation.

MR. GAPP:

Thank you, Richard.

I would like to mention that I am an associate casualty actuary with the California Department of Insurance, and Mr. Snader has gratiously today given me this opportunity to highlight and distribute a paper written by John Montgomery, chief actuary for the California Department, entitled the "NAIC Statement Blank: Where Do We Go From Here?" The paper proposes widespread changes to both the life and casualty blanks, the ultimate goal being uniform reporting and a consolidated blank.

Before I go into the specifics of the paper, I'd like to give you a little background information. John Montgomery, who could not be here today, is a Fellow of the Society of Actuaries. He is a member of the NAIC Blanks Task Force and he is also a director of the American Academy of Actuaries.

An earlier draft of his paper was presented to the NAIC Blanks Task Force in September. This paper was presented to the Society of Actuaries at the Toronto meeting last month and will again be presented to the Society of Actuaries in May of 1985 at its St. Louis meeting.

Now, to highlight the paper briefly, there are two main thrusts for change. The first one is uniform reporting. That is, certain existing exhibits will be modified so that, in essence, they will be identical for both the life, casualty, and A & H business.

Second, there would be additional information required in the annual statement. Now, there are many reasons for requiring additional information. I'll give you a few. The ones that come to mind are the regulatory complications due to the manipulations by the holding company, the advent of the intervative financial services, and the Baldwin-United single premium annuity problem.

I'd like to mention a few of the proposals. Any financial statement involving an insurance company must relate the operations of that company to those of all other affiliates in the same corporate family. The balance sheet, summary of operations, and cash flow formats should be common for all lines of business.

A balance sheet should be presented for not only the entire insurer and possibly his holding company, but for each line of business for which assets and/or liabilities are segregated. The balance sheet should reveal both the market and statement value of assets as well as liabilities payable on demand.

Each summary of operations, for example, underwriting operations, investment operations, and non-insurance operations, should be presented separately under the following six column headings: direct business, re-insurance seated, directless seated, re-insurance assumed, retroceded business, and net business. It's quite a bit more information.

Additionally, the cash flow statements should be parallel in form to the operation statement. As for Schedule T, a schedule of premiums paid by state should be split by major groups or lines of business.

Finally, I should also mention that the concepts set forth in the paper are related to the health statement of opinion, casualty loss reserves, and in valuation actuary concept discussed earlier by the other panel members. Thank you very much.

AMERICAN ACADEMY OF ACTUARIES
WORKSHOPS

TUESDAY, NOVEMBER 13, 1984
8:00 - 9:30 A.M.

#10 - TAXES AND THE ACTUARY

MODERATOR: JAMES A. FABER
Principal
Peat, Marwick, Mitchell & Company

PANEL: MARTIN ADLER
Vice President and Actuary
Government Employees Insurance Company

JAY A. NOVIK
Vice President
North American Reinsurance Corporation

RICHARD S. ROBERTSON
Senior Vice President
Lincoln National Corporation

WORKSHOP - TAXES AND THE ACTUARY

MR. FABER:
Good morning.

This is an American Academy of Actuaries workshop: Taxes and the Actuary.

For the record, I'm Jim Faber, a fellow of the Casualty Actuarial Society, a member of the American Academy and a principal in the firm of Peat, Marwick, Mitchell & Co. I will serve as moderator for the session.

Why taxes and the actuary? Historically, the life actuary has played a much more involved role in company taxation planning than has the casualty actuary. While this is not likely to change, some things are happening that may involve the casualty actuary more in this process.

The life actuary's role is not likely to decrease with the passage of the Deficit Reduction Act of 1984, commonly known as DEFRA. We will look at that act and its impact on life insurance company taxation. We'll also look at the ramifications to reinsurers of Section 845 of the act and possible effects for property casualty companies.

While no specific changes in taxation have been passed for property casualty companies, proposals have been made, perhaps the principal being the General Accounting Office (GAO) study. And as you know, the Internal Revenue Service (IRS) in recent years, has been looking at loss reserve evaluations in a manner differently than in the past. Gone is the luxury of the 15% tolerances.

All of this affects the actuary. The actuary's expertise is a benefit in tax planning, perhaps a necessity. Prior to the close of our session, we will explore the actuary's tax planning role. How does it differ for the different specialties?

I'm pleased to have as participants this morning three distinguished actuaries. Our first speaker is Dick Robertson. Dick is senior vice president of Lincoln National Corporation. He is responsible for financial reporting, investor relations, tax compliance, internal audit, and strategic planning. He is a fellow of the Society of Actuaries and it's newly elected president-elect. Dick is a member of the American Academy of Actuaries and has served as one of its vice presidents. In addition, he serves as deputy to the Steering Committee on Tax Legislation of the American Council on Life Insurance.

MR. ROBERTSON:
Thank you, Jim. Before I talk about the role of the actuary in life insurance taxation, I thought it might be useful to give a brief summary of the tax law, itself, as it affects life insurance companies. It's a very complicated bill; although conceptually, it's relatively simple. The 1984 law is essentially a tax on income. And this is a relatively new concept in the life insurance area. For most companies, all of the historical laws have involved, to some degree or another, taxes on investment income.

The 1984 law, unlike past laws, no longer gives us much latitude in how we determine our reserves. Those of us who were involved in tax planning have gotten quite skilled at determining how to use reserves to the greatest tax advantage. And those who are responsible for enacting this law began to appreciate this; they determined that this is something they didn't want us to have any more.

The law essentially says that the reserve will be the lowest reserve that is permitted by a majority of the states, but not less than the cash value under the policy, for policies with cash values. And there are ramifications with respect to other than individual insurance, group insurance, health insurance, or whatever.

The second major difference is that we do get some credit for our tax exempt investment income -- state and municipal bonds, preferred and common stock dividends. However, the rules for life insurance taxation for many years have involved prorating that investment income between that deemed to accrue for the benefit of our policyholders, which is not excluded from income, and that deemed for the benefit of the company or the company shareholders, which is excluded.

The new law, in contrast to old laws, gets much tougher in how that proration is accomplished, with the consequence that most life insurance companies will not find tax exempt income attractive. And I think most of us are in the process of going through and weeding out a lot of our existing tax-favored investments.

The third major difference involves mutual companies. One of the biggest issues in this tax legislation was determining how mutual companies are going to determine their tax base. The problem is that there is a belief or perception that part of the dividend paid policyholders by mutual life insurance companies is comparable to the dividend paid stockholders of stock life insurance companies. The dividend paid by stock companies, of course, is not deductible, and those of us in the stock side wanted to be sure that the mutual companies don't get a competitive advantage by being able to deduct that component of their dividends. And the problem boiled down to determining just how you sort out what part of the dividend is a return of premium, and what part a return on capital.

The rule that was adopted examines the return on equity of the larger mutual companies and compares that with the return on equity of the larger stock companies, and historically, there's been a significant difference. The difference is deemed to be that part of the earnings of the mutual companies that is refunded to its customers. And there is, in essence, an imputed profit attributed to mutual companies based on this difference. What it amounts to is a tax on the surplus of mutual companies that will vary according to the earnings of mutual companies, in the aggregate. And it gets very, very complicated trying to determine how that's calculated and the implications with respect to companies.

This law has a few implications with respect to the products we sell. There are some changes in the way life insurance policyholders are taxed, but they aren't basic. That is, the authors have really tried to curb what were perceived as abuses, or to better define, in the case of universal life and other flexible premium policies, exactly what characteristics a policy must have to qualify as life insurance and receive the favorable tax treatment that policyholders get under life insurance taxation.

Let me now turn to the main topic of our discussion: the role of the actuary. I've identified four different areas in which the life insurance actuary has a role in taxation: (1) tax planning, (2) accounting issues, (3) the administration of the law, and (4) the actuary's involvement in the creation and enactment of the law. I'll take the last one first.

There were a lot of people involved, bringing together a lot of different disciplines. There were at least two kinds of attorneys. There were the government relations attorneys, the lobbyists, if you will. Their function was, of course, to present our case to Congress, to the Treasury or to whomever we had to make our case to, in order to get what we wanted. There were, of course, the tax attorneys, whose role was very helpful in the actual drafting of the legislation and in the examination of what had been drafted to determine any implications with respect to us. And of course, there were tax

practitioners involved, who also had the role of trying to determine the effect of various proposals on companies or on policyholders.

Chief executives were involved. I got to know a fair number of the life insurance executives. Their role partly involved helping to establish policy, and partly they were very effective as lobbyists. And finally, there were a large number of actuaries there. The actuary was really about the only player in this process who could put the whole thing together, who could understand the implications of some of the notions that were being talked about with respect to tax legislation. The actuary could figure out what it all meant in terms of the amount companies would pay, the effect on their financial condition, the effect on the products that we could sell, and where it would leave us with regard to our competitive position.

Let me move from the shaping of the law to what we have now that it is enacted. I said that the actuary has a role in administration. That's largely because of the job of determining what the reserve is for tax purposes. Although if we get into things like discounting loss reserves, we're going to put ourselves right in the middle of trying to determine what our reserves are for tax purposes. Of course, we've got more than loss reserves to worry about. We've got the active life reserves. And the actuary is very much involved in trying to determine what, in fact, that is, and trying to develop a methodology for getting it calculated.

With respect to accounting, there are a number of issues. The most significant, currently, is the issue that involves how you account for the change between the old law and the new. Under the old tax law, we were allowed to carry relatively high reserves, and those of us who had taxable income generally tried to maximize our tax reserves. The new law essentially requires us to minimize our tax reserves. As part of the political process of getting this law enacted, they gave us a benefit by saying they are not going to try to tax us on the difference on those reserves.

For shareholder accounting purposes, we've established deferred taxes. But now that the reserves are not to be released, we suddenly don't need them. The Financial Accounting Standards Board (FASB) tells us those are to be recognized in income during 1984. And it's going to take a lot of work for us to try and figure what that really means and how that difference is to be calculated. And we've got our actuaries working very hard to try and do that, in time for us to report our year-end results.

On an ongoing basis, we've got at least to ask the question: Do we need deferred taxes in our statutory returns? I don't know how that's likely to come out. There are arguments on both sides.

We also have allocation issues. It's a new law, and we will need to allocate that to our different product lines: the actuary is going to need to, if not set the policy, at least participate in setting the policy regarding how that's to be done.

With respect to tax planning, this law is new enough that the tax planning opportunities have not yet really been identified, or if they have, the people who identified them have not talked a great deal about them yet. However, we do have a situation where different companies continue to have different tax bases, the way life insurance companies are taxed, of course, is very different from the way property casualty companies are taxed.

One of the challenges to us will be to determine how we can use these differences to promote most effectively the interests of the company and its shareholders or policyholders.

Beyond reinsurance, which will be discussed later, in many cases, we may even have a choice as to the kind of company we choose to write a particular

class of coverage. We certainly don't have an obligation to write business in the company that gives the highest tax rate. In contrast, we probably will find it advantageous to use whatever kind of company gives the most favorable tax position. And in fact, competition may well force us to do that; there are a number of circumstances that we will have to examine.

I did neglect to mention one significant additional difference between statutory accounting and tax accounting. Under old laws, life insurance companies had various types of special deductions to recognize special characteristics of our business or, in fact, to produce what was deemed to be an appropriate level of revenue. For example, many companies were able to deduct 2% of group and health insurance premiums. There were special deductions for stock companies whose income exceeded a certain level.

All of these particular deductions were taken away and we were given one general deduction, called taxable income adjustment, that allows us to take 20% of our taxable income off the top, reducing our taxable income by 20%. The effective result of this is that it reduces our tax rate from the general corporate rate of 46% to about 37%. So that life insurance companies generally enjoy a lower effective tax rate than general corporations.

There are tax planning opportunities in the investment area. When you get into mutual companies, I am told that the interplay of the surplus tax and the income tax can produce some complications on investment policy that we don't have in the stock company area. And it's taking some sorting out to determine the real effective tax rate on various kinds of investments. Of course, we still have the need to examine when it's appropriate to take capital gains, when it's appropriate to take capital losses, and all the things we're accustomed to looking at in the investment area.

They haven't completely taken the reserve opportunities away from us. I don't think we have the opportunity for very large-scale tax planning, based on the choice of reserves. But the reserves issues are complicated enough that there is an opportunity for some careful examination of what reserves we're going to hold to try and determine the one that produces the best corporate results, which includes the tax consequences.

The current law, in a sense, allows the National Association of Insurance Commissioners (NAIC) to establish what the tax reserves are, in the sense that it uses the NAIC standards as the basis for defining our reserves. That's a new responsibility for the regulators, and when the proposals are put before the NAIC that will change the reserve basis or, let's say, even better define it, there will be tax implications.

Well, I hope I've given you a fair amount of the flavor of the kinds of things that those of us on the life insurance side are seeing in the tax law. Thank you.

MR. FABER:
Thanks very much, Dick.

Our next speaker, Jay Novik, will address the act as it relates to reinsurance. Jay is a vice president of North American Reinsurance Corporation and senior vice president of Atrium Corporation, a subsidiary reinsurance intermediary. Jay is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

MR. NOVIK:
Dick has reviewed a very broad, complicated area. I'm going to be reviewing a very narrow, complicated area.

WORKSHOP - TAXES AND THE ACTUARY

In the Tax Act of 1984 there are numerous provisions that affect general businesses and casualty insurance companies. This includes changes in provisions on foreign taxation, investments, captive taxation, and definition of consolidation. In addition, there is a provision specifically aimed at curtailing some of the transactions in the reinsurance area that have been occurring over a number of years. The provision is applicable to casualty companies. This is called Internal Revenue Code (IRC) Section 845. It is applicable to both life and property casualty companies, and it is something that you should be aware of in any tax or financial planning.

Just a brief bit of history. In the mid-'70s, insurance companies started using reinsurance to a very extensive degree as a means for reducing their taxable income. For many companies, the old life company tax law had taxation based on investment income only, with no taxation on underwriting income. There was a somewhat obscure provision in the life company tax law that allowed the companies taxed on investment income to move investments and investment income off their books, on a tax form basis, to a company that would shelter the taxable income for them. Billions of dollars were saved over a three- or four-year period, with various combinations and permutations of this technique, called the Section 820 election.

TEFRA, passed a few years ago, ended that. During the two years when TEFRA was applicable, companies found further ingenious ways of sheltering taxes through reinsurance. By the time the conference committee was reviewing the legislation on life company tax reform, I think they were at a point where they had given up the attempt to try to outwit the reinsurance community and had decided to do their best to obstruct all transactions with the understanding that if we could prove that we were innocent, they'd allow a transaction to go through. That was somewhat of a reversal of the general "innocent until proven guilty." Now everything's suspect until we can prove we have clean hands.

I don't know if in application, when regulations are introduced, that the burden will be as onerous as the section language, but we'll only know that over a few years. In any case, it's something that you must consider in any reinsurance transaction.

The first part of this section, 845(a) involves related party reinsurance. Those of you who are involved in taxes at all are aware that for many years the companies in an affiliated group, even unconsolidated, have had to deal with Section 482, which allows the IRS broad authority to reallocate transactions between related parties to reflect the proper source of income.

Under TEFRA, a provision comparable to 482 was introduced, and this was referred to as 818(g). The new law has replaced 818(g) with 845(a). This is not of any great importance in the history, except to realize that to a certain extent, 845(a) has been with us in various guises for many years and will not be a major shock to most corporations, although there is an expansion of authority for the IRS in 845(a).

But basically, the Treasury can allocate among the parties and recharacterize income deductions, assets, reserves, credits, and any other items related to a reinsurance agreement. And they can do this to reflect the proper source and character of the item.

Related parties are defined as in IRC Section 482, and there's some difference between what you might expect a related party to be in common sense and the way they'd be defined in 482. In addition, there was a specific comment about transactions between related parties through a conduit. And those can also be reallocated under this 845(a).

The effective date of the 845(a) is risks reinsured after September 27, 1983. That means the related party reinsurance provisions are already in effect for your companies.

Many casualty companies are unaware that they are affected by 845(a). If you have any involvement in taxes, you should take the initiative in your company and explore whether you have any reinsurance transactions that you might want to alter or eliminate.

The second part of 845, 845(b), is a much greater shock, both to the reinsurance community and to the insurance community. This section allows the IRS to reallocate income and deductions among unrelated parties to a reinsurance agreement where there is a significant tax avoidance effect. The definition of this is still somewhat ambiguous. Where reinsurance has a significant tax avoidance effect, the Secretary can make adjustments to one or both parties. In related party adjustments, you have to make correlative adjustments, so that a transaction cannot result in taxable income for both parties to the transaction.

There are many weapons with which the IRS can attack the agreement. They can reallocate, recharacterize, or treat the contract as having been terminated at the end of the year and reinstated in the following year on a tax basis only.

In order to get some information about how 845 might be applied, we really have to look at the conference reports. In reading through the language underlying the law, one of the comments is that the motivation of the parties is not important in the determination of whether there's a significant tax avoidance effect. This means that you could enter into a transaction because of concerns for your company's surplus position or concerns of the risk you're taking on in a line of business, if it is determined to have a significant tax avoidance effect, the transaction could be reallocated on a tax basis.

Among items that will not protect you from a reallocation are the fact that you have a valid business purpose, arm's length terms, and a lack of tax avoidance as your principal purpose for the transaction.

Traditionally, if a transaction had all these factors, one felt secure that it was a valid transactin for tax purposes. And that's no longer going to be applicable, at least according to the committee reports.

Section 845 is just an addition to the arsenal that the IRS has. All of the cases and rulings that have arisen related to captive taxation are applicable. All the determinations of what is and what is not insurance still apply. If you escape 845, you have to deal with all the other areas where the IRS is questioning reinsurance or insurance transactions.

Some of the examples of tax avoidance specifically mentioned in the committee report include: (1) an artificial reduction in tax equity; (2) a change in source of character of an item; (3) deferred taxation; (4) elimination of separate return limitation year, and (5) transferring tax benefits or extending a carryover period. The conference committee indicated that tax avoidance is significant if it's disproportionate to the risk transferred.

As brief aside, what you're going to find is that taxation will become much more specialized to the property-casualty business, much less like other businesses and will require more actuarial input. If there ever was an area that's going to require some actuarial analysis, it's the concept of whether tax benefits are commensurate with risk transfer.

There are some indications of "safe harbors" for reinsurance transactions. If the reinsurance had essentially the same impact on a reinsurer as the primary business had on the writing company, there's some

protection for the transaction. It's going to be hard to prove that the impact is identical.

The existence of significant tax avoidance effect may be difficult to determine. The conference indicated that some of the factors that would be considered in this determination would be age of business, character of the business, existence of experience refunds. I think that you can quickly see this applies as much to casualty as to life. There is a presumption that the reinsurance of a new business is riskier than reinsurance of an old block of business.

There's a preliminary indication that much of the reinsurance on the non-life side would not have a significant tax avoidance impact, because it does seem to fall into an area that's somewhat sheltered. Existence of experience refunds, retrorating, and experience refunds are much more prevalent in the casualty reinsurance area. The duration of the agreement is also an indication of whether there is a tax avoidance effect. The longer an agreement's in force, the more blessed it seems to be. Termination provisions are important. If a treaty has a termination provision that requires payback to the reinsurer, that would be highly suspect.

The relative tax position of the parties is another indicator. Companies in a parallel tax position, almost never exactly the case, would be indicative that there is not a significant tax avoidance effect. And the financial position of the parties. Surplus relief provided to insolvent parties should be acceptable to the IRS, but may not be acceptable to the management at the reinsurance company.

There are some safe harbors. And unfortunately, and very importantly, the safe harbors are all framed in terms of life practices and life companies. Therefore, in a real sense, right now, non-life companies have no safe harbor. One of the safe harbors if YRT, which is basically risk premium reinsurance comparable to a lot of the transactions in the reinsurance area on the casualty side - excess of loss, catastrophe covers.

Coinsurance of YRT. Again, if you can extrapolate and try to develop a safe harbor, coinsurance of YRT coverage is equivalent to reinsurance, quota share, and suplus share reinsurance of almost everything that written in the non-life side. So by extrapolation, there's a valuable safe harbor there. The question is, can you justify the extrapolation?

The ACLI has been working on developing regulations for Section 845. The sub, sub task force specifically assigned the problem of developing the regulations has come up with a proposed regulation which, for the most part, ignores non-life insurance activities.

The Reinsurance Association of America will be conducting a meeting in the next few weeks, inviting many of the non-life insurance industry groups to get some input as to what kind of changes they need in the way of regulations. And most specifically, I'm sure, they're interested in getting some safe harbors.

I think that any of you who are involved in taxes or have an interest in reinsurance should take a look at the proposed regulations and make some comments through the appropriate person in your company to your industry group as to ideas you have on how these should be implemented.

MR. FABER:

Thanks very much, Jay.

Our final presenter this morning, here to discuss some of the aspects of tax proposals that relate to the property casualty area, is Marty Adler. Marty is vice president and actuary of Government Employees Insurance Company.

He holds a bachelor's degree from nearby Harvard. He is a fellow of the Casualty Actuarial Society, and a member of the American Academy of Actuaries. Marty's a member of the Board of Directors of the Casualty Actuarial Society and has served as the chairman of their Committee on Reserves.

MR. ADLER:
Good morning.

I thought that I would address two aspects of taxation of casualty companies. One is the role of reserves, and the other, the current proposals for changes in the tax laws as they impact property casualty companies.

Now the reason for the focus on reserves is that it impacts when income is recognized. I think all of us realize that it's not the reserve that determines the loss, it's the actual occurrence of the claim and then the payment or settlement of the claim; however, since many claims are not settled for a number of years after occurrence, what impacts any year's income is the reserve that's set aside for the set of claims.

I have a brief history of reserve testing from the perspective of the IRS. I'll go back to 1944. The IRS mimeograph 1366 set the essential guidelines that stood for a long time. It set a one-year run-off of claims, property claims under Schedule O, but a five-year average of the one-year run-offs. If it developed within 115% of the reserve at year end, it would be considered to show a reasonable estimate on the part of the company. The agent could then assume that the year under examination was adequately reserved for tax purposes and no adjustment needed to be made.

In 1961, a confidential, unpublished IRS memorandum went a little bit further and said that not only was the 115% appropriate for not adjusting any particular line, but that it was a reasonable tolerance. The 115% test came to be used for Schedule P lines, which was a lot more critical, and in 1965, a series of private rulings confirmed that the 115% would be used for Schedule P. However, in 1975, a revenue procedure put out by the IRS said two things: (1) that they were going to adjust incurred losses for subsequently received salvage, and (2) that the 15% tolerance was out, and the proper test was going to be the reasonableness of the reserves.

That leads us to the next development, which is one that is still being discussed between the industry and the IRS. I think most of us have heard of the infamous "closed claim" method. It came from an IRS specialist memorandum in 1980. The memo said that the proper determination of reserves could only be determined objectively by comparing claims closed against the case reserves that were set up. And to make sure that there was no bias, there was going to be a five- to seven-year development for three test years. That is, the most recent test year that would be used would be five years old, the next one six and the third one back, seven years old.

The average development of only claims closed against the case reserves for those claims would develop an experience rate. The experience rate would be applied to the year under examination to establish what the reserve should have been for tax purposes and then to determine what the income really was for tax purposes. This is an oversimplication of the closed claim method, but that is the essence of it.

There are a number of flaws in this. I'm not going to go into that. I want to focus instead on discussions between the industry and the IRS in determining the proper method for testing casualty company reserves. This past year, the industry thinks that it has made quite a bit of progress, because an IRS letter to the three major industry associations said that the issue was

whether estimates were reasonable. Now we don't know what this is going to be in practice. We think, though, that that is the proper approach, that the tests alone do not show reasonableness. However, the company will have the burden of proof if it fails the audit test. The audit test will still be one of saying how reserves developed in the past. This particular letter did not address the reduction of the incurred loss for collected salvage and subrogation. So, it's an unresolved issue.

Now the industry has proposed an alternative to the closed claims test, and from what I've seen of it, it is one that would substitute a more traditional incurred claim development for the closed claim test. It has the advantage of not being inherently biased; however, I think that actuaries would say that that's not the way to examine reserves. It's too simplistic.

Now I want to move from that to tax change proposals, and I think the focus here is the previously alluded to GAO draft report. What GAO said in its report was that the loss reserves for tax purposes should be discounted, that the discount rate would be based on a moving average of pre-tax returns.

In addition to that, there are a couple of aspects that haven't been touched on yet. The Deferred Policy Acquisition Cost (DPAC) is an accounting item. Actually, I'm misstating it here to say we're eliminating DPAC. We're not going to eliminate it. We're going to eliminate the tax benefit of the item that's carried for GAAP reporting purposes, deferred policy acquisition.

Companies take the current expenses off the current year's income, even though the policy contracts remain in effect, and the proposal in the GAO report is that the insurance companies should allocate the expense over the lifetime of the contracts. This obviously would spread out expenses, allow lower expenses in the current year, and therefore, accelerate income for tax purposes.

GAO would also consider eliminating the PAL account. The PAL account is a protection against loss account. It applies to mutual insurance companies. As I understand it, there is a percentage of the premium volume that is shielded from taxes. The rationale for that is that the mutual company does not have the ability to raise equity in the marketplace in case a disaster occurs, and it needs to shore up its surplus position. This PAL account would give that benefit to the companies to help them to continue in existence in case of dire, unforeseen circumstances.

In addition to what the draft report recommended, they think that the Congress should focus on the consolidation of income, both with life insurance companies and with other nonfinancial services corporations. Moreover, they think that the question of tax-exempt income from investments should be examined in addition to the question of the use of captive insurance subsidiaries for other companies.

Briefly, the industry response to the proposals is that statutory accounting does not mismatch income and expenses. Rather, discounting would accelerate the recognition of future investment income. The industry says, no, we haven't earned that income yet. It should be taxed when it's earned. Furthermore, it would disadvantage U.S. companies vis-a-vis foreign reinsurers, which are shielded from taxation in the manner in which they're regulated, because of questions of solvency and solidity. It would increase the use of captives and self-insurance. It would create pressures on solvency regulation. I just need remind you of all the comments made regarding the widespread opinion within the industry about the adequacy of property-casualty reserves. If they were discounted, there's a great chance that companies would think they're in a better financial situation than they are,

and that would hasten the possible insolvency of a number of companies. It would also be an administrative nightmare. How do you account for the discount? How do you show it from year to year? What rate do you use?

Regarding the acquisition expenses, the industry maintains that they are the current cost of administrating assets. They should be deducted currently. Moreover, the acquisition expenses vary by the marketing approach of the different distribution systems, and that could lead to serious disruptions.

Regarding the PAL account, that has served its purpose, especially for small companies.

Briefly, regarding other proposals, the question of reinsurance has been brought up. Congress may be examining the question about reinsurance without a real risk transfer, the question of limitations on tax-exempt income, and whether a minimum tax should be applied in certain circumstances.

Remember, the purpose of all this is to raise money. Congress wants to balance the budget. We prefer that the insurance industry is not discriminated against in the process. And because of the need to raise money, the idea has arisen that perhaps a premium tax would be the surest method of raising that money, particularly since so many companies are not in a very taxable position right now.

The primary role of the casualty actuary in tax planning is forecasting underwriting profit or loss, because this could help affect the company's investment strategy. The actuary could also forecast the timing of that profit or loss into the future, as it affects the possible use of the various carry back/carry forward opportunities.

And finally, a whole topic that we could spend the morning on, if discounting is going to be imposed on the industry in any way, obviously, the casualty actuary is going to have a major role in how that's treated. What is a discount rate? The actuary will not only have to project the ultimate losses which will be paid, but he or she will probably have to project the rate at which claims will be paid out, because that will determine how much is going to be discounted.

MR. FABER:
I think our time has elapsed, so I would like to take this opportunity to thank the panelists for their participation and also for your participation as an audience.

Taxation is a subject of great importance, and we believe that it behooves all of us to be conversant with the tax impacts, both real and potential. Our goal this morning was not to make you tax experts, but rather to provide you with a basic working knowledge. We hope that we have succeeded in that regard, and we thank you for attending.

1984 ACADEMY STATEMENTS

Each year's Journal includes the text of the statements released by the Academy during that year. The summary that follows provides background information, including cross-references to previous statements. Statements are assigned numbers by calendar year and order of release, e.g., 1984-1 is the first statement released during 1984. In addition, the summaries give the page number of which the full text appears.

The guidelines by which these statements are developed appear in the Academy's yearbook.

Index Code: **1984-1**
To: Financial Accounting Standards Board
Date: January 12, 1984
Length: 6 pp.
Concerning: Accounting for pension plans
Background: This testimony was presented at a public hearing held by the Financial Accounting Standards Board on employers' accounting for pensions and other postemployment benefits. The Academy had previously filed extensive written comments on December 1, 1983 (see statement 1983-44).
Drafters: The Committee on Pension Accounting Matters, chaired by James F.A. Biggs, developed the written statement. Testimony was presented by James F.A. Biggs, Paul A. Gewirtz, and Willard A. Hartman on behalf of both the Academy and the Conference of Actuaries in Public Practice.

Index Code: **1984-2**
To: Internal Revenue Service
Date: January 12, 1984
Length: 4 pp.
Concerning: Revision of actuarial tables and interest factors
Background: This letter was submitted to the Internal Revenue Service for the record of a public hearing on proposed regulations relating to tables for valuing annuities, life estates, terms for years, remainders, and reversions for purposes of federal income, estate, and gift taxation. These proposed regulations appeared in the Federal Register on October 31, 1983 (48 FR 50087-50111).
Drafters: Executive Director Stephen G. Kellison

Index Code: **1984-3**
To: Senator Don Nickles
Date: February 7, 1984
Length: 7 pp.
Concerning: Congressional retirement system
Background: This statement was submitted to Senator Don Nickles (R-OK) in response to a request from the Senator for a critique of his proposed alteration to the Congressional retirement system. He also had requested and received an analysis of a

study of the system which had been conducted by the National Taxpayers Union.

Drafters: The Subcommittee on Single Employer Plans (Excluding Title IV) of the Pension Committee. The respective chairmen are Leroy B. Parks, Jr. and Willard A. Hartman. The statement was accompanied by a transmittal letter from General Counsel Gary D. Simms.

Index Code: 1984-4
To: American Institute of Certified Public Accountants
Date: February 13, 1984
Length: 4 pp.
Concerning: GAAP accounting for annuities
Background: This statement was submitted to the AICPA in response to a draft Issues Paper on accounting for single premium deferred annuities. The Academy had previously commented on this matter in 1982 (see statement 1982-9).
Drafters: The Committee on Life Insurance Financial Reporting Principles, chaired by Virgil D. Wagner.

Index Code: 1984-5
To: NAIC Investment Income (D) Task Force
Date: March 7, 1984
Length: 2 pp.
Concerning: Investment income in rate-making
Background: This testimony was presented at a public hearing of the NAIC Investment Income (D) Task Force concerning the use of investment income in rate-making for property and liability insurance. The Task Force had released a major Exposure Draft in December 1983 which was the subject of the hearing.
Drafters: The Committee on Property and Liability Insurance, chaired by Jerome A. Scheibl, who also presented the testimony at the public hearing.

Index Code: 1984-6
To: General Accounting Office
Date: March 8, 1984
Length: 2 pp.
Concerning: Social Security actuarial projections
Background: This letter was submitted to the General Accounting Office in response to its report "Social Security Actuarial Projections" (GAO/HRD-83-92) dated September 30, 1983. This report contained the results of a survey of a random sample of actuaries conducted by the GAO.
Drafters: President A. Norman Crowder, III, at the request of the Committee on Social Insurance, chaired by Preston C. Bassett.

1984 ACADEMY STATEMENTS

Index Code: 1984-7
To: Department of Labor Advisory Council
Date: March 15, 1984
Length: 4 pp.
Concerning: Pension legislation
Background: This letter was submitted to the Advisory Council on Employee Welfare and Pension Benefit Plans of the Department of Labor in connection with a meeting devoted to the impact of ERISA and related legislation on the development of private retirement plans.
Drafters: Executive Director Stephen G. Kellison, on the basis of a compilation of past positions taken by the Academy Pension Committee.

Index Code: 1984-8
To: Joint Board for the Enrollment of Actuaries
Date: March 16, 1984
Length: 1 pp.
Concerning: Enrollment standards
Background: This letter was submitted in reaction to the transition arrangement for partial credits in the revised examination program of the Joint Board for the Enrollment of Actuaries. The Academy had commented three times on the revised examination program in 1982 and 1983 during its development (see statements 1982-20, 1982-31, and 1983-17).
Drafters: Executive Director Stephen G. Kellison

Index Code: 1984-9
To: General Accounting Office
Date: March 26, 1984
Length: 5 pp.
Concerning: Risk classification
Background: This statement was submitted to the General Accounting Office in reaction to its report entitled "Economic Implications of the Fair Insurance Practices Act" dated April 6, 1984 (GAO/OCE-84-1).
Drafters: The Committee on Risk Classification, chaired by Robert L. Knowles.

Index Code: 1984-10
To: House Committee on Ways and Means
Date: April 2, 1984
Length: 3 pp.
Concerning: Pension legislation
Background: This statement was submitted to the Subcommittee on Oversight of the House Committee on Ways and Means for the record of a hearing on the financial status of the PBGC single employer insurance program held on March 20, 1984.
Drafters: The Subcommittee on PBGC (Single Employer Plans) of the Pension Committee. The respective chairmen are Peter A. Bleyler and Willard A. Hartman. The statement was accompanied by a transmittal letter from General Counsel Gary D. Simms.

1984 ACADEMY STATEMENTS

Index Code: 1984-11
To: Joint Committee on Taxation
Date: April 4, 1984
Length: 1 pp.
Concerning: Qualification standards
Background: This letter was sent to the staff of the Joint Committee on Taxation in connection with appropriate qualification standards for actuaries providing opinions on the financing of voluntary employee benefit associations.
Drafters: Executive Director Stephen G. Kellison.

Index Code: 1984-12
To: Senate Committee on Commerce, Science and Transportation
House Committee on Energy and Commerce
Date: April 20, 1984
Length: 2 pp.
Concerning: Risk classification
Background: These letters were sent to the Senate Committee on Commerce, Science and Transportation and the House Committee on Energy and Commerce in connection with pending legislation which would eliminate sex as a rating variable (S. 372 and H.R. 100). These letters were in response to the release of the report of the General Accounting Office and were accompanied with the response of the Committee on Risk Classification to the GAO on March 26, 1984 (see statement 1984-10).
Drafters: Executive Director Stephen G. Kellison.

Index Code: 1984-13
To: NAIC Standing Technical Actuarial (EX5) Task Force
Date: May 10, 1984
Length: 4 pp.
Concerning: Health insurance valuation standards
Background: This progress report was submitted to the NAIC Standing Technical Actuarial (EX 5) Task Force in connection with the ongoing review of valuation standards for health insurance.
Drafters: The Subcommittee on Liaison with NAIC Accident and Health (B) Committee of the Committee on Health. The respective chairmen are E. Paul Barnhart and Robert H. Dobson.

Index Code: 1984-14
To: Joint Board for the Enrollment of Actuaries
Date: May 17, 1984
Length: 2 pp.
Concerning: Enrollment standards
Background: This statement was presented at an open meeting of the Joint Board Advisory Committee on Actuarial Examinations concerning the revised examination program for enrollment. The Academy had previously commented on this subject on March 16, 1984 (see statement 1984-8).
Drafters: Executive Director Stephen G. Kellison

1984 ACADEMY STATEMENTS

Index Code: 1984-15
To: Securities and Exchange Commission
Date: May 22, 1984
Length: 9 pp.
Concerning: Casualty loss reserve disclosure
Background: This statement was submitted to the Securities and Exchange Commission in response to proposed regulations on casualty loss reserve disclosure which appeared in the Federal Register on February 24, 1984 (49 FR 6911-6918). The Academy had previously commented on an earlier SEC draft in 1983 (see statement 1983-41).
Drafters: The Committee on Property and Liability Insurance Financial Reporting Principles, chaired by Richard H. Snader.

Index Code: 1984-16
To: General Accounting Office
Date: May 25, 1984
Length: 6 pp.
Concerning: Multiemployer pension plans
Background: This statement was submitted to the General Accounting Office in reaction to a draft of its report entitled "Incomplete Participant Data Affect Reliability of Values Placed by Actuaries on Multiemployer Pension Plans" (GAO/HRD-84-38).
Drafters: Jointly on behalf of the Pension Subcommittee on Multiemployer Plans, chaired by Joseph A. Lo Cicero, and the Committee on Pension Actuarial Principles and Practices, chaired by Thomas M. Malloy.

Index Code: 1984-17
To: NAIC Standing Technical Actuarial (EX5) Task Force
Length: 1 pp.
Concerning: 1980 CSO tables
Background: This letter was sent to the NAIC Standing Technical Actuarial (EX5) Task Force to comment on calculation specifications for monetary values on the 1980 CSO tables. The Academy had previously commented on this subject on October 4, 1983 (see statement 1983-34).
Drafters: The Committee on Life Insurance, chaired by Richard S. Robertson.

Index Code: 1984-18
To: Senate Committee on Labor and Human Resources
Date: May 31, 1984
Length: 5 pp.
Concerning: Pension legislation
Background: This statement was submitted to the Subcommittee on Labor of the Senate Committee on Labor and Human Resources for the record of a hearing on the Multiemployer Plan Termination Reform Act of 1984 (S. 2329).

1984 ACADEMY STATEMENTS

Drafters: The Subcommittee on Multiemployer Plans of the Pension Committee. The respective chairmen are Joseph A. Lo Cicero and Willard A. Hartman. The statement was accompanied by a transmittal letter from General Counsel Gary D. Simms.

Index Code: 1984-19
To: NAIC Standing Technical Actuarial (EX5) Task Force
Date: June 2, 1984
Length: 1 pp.
Concerning: Dividend principles and practices
Background: This status report was presented to the NAIC Standing Technical Actuarial (EX5) Task Force on the activities of the Committee on Principles and Practices for Dividends and Other Non-Guaranteed Elements. This report follows numerous previous submissions on this subject to the NAIC (most recent statement 1983-45 on December 3, 1983).
Drafters: Claude Thau, a member of the Committee on Principles and Practices for Dividends and Other Non-Guaranteed Elements.

Index Code: 1984-20
To: NAIC Standing Technical Actuarial (EX5) Task Force
Date: June 3, 1984
Length: 10 pp.
Concerning: Valuation actuary
Background: This package of materials relating to proposals to create a position of "valuation actuary" in financial reporting for insurance companies was presented at a meeting of the NAIC Standing Technical Actuarial (EX5) Task Force.
Drafters: This material is a composite of items prepared by the Insurance Subcommittee on Actuary/Auditor Relationships, chaired by Allan D. Affleck; the Joint Committee on the Role of the Valuation Actuary in the United States, chaired by Gary Corbett; and the General Counsel of the Academy, Gary D. Simms. The presentation at the meeting was made by Walter S. Rugland, a Vice President of the Academy.

Index Code: 1984-21
To: House Committee on Energy and Commerce
Date: July 20, 1984
Length: 4 pp.
Concerning: Risk classification
Background: This statement was submitted to the Subcommittee on Commerce, Transportation, and Tourism of the House Committee on Energy and Commerce for the record of a hearing on the Fair Insurance Coverage Act (H.R. 4642). This bill would prohibit classifying risks for insurance purposes on the basis of blindness unless such treatment could be justified by "sound actuarial evidence."
Drafters: Executive Director Stephen G. Kellison in collaboration with Robert L. Knowles, Chairman of the Committee on Risk Classification.

1984 ACADEMY STATEMENTS

Index Code: 1984-22
To: American Institute of Certified Public Accountants
Date: July 30, 1984
Length: 3 pp.
Concerning: Reinsurance accounting and auditing
Background: This statement was submitted to the AICPA Reinsurance Auditing and Accounting Task Force in response to the AICPA Exposure Draft of a Proposed Statement of Position on Auditing Life Reinsurance. The Academy had commented previously on an earlier draft of the AICPA pronouncement on March 8, 1983 (see statement 1983-13), a copy of which was attached to the statement.
Drafters: The Task Force on Reinsurance Accounting, chaired by Ronald E. Ferguson, with a cover letter from Executive Director Stephen G. Kellison.

Index Code: 1984-23
To: Senate Committee on Finance
Date: July 31, 1984
Length: 6 pp.
Concerning: Taxation of employee benefit plans
Background: This statement was submitted to the Subcommittee on Taxation and Debt Management of the Senate Committee on Finance for the record of a hearing of the taxation of employee benefit plans.
Drafters: Executive Director Stephen G. Kellison.

Index Code: 1984-24
To: American Institute of Certified Public Accountants
Date: August 22, 1984
Length: 2 pp.
Concerning: Reinsurance accounting and auditing
Background: This statement was submitted to the AICPA Reinsurance Auditing and Accounting Task Force in response to the AICPA discussion paper on "Accounting for Loss Portfolio Transfers That Are Financing Arrangements." This is the latest in a series of Academy statements on reinsurance accounting and auditing, the most recent of which was on July 30, 1984 (see statement 1984-22).
Drafters: The Task Force on Reinsurance Accounting, chaired by Ronald E. Ferguson.

Index Code: 1984-25
To: NAIC (EX-4A) Study Group on Loss Reserve Discounting
Date: August 29, 1984
Length: 1 pp.
Concerning: Discounting casualty loss reserves
Background: The statement was submitted in response to the report of the NAIC Accounting Practices and Procedures (EX4-A) Task Force Study Group on Loss Reserve Discounting dated May 17, 1984.
Drafters: The Committee on Property and Liability Insurance Financial Reporting Principles, chaired by Richard H. Snader.

Index Code: 1984-26
To: Department of Labor National Pension Forum
Date: September 12, 1984
Length: 5 pp.
Concerning: Pension policy
Background: This testimony on pension policy was presented at a special hearing of the National Pension Forum of the Department of Labor to commemorate the tenth anniversary of ERISA.
Drafters: Executive Director Stephen G. Kellison and General Counsel Gary D. Simms, who presented the testimony.

Index Code: 1984-27
To: House Committee on Ways and Means
Date: September 13, 1984
Length: 7 pp.
Concerning: Medicare
Background: This testimony was presented at a public hearing on Medicare financing held by the Subcommittee on Health of the House Committee on Ways and Means. It is an analysis of the recommendations of the Advisory Council on Social Security released on December 15, 1983.
Drafters: The statement is the joint product of the Committee on Health, chaired by Robert H. Dobson, and the Committee on Social Insurance, chaired by Preston C. Bassett. Mr. Dobson presented the testimony at the public hearing.

Index Code: 1984-28
To: House Committee on Ways and Means
Date: September 17, 1984
Length: 7 pp.
Concerning: Taxation of employee benefit plans
Background: This statement was submitted to the Subcommittee on Social Security and Subcommittee on Select Revenue Measures of the House Committee on Ways and Means for the record of a hearing on the taxation of employee benefit plans. This statement was previously submitted to the Senate Committee on Finance on July 31, 1984 (see statement 1984-23).
Drafters: Executive Director Stephen G. Kellison

Index Code: 1984-29
To: House Committee on Education and Labor
Date: September 20, 1984
Length: 7 pp.
Concerning: Age discrimination in employment
Background: This statement was submitted to the Subcommittee on Labor-Management Relations of the House Committee on Education and Labor for the record of a hearing on proposals of the Equal Employment Opportunity Commissioner (EEOC) to require pension accruals for service during deferred retirement. This statement was based on extracts of the Academy's submission to the EEOC on November 14, 1983 (see statement 1983-40).

Drafters: The Subcommittee on Single Employer Plans (Excluding Title IV) of the Pension Committee. The respective chairmen are Leroy B. Parks, Jr. and Willard A. Hartman. The statement was accompanied by a transmittal letter from Executive Director Stephen G. Kellison.

Index Code: 1984-30
To: Financial Accounting Standards Board
Date: September 20, 1984
Length: 1 pp.
Concerning: Accounting for health and welfare plans
Background: This letter was submitted in response to the Financial Accounting Standards Board Exposure Draft on Disclosure of Postretirement Health Care and Life Insurance Benefits Information dated July 3, 1984.
Drafters: The Subcommittee on Health and Welfare Plans of the Committee on Health. The respective chairmen are Thomas G. Nelson and Robert H. Dobson.

Index Code: 1984-31
To: House Committee on Education and Labor
Date: September 26, 1984
Length: 5 pp.
Concerning: Health and welfare benefit plan legislation
Background: This statement was submitted to the Subcommittee on Labor-Management Relations of the House Committee on Education and Labor for the record of a hearing on the need to extend participation, vesting, and funding standards to health and welfare plans.
Drafters: The Subcommittee on Health and Welfare Plans of the Committee on Health. The respective chairmen are Thomas G. Nelson and Robert H. Dobson.

Index Code: 1984-32
To: American Institute of Certified Public Accountants
Date: September 27, 1984
Length: 36 pp.
Concerning: Accounting for universal life
Background: This Discussion Memorandum on accounting for universal life was presented to the Non-Guaranteed Premium Task Force of the AICPA. Neither the accounting nor actuarial literature has addressed GAAP accounting for such products and a variety of practices have developed. This Discussion Memorandum evolved out of earlier work on accounting for single premium deferred annuities (see statement 1982-9).
Drafters: The Committee on Life Insurance Financial Reporting Principles, chaired by Virgil D. Wagner.

1984 ACADEMY STATEMENTS

Index Code: **1984-33**
To: Internal Revenue Service
Date: October 1, 1984
Length: 5 pp.
Concerning: Taxation of employee benefit plans
Background: This statement was submitted to the Internal Revenue Service in response to an invitation to comment on its regulatory agenda in the aftermath of the passage of the Deficit Reduction Act of 1984. The notice appeared in the Federal Register on August 22, 1984 (49 FR 33396). Two prior Academy statements on the taxation of group term life insurance made in 1983 were attached to the statement (see statements 1983-30 and 1983-37). Also, major portions of the statement were drawn from 1984 Congressional testimony on the taxation of employee benefit plans (see statements 1984-23 and 1984-28).
Drafters: Executive Director Stephen G. Kellison compiled the submission from prior Academy statements.

Index Code: **1984-34**
To: NAIC Standing Technical Actuarial (EX5) Task Force
Date: October 2, 1984
Length: 1 pp.
Concerning: Valuation standards
Background: This statement was submitted to the NAIC Standing Technical Actuarial (EX5) Task Force in connection with proposed changes in valuation standards for policies with cash values in excess of reserves.
Drafters: The Committee on Life Insurance, chaired by Richard S. Robertson.

Index Code: **1984-35**
To: Financial Accounting Standards Board
Date: October 19, 1984
Length: 13 pp.
Concerning: Accounting for health and welfare plans
Background: This background material containing data on postemployment health and welfare plans was submitted to the Financial Accounting Standards Board in response to a request for such information. This statement follows a prior letter submitted on September 20, 1984 (see statement 1984-30).
Drafters: President A. Norman Crowder, III.

Index Code: **1984-36**
To: Department of Labor
Date: November 12, 1984
Length: 4 pp.
Concerning: Health and welfare benefit plan legislation
Background: This statement was submitted to the Department of Labor in connection with its investigation involving possible congressional activity relating to health and welfare benefit plans. Attached to this statement was the Academy testimony on this subject on September 26, 1984 (see statement 1984-31).

Drafters: The Subcommittee on Health and Welfare Plans of the Committee on Health. The respective chairmen are Thomas G. Nelson and Robert H. Dobson.

Index Code: 1984-37
To: Financial Accounting Standards Board
Date: November 14, 1984
Length: 1 pp.
Concerning: Accounting for health and welfare plans
Background: This letter served as a transmittal of several items to the Financial Accounting Standards Board relating to its study of accounting for health and welfare plans. There were three attachments to the letter:

1. The document entitled "Summary Description of Post-Retirement Health and Welfare Valuation" attached to statement 1984-36.
2. Statement 1983-44.
3. Statement 1981-29

This statement follows two prior submissions to the FASB during 1984 (see statements 1984-30 and 1984-35).

Drafters: The Subcommittee on Health and Welfare Plans of the Committee on Health. The respective chairmen are Thomas G. Nelson and E. Paul Barnhart.

Index Code: 1984-38
To: NAIC Standing Technical Actuarial (EX5) Task Force
Date: December 8, 1984
Length: 12 pp.
Concerning: Valuation actuary
Background: This package of materials was presented at a meeting of the NAIC Standing Technical Actuarial (EX5) Task Force on the subject of valuation actuary. The cover page of the statement provides additional background information.
Drafters: The material and the presentations came from a variety of sources as described on the cover page of the statement.

Index Code: 1984-39
To: NAIC Technical Services (EX5) Subcommittee
Date: December 12, 1984
Length: 3 pp.
Concerning: Actuarial liaison with the NAIC
Background: This statement was presented at a public meeting of the NAIC Technical Services (EX5) Subcommittee and addresses the establishment of a more organized coordination between the NAIC and the actuarial profession.
Drafters: Executive Director Stephen G. Kellison

STATEMENT 1984-1

TESTIMONY OF
JAMES F. A. BIGGS, PAUL A. GEWIRTZ, WILLARD A. HARTMAN
FASB HEARINGS ON PENSION ACCOUNTING
NEW YORK, NEW YORK
JANUARY 12, 1984

BIGGS:
I am Jim Biggs. I am here in my capacity as chairman of the Committee on Pension Accounting Matters of the American Academy of Actuaries. With me to my direct left is Bill Hartman who is chairman of the Pension Committee of the Academy. On Bill's left is Joe Brownlee, who is a member of my Committee on Pension Accounting Matters, and on my right is Paul Gewirtz, who is also a member of the Committee.

As Don Kirk indicated, we are also appearing on the behalf of our sister organization, the Conference of Actuaries in Public Practice. Paul, as chairman of the Pension Committee of the Conference, will have some prepared remarks on the subject of disclosure on which his committee has done a great deal of work in the last couple of years. I know the Board is very interested in this project.

I would like to begin with a brief summary of the highlights of our written presentation. First, where the company and the plan are both expected to continue in existence, the committee believes that the primary focus of accounting should be the determination of pension cost allocable to the period. The disclosure of the funded or accrued status of the plan is also important and useful, but we regard it as secondary in those situations in which termination of the plan is not considered to be likely.

Furthermore, disclosure at a particular point in time can be quite misleading. I was interested this morning during another presentation in which there was a brief reference to the fact that if a company were able to terminate its pension plan and recapture substantial assets, that was certainly something that would be of great interest to the readers of the financial statements. I think it is interesting to note that under the accounting proposed in Preliminary Views, it would be perfectly possible to have the financial statement display a substantial net pension liability and yet have the pension plan terminated the day after the balance sheet date and have the corporation make a substantial recovery of surplus assets.

The next point I would make is that from our standpoint the pension transaction is a future-oriented exchange. And that from our standpoint, cost should drive liability and not vice versa.

Next, that pensions are a long-term undertaking. The value of a day, or an hour, or a year of service performed by an employee in exchange for the employer's pension commitment does not really vary widely from year to year. And neither, we believe, should the pension costs related to the performance of that service. We believe that an effort should be made to assess the total cost of the plan and that this total cost should be allocated in a rational, stable fashion. To put it another way, we do not think that the company should indicate that either it got a tremendous bargain on employee services in any one year or else that it had to pay two or three times as much

for employee services in any one year, just because of changes in the value of the pension fund.

We believe that comparability between companies at a point in time is certainly a desirable objective to the extent that it is truly obtainable. But this comparability should not be forced. Relevance of methods and assumptions to the particular plan, and the ability to compare the results of that plan over a period of years and to assess that plan's progress in meeting its funding or accrual target, we believe to be more important than comparability between companies at any point in time.

To the extent possible, we believe that financial statements should be both understandable and credible. We have doubts that the intangible asset and the measurement valuation allowance meet these tests. The MVA in particular, in serving its function as we see it in Preliminary Views as a cost smoothing device, tends to reduce both the validity and the usefulness of the net pension liability number which appears on the balance sheet.

We do not believe that the present system is seriously flawed. We think that pension cost, by and large, is now being determined in a rational and systematic manner by employers. We think it is quite possible that there should be some reduction or there could be some reduction in the permissible periods of amortization of past service costs. However, as I say, we believe that pension cost, in general, is being determined in a rational and systematic manner. Furthermore, with respect to unfunded liabilities, we believe that the present disclosure requirements certainly would call the attention of any knowledgeable reader of a financial statement to the fact there do exist significant termination liabilities. We think it is perfectly possible to improve disclosure. That is a subject that Paul will be addressing later on.

Finally, I would like to compliment the staff of the Board on the work that they have done on this project. They have been dealing with a very complex set of problems. I think they have attacked them from first principles and developed a very fine understanding. I think by their going back to first principles, it has caused a lot of us to go back to first principles; and perhaps view some of the problems in a different perspective than we have been accustomed to using in the past. I know that a number of members of the staff have been engaged in what you might term an outreach project. My own experience, in particular, in the last couple of years has been exposure to the appearances Tim Lucas has made at several meetings of various actuarial organizations. I would like to comment that it has been quite common for Tim in those situations to be facing an audience that was not necessarily hostile to him, but was certainly hostile to his views. He has handled himself in a manner which is courteous, friendly, professional, and persuasive. I think you, as his employer, should know that he has done an outstanding job in this outreach program.

With that, Paul will be speaking on the subject of disclosure. Bill will have some words on the subject of criteria for selection of actuarial cost methods.

GEWIRTZ:
As strictly a division of labor within the actuarial profession, the Conference of Actuaries in Public Practice, which is our consulting arm and in which I chair the Pension Committee, was asked two years ago by our Board of

Directors to develop pension disclosure as an alternative to more straight-jacketed pension accounting that was being discussed. We undertook this project and I am going to discuss with you briefly what we have achieved. Bill Hartman, after I am finished, will discuss another project that we undertook just six weeks ago, which was to determine the viability of developing guidelines and criteria to help the accounting world choose between one actuarial cost method and another by showing how actuaries go through the process. He will tell you something about our progress on this progress.

Going to disclosure, as an alternative to Preliminary Views, what we are here to do is to present it as a practical alternative. Simply because what we have heard is that most of the respondents are saying that Preliminary Views will not achieve the objectives that it set out to achieve without a big price to pay. On the one hand, we believe that the goal of comparability between companies is an achievable goal. On the other hand, we believe that it is illusory to think that Preliminary Views and a single actuarial cost method will achieve this goal, since assumptions prevent any real comparability, and also there are many other problems that you have heard about with Preliminary Views.

The practical consequences of imposing a single actuarial cost method for expensing as a way to achieve comparability have been demonstrated to be harmful to the private pension system in that funding will likely move in lock-step with the expensing whether you like it or not. To keep it simple, that is the way the corporate world will go. If additional contributions are to be called for to move up to the expensing, that might be considered a wasteful use of corporate dollars. If expensing were to be lower than what the company has recommended as a contribution, they will probably drop downward and that will be a short-changing of the plan. Either way there are harmful consequences and the goal of achieving comparability has a big pricetag connected to it. We believe, though, that expanded disclosure of certain items can increase comparability and understandability without any harmful effects at all. The purpose of disclosure is to help diagnose comparability between companies.

Now we understand there is a precedent in accounting to allow choices in accounting methods, so long as these methods are rational and systematic, and provided that there is a way for analysts to judge comparability through disclosure in the financial statements. For example, I am told that companies can choose routinely between LIFO and FIFO accounting, and that a trained analyst can, in fact, gauge the effect of the other method simply by examining the financial statements for certain tell-tale signs. Also we are told that the choice between straight line and accelerated depreciation is permitted, and that a trained analyst there also can ferret out the comparative effects by going to certain items in the financial statement. We think that we in the actuarial profession can help assemble a sufficient amount of pension disclosure that will serve as an effective diagnostic tool for comparability.

Now, two years ago we set out on this project in developing what for the actuarial profession would be a standard for pension disclosure. We had no intention to impose it on the rest of the world, nor could we if we wanted to. What we arrived at we submitted to the Board, and when you read through it, we are the first ones to agree that what we have there is double or triple what

you need in the way of disclosure to do the job. It was set up originally as a standard by the actuarial profession for inquisitive actuaries who probably were going through an acquisition-type assignment for a client. That would be the level of disclosure that the actuary would like to have available, if he were to do an effective job. But you can do the job with only half the amount that we were recommending. Now we recognize when we came up with what we did, that some of what we suggested would be very controversial in the business world. When we circulated this disclosure standard among the actuarial profession, 5000 of us, we got an overwhelming supportive response, between 75% and 90% of the respondents were supportive item by item, question by question, of what we recommended.

We believe that disclosure should help a trained analyst to better assess future cash flows of a company. We believe that better disclosure should help identify if games are being played or manipulation is occurring. Now, what are some of the items that we would recommend, not necessarily as a minimum standard, but as a reasonable series of items that would acheive this end? Let me list a few of them.

One item is to have the company disclose the pension expense under a standard actuarial cost method. Not just what it is actually expensing, but a standard method. And in terms of a cost-benefit analysis, what would be the cheapest way to achieve this?

Should every company disclose what its pension expense under the aggregate cost method would be for each of the last three years, both as a dollar amount and as a percentage of covered payroll? Also, disclosed would be the actual amount it expensed in the last three years, both as the dollar amount and as a percentage of covered payroll. In addition, whatever it funded in the last three years, both as a dollar amount and as a percentage of covered payroll, would also be disclosed. The actuarial cost method used for expensing would be identified in each of those years, and if it changed, what it changed from and to. The same information would be disclosed for the actuarial cost method used for funding in each of those years. As well, we recommended that the economic assumptions, the interest rate, and salary scale used for each of these three pension expense or funding amounts for each of the years be disclosed. This is a very controversial point because it means disclosing the interest rate and the salary scale. A suggestion we have heard as a reasonable alternative to disclosing interest rate and salary scale might be to disclose simply the spread between the numbers without giving away what the actual salary scale was, so that we do not have a bargaining problem with unions.

Also, disclosure would be provided of the different tiers, different levels, of obligations that a company has i.e. vested benefit obligations, accumulated FASB No. 36 obligations, and the same amount with a salary scale. All three levels would be disclosed, as well as the market value of assets, as well as the ratio of assets to each one of those liability items for each of the three years. So we can see how the progress of the coverage of obligations has been achieved in the last three years. Now, why will this amount of disclosure help achieve, or how will it help achieve comparability?

If a company has revealed that its actual expense charge has been rising in each year, a statement would be disclosed as to the nature of the pension

plan. If it is pay-related, whether final pay or career pay, or whether it's a dollar-a-month plan, and a simple statement of the average age and average service of the covered work force. Now how will this achieve comparability?

If the numbers show that the pension charge as a percentage of payroll has been rising in each of the last three years, the trained analyst will have access to the nature of the method and will understand whether by itself it rises over time or falls over time. If it is one that purports to be level over time, he can then look at the aggregate cost method which is also disclosed and see whether the cost disclosed under that method is substantially different from the actual charge put on the books. If the assumptions used have not been achieved in practice, the trend in the cost as a percentage of payroll will mirror the experience of the plan over that period of time. There are a variety of clues from even the simple charts of disclosure that will give a trained analyst the ability to pierce through the numbers and to assess where the costs of this plan are likely to go, both in cash funding amounts as well as in expense charges, over the years to come.

Now, some have said that to have this kind of disclosure requires overcoming some very practical problems if a company has more than one pension plan. So we come to the problem of aggregation for disclosure purposes. We think that is a practical implementation issue, but it is achievable. We have a few examples of how it can be done quite simply. For example, we have suggested that all of the pension plans of a particular company, be it one or several dozen, be recast in terms of percentage of payroll under the aggregate method. We then simply take the weighted average of all the various percent of payroll amounts that are developed and we then have a single weighted average percentage of payroll charged under the aggregate method for all the plans domestically and world-wide. For the dollar amounts that are charged, just add them up.

Actuarial assumptions, how do you aggregate those? Interest rates could be weighted averaged worldwide if they are different in different countries or different subsidiaries. So, too, could salary scales be weighted averaged by a proportion of pension expense. For obligations, vested, accrued, or accrued with a salary scale, simply add them up. The dollar amounts are no problem if added, and the percentage of payroll amounts can be weighted averaged. If pension costs are material to a particular company's operation, more expanded disclosure is called for. If pension costs are immaterial to a particular company in the aggregate, then less disclosure is necessary.

Now, what have we done here? What we have done is to show that it is possible to create a wheel. A lot of people have suggested that disclosure is the root. We have shown how it can be done, but what we have come up with is not the only wheel. We have created one wheel; we can help create another wheel. We recommend to the Board that the process can be re-started, and coming up with this approach is an alternative to Preliminary Views, and that the actuarial profession stands ready to serve on an advisory basis to the FASB in its efforts.

Now, Bill Hartman has some comments to make on the viability of selecting guidelines for choosing between actuarial cost methods.

HARTMAN:
We have at present two families of cost methods now in use; the benefit allocation and the cost allocation methods. Since APB No. 8, considerable narrowing has already occurred. Most plans use one of the IRS-sanctioned methods, and under the IRS regulations they have eliminated many of the methods and narrowed the applications within methods. Differences in pension expense among most of the methods is relatively small and generally less than 15%. If the Board narrows the amortization period from 40 years to something less, in general, these differences in pension expense would be further narrowed.

Actuaries choose methods based on facts and circumstances; such as the maturity of the company, the plan provisions themselves, whether the plan is over-provided or under-provided, the likely length of the future operation of the sponsor, the type of industry that is sponsoring the plan, the nature of the business, i.e. whether it is service-oriented or a product-oriented manufacturer, and other factors. We support the continued flexibility in the choice of actuarial cost method. The actuarial profession can develop criteria for selecting the cost method, but this project, under our procedures, would require internal exposure, time for comments, analysis, and restructure. We offer to do that.

STATEMENT 1984-2

Mr. Neil W. Zyskind
Legislation and Regulations Division
Office of the Chief Counsel
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

RE: IRS public hearing, January 12, 1984, on revision of actuarial tables and interest factors (LR-85-80)

Dear Mr. Zyskind:

The purpose of this letter is to comment on the proposed regulations relating to tables for valuing annuities, life estates, terms for years, remainders, and reversions for purposes of federal income, estate, and gift taxation which appeared in the Federal Register on October 31, 1983 (48 FR 50087-50111). We apologize for not providing these comments to you by your requested date of December 30, 1983.

By way of background, the American Academy of Actuaries is a professional organization of approximately 7400 qualified actuaries who practice in all areas of specialization - life and health insurance, property and liability insurance, and pensions and employee benefit plans. The Academy deals with public policy issues involving actuarial considerations. The proposed regulations in question do involve substantive actuarial content.

In particular, the proposed regulations contain extensive actuarial tables based on an assumed mortality table and an assumed rate of interest. These tables replace tables which have been in effect for a good many years. In particular, the proposed tables would be based on a 10% rate of interest instead of 6% and a unisex mortality table instead of a sex-based mortality table.

We note in the prefatory material to the proposed regulations the following:

> "The Internal Revenue Service will periodically reexamine the interest rates contained in the regulations, and if necessary revise them, so as to correlate the regulatory rate to the market rate."

We applaud this statement of intent by the IRS to base its tables on a current interest rate. However, we would note that it is equally important that the tables be based on a current mortality table as well. The values in the tables are also sensitive to changes in the mortality table used.

The use of actuarial tables to compute certain values required in the tax code is quite appropriate, but may appear arcane or even obscure to many taxpayers. Maximum credibilty will be achieved if taxpayers perceive that the tables are based on current interest and mortality factors rather than ones that may appear obsolete. Such credibility should be a public policy objective of the IRS.

This is not an insignificant point, since the IRS has been slow to update these tables in the past. We would encourage the IRS to review not only the interest rate assumed but also the mortality table used on a periodic basis every few years. This will ensure that the tables will be kept current in perception as well as in fact.

The American Academy of Actuaries would be pleased to be of assistance to you in any way we can in connection with these proposed regulations. We appreciate your consideration of our comments.

Yours truly,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-2

Mr. Neil W. Zyskind
Legislation and Regulations Division
Office of the Chief Counsel
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

RE: Supplementary comments on IRS public hearing, January 12, 1984, on revision of actuarial tables and interest factors (LR-85-80)

Dear Mr. Zyskind:

It was a pleasure meeting you at the above-noted IRS public hearing. The purpose of this letter is to supplement my earlier letter addressing the desirability of using up-to-date mortality tables with some further observations on the interest rate to be used in these regulations.

First, the suggestion was made at the public hearing to move away from a fixed rate to a variable rate determined on a "facts and circumstances" basis. In my opinion, such an approach would create such an enormous multiplicity of actuarial tables and create such uncertainty and confusion among taxpayers affected by these regulations that it is simply not a practical approach. Furthermore, the interest rate used is not the only arbitrary factor, the mortality table assumed is also arbitrary.

Second, we call attention to two extracts from the prefatory material to the proposed regulations:

- "The proposed regulations contain tables based on a 10 percent discount and income factor. This percentage rate reflects the average annual rate paid on U.S. Government obligations of 10 year maturity rounded to the nearest whole percent."

- "The Internal Revenue Service will periodically reexamine the rates contained in the regulations, and if necessary revise them, so as to correlate the regulatory rate to the market rate."

Although we concur that it is not unreasonable for the IRS to want to use an interest rate which bears a reasonable relationship to market rates of interest, these extracts may imply a more direct linkage than is desirable. For example, interest rates have been increasingly volatile in recent years. The rate on "U.S. government obligations of 10 year maturity rounded to the nearest whole percent" could change several times in one year. Obviously, no one wants to have the rate change that often. As a second example, if the rate is set by the stated procedure at a point in time for which this market rate is abnormally high or low and then that rate is used for an extended period, a distortion will have been introduced.

One way of avoiding these types of problems is to average interest rates over a period of time. This approach will create interest rates that are much more stable and change more gradually. It also avoids the arbitrariness of using a sole point in time as the reference point. Since there is a wide range of interest rates being earned by different trusts at the same point in time and by the same trust over different periods of time, a more stable average rate would seem to have many advantages over a more volatile rate based on one type of investment at one specific point in time.

We hope these additional comments are useful to you. As before, we would be pleased to be of further assistance to you in connection with these proposed regulations.

Yours truly,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-3

February 7, 1984

The Honorable Don Nickles
713 Senate Hart Office Building
Washington, D.C. 20510

Dear Senator Nickles:

At the request of W. Bret Bernhardt of your staff, members of the American Academy of Actuaries have undertaken an analysis of your proposed alteration of the Congressional retirement system. Your proposal would substitute a new defined contribution plan for the defined benefit plan which is currently in use.

In addition, the Academy was requested to review and critically analyze a study prepared by the National Taxpayers Union on the current Congressional retirement system. The Academy analysis of the NTU study, as well as our comments on your proposal, are attached in the enclosed document, which was prepared by the Academy's Pension Subcommittee on Single Employer Plans (Excluding Title IV), chaired by Leroy B. Parks, Jr.

On behalf of the Subcommittee, please accept our thanks for providing an opportunity to be of service to you in this matter. We are of course prepared to respond to any inquiries which you or your staff might have regarding our comments, and we look forward to continue working closely with you on this or any other subject which raises issues of actuarial concern.

Sincerely,

Gary D. Simms
General Counsel

STATEMENT 1984-3

RESPONSE TO
SENATOR NICKLES REGARDING
CONGRESSIONAL RETIREMENT PLAN FROM
AMERICAN ACADEMY OF ACTUARIES PENSION COMMITTEE
SUBCOMMITTEE ON SINGLE EMPLOYER PLANS (EXCLUDING TITLE IV)

A. INTRODUCTION

The American Academy of Actuaries has been requested by the staff of Senator Nickles (R-OK), Chairman of the Labor Subcommittee of the Senate Committee on Labor and Human Resources, to provide an analysis of two items relating to the Congressional Retirement System (CRS). First, he is seeking a review of the study undertaken by the National Taxpayers Union (NTU) which criticizes the current CRS. Second, he is requesting comments on the bill that he introduced in the Senate which would convert the present system from a defined benefit pension plan to a defined contribution plan.

Before presenting our commentary regarding the two areas of consideration, we would like to make the following preliminary observations:

(1) In general, the members of the Subcommittee derive more income from defined benefit pension plan activities than from work in the area of defined contribution plans. Long-term changes of retirement programs from defined benefit pension plans to defined contribution plans would serve to reduce our income. Therefore, we have a possible conflict of interest in commenting on the Senator's bill.

(2) We believe that a thorough study of the CRS would be most appropriate before implementing changes. Such a study should consider a determination of the objectives for retiring members of Congress, and an examination of the current and proposed plans relative to those objectives.

The Subcommittee would be pleased to review this response with members of Congress and their staffs, and to further assist in a thoughtful analysis of the complex issues involved.

B. BACKGROUND

The present Congressional Retirement System is a defined benefit pension plan whereby the benefits payable under the plan are determined by a formula that recognizes the salary and service of a member. The benefit formula is 2.5% of the member's highest three-year average annual pay multiplied by the years of Congressional service (plus certain military service). Additional benefit credit is granted, at a lesser accrual rate, for other government service.

The member is required to contribute 8% of pay in order to be eligible for the CRS, with the remainder of the cost of the plan paid by contributions from general revenues and investment earnings on amounts contributed. The plan provides for unreduced benefits payable as early as age 60, with reduced early retirement benefits available below that age using a 2% per year early

retirement reduction factor. The plan also provides for post-retirement pension increases based upon the changes in cost-of-living.

C. ANALYSIS OF NATIONAL TAXPAYERS UNION STUDY

The study prepared last year by the NTU developed the estimated benefit under the CRS for all members of Congress who will have vested rights under the plan at the completion of their current term of office. The study then determines the anticipated aggregate payout during the retired lifetime of each member, and compares these amounts to the benefits received from a private sector pension plan. Although we believe that much of the underlying analysis and assumptions that were incorporated in study are reasonable, we feel that the conclusions and presentation of results may not represent an impartial, scholarly analysis of the CRS.

The following eight points support this contention:

(1) The headlines of the news release dated October 16, 1983 from the NTU indicate that its study shows 36 potential "pension millionaires" in Congress. The NTU definition of a "pension millionaire" is any individual who expects to receive in the future accumulated pension benefits totalling at least $1 million. We would not define millionaires as people who expect an increasing stream of payments which total $1 million. As one analogy, an individual who begins work today at age 25 at the pay level of $1,000 per month, can expect to receive in excess of $1 million in wages before he reaches age 60, if his salary increases by 5% per year. Since we would not describe this individual a "working millionaire," we cannot accept the NTU definition of a "pension millionaire."

(2) The NTU release further notes that members of Congress "quietly accumulate hundreds of thousands, if not millions, of dollars in pension benefits." This observation inaccurately describes the operation of a defined benefit pension plan. In point of fact, no specific monies are accumulated on behalf of any member. Instead, the member accrues a right to future benefit payments. The amount of benefits he will actually receive after he retires depends upon the length of his retired lifetime and the cost-of-living adjustments made to future payments.

(3) The NTU study indicates that the Civil Service Retirement System (CSRS), which includes Congressional members, has accumulated an unfunded liability of over $500 billion. No mention is made as to the unfunded liability with respect to the CRS alone, but it is likely that such amount is only a minuscule portion of the entire liability for CSRS.

(4) The NTU study states that "over 85% of funds for the Civil Service Retirement System comes out of the general revenue." Based upon the current 8% contribution rate for members, we would have reason to doubt that the taxpayers are bearing 85% of the cost of the CRS as is implied by the above quote. The funding of a contributory defined benefit pension plan comes from four sources:

(1) employee contribution; (2) investment earnings on employee contributions; (3); employer contributions; and (4) investment earnings on employer contributions. We have examined the cost of providing the retirement benefits under the CRS for several hypothetical members. This analysis assumes: a 5% per year pay increase before retirement; a 5% per year pension increase after retirement; a 7% per year investment return; and a standard mortality table (GAM 1971) for post-retirement mortality. Employer contributions are calculated as the required level percentage of pay during the working lifetime of the member. Considering the example of a longer-service member who spends 30 years in Congress retiring at age 65, we find that the cost of providing his benefit is allocated as follows:

Employee contributions	14%
Investment earnings on employee contributions	12
Employer contributions (from general revenue)	40
Investment earnings on employer contributions	34

(5) The NTU study develops figures based upon the assumption that each vested member of Congress will step down at the end of his current term. This assumption exacerbates the effect of the generous early retirement provisions of the CRS. It also overstates the future payments that members may expect from the plan.

(6) The NTU study presents a comparison of benefits provided under the CRS with those generated under a "typical generous private sector pension plan." The latter plan was selected from a study prepared by the Bankers Trust Company (Bankers) entitled "Corporate Pension Plan Study: A Guide for the 1980's." We have identified the plan used in the comparison. The Bankers study for a hypothetical individual with final year's compensation of $50,000 indicates a combined private pension plus Social Security benefit equal to 80% of the final year's compensation, the highest such percentage in the survey. However, our calculations would indicate that the correct percentage is approximately 55%. Thus, the plan selected was not actually the most generous pension coverage for individuals with salaries of $50,000, as indicated in the NTU study.

In addition, we feel that the comparisons made which involved this plan distorts the true relationship between the CRS and the private pension plan for the following reasons:

(a) The private pension plan selected for comparison is sponsored by a Fortune 500 industrial company and provides a career average formula which was updated in 1979 to reflect the average of the five highest consecutive years of pay for years of credit prior to 1979. Thus, the plan as it was considered in the Bankers study as of January 1, 1980, basically represents a final pay plan with respect to participants retiring on that date. However, the plan as considered in the NTU study was based upon the average pay from 1975 to 1979, plus career

compensation from January 1, 1980 until assumed future retirement date.

(b) The Bankers study indicates that the significant majority of plans included in the survey (approximately 80%) provide for a full accrued pension at some early retirement date prior to age 65. The plan selected, however, was one of the few that did not provide for unreduced early retirement benefits. Therefore, the selected plan is not indicative of a typical generous private pension plan when used in comparisons involving individuals retiring prior to age 65.

(c) The comparison of expected aggregate future benefits from the CRS and the private plan does not include an interest discount for future payments. This not only over-inflates the current worth of the anticipated benefits under both plans, but also exaggerates the difference between the two plans as a result of the assumed cost-of-living increase for the CRS. The assumption that the pensions under the CRS will increase by 5% each year means that a member's expected monthly pension will double in size in approximately 14 years. Many of the members included in the study have anticipated periods of retirement in excess of 30 years. Thus, the comparison for such individuals includes a consideration of CRS benefits that have increased several-fold versus an assumed constant benefit payable from the private plan, with only the Social Security pension subject to the 5% increase.

(d) The benefit comparison does not attempt to reflect the fact that the majority of private pension plans proved for periodic ad hoc increases to pensioners. In fact, the private plan under consideration granted increases to pensioners effective January 1, 1978 which provided for benefit improvements of 30% for all those retiring prior to 1974. This plan also provided increases in 1980 and again in 1984.

(7) The NTU study does not give due consideration to the fact that the members of the CRS contribute toward the cost of their pension. The substantial majority of private pension plans, including the one used for comparison, do not require or allow for employee contributions. However, employees do contribute to the cost of their Social Security benefits. The fact that a member makes contributions toward his CRS benefits would justify a more generous plan than would be the case under a non-contributory arrangement.

(8) Finally, it should be pointed out that the majority of major corporations provide additional deferred compensation arrangements, over and above the usual defined benefit pension plans. Such arrangements usually take the form of a thrift/savings plan or a profit-sharing plan. In fact, the company sponsoring the pension plan used in the NTU study provides a companion savings and investment plan which features matching employer contributions. In order to properly assess and compare the overall

generosity of various retirement programs, it would clearly be necessary to consider all components of the retirement benefit package.

D. COMMENT ON CONGRESSIONAL RETIREMENT REFORM ACT OF 1983

The proposed bill introduced by Senator Nickles would provide for the replacement of the current plan with a defined contribution plan requiring an 8% of pay contribution from members and a 100% matching contribution from General Revenue. In general, such a conversion should only be considered after the objectives of the CRS have been established and a determination made as to whether or not the current type of plan or a defined contribution plan can best meet those objectives. The Employee Benefit Research Institute recently published a booklet entitled "Economic Survival in Retirement: Which Pension is for You?" that contains extensive discussion and comparison of defined contribution plans. A review and understanding of this subject would indeed be worthwhile.

We would like to make the following specific observations for your consideration regarding the proposed Bill:

(1) Based upon the assumptions indicated in Item (4) of Section C, the proposed plan would accumulate a fund (ignoring the effect of taxes) that could purchase a level pension at age 65 (for a member with 30 years of service) equal to approximately 75% of final pay. On the other hand, the current CRS plan generates an initial benefit of 71% of such pay, with the benefit linked to the Consumer Price Index. In general, for members with less than 30 years of service the proposed plan would provide smaller benefits. Even for members with 30 or more years of service the post-retirement cost of living increases of the current CRS plan will provide higher total benefits. Of course, the relative values of the present and proposed plans are a function of many factors, including the rate of pay increases to Congressmen and the actual earnings of the assets of the defined contribution plan.

(2) The conversion of a plan from a defined benefit to a defined contribution basis can produce equity and adequacy problems with respect to those individuals affected by the change. Clarifying language would be necessary to provide a smooth transition from the current to the proposed plan.

(3) The establishment of individual retirement accounts for each participating member would give each Congressman the possible investment authority over potentially large sums of money. Consideration might be warranted to establish a procedure that would avoid the possible appearance of a conflict of interest.

(4) The proposal appears to allow for tax deductible contributions to an IRA by members of 8% of pay. Thus Congressmen would be deferring tax on income in excess of $5,000 per year at current pay levels. This seems inconsistent with the current maximum on IRA contributions for other taxpayers of $2,000 ($2,250 for married individuals with non-working spouses).

E. GENERAL CONSIDERATIONS REGARDING CONGRESSIONAL RETIREMENT SYSTEM

Before considering a change in the current CRS, it would seem essential to reflect upon the objectives that the plan is trying to achieve. A major consideration in designing the benefit level of a pension plan is usually the intent of providing a pension for career employees which, together with other sources of retirement income, would result in a total income at retirement sufficient to enable the maintenance of the standard of living enjoyed prior to retirement. A final salary pension plan, such as the CRS, is a usual device for achieving this objective. The recent President's Commission on Pension Policy gave considerable attention to this subject, and its report provides useful information regarding this matter.

As a result of our review of the current CRS, we feel that it is a very generous pension program. The major components contributing to the liberalness are:

(1) The benefit accrual rate of 2.5% of pay for each year of service, which compares to rates in many private pension plans that are usually under 2.0%.

(2) The liberal provisions with respect to early retirements, whereby members leaving Congress after age 60 suffer no reduction in their benefits. Those who leave prior to that age experience only a modest benefit cutback.

(3) The cost-of-living adjustment feature that provides for automatic increases in the benefit payable during the retired lifetime of the member.

Some areas of the CRS that might warrant review include the following:

(1) The new requirement of extended Social Security coverage to future Congressmen should be reflected in any modification of plan design, both with respect to contributions and benefits.

(2) The justification of the very liberal early retirement feature should be considered, and reaffirmed or changed.

(3) The desirability or necessity of automatic cost-of-living adjustments should be re-examined.

Pension Committee
Willard A. Hartman, Chairman

Subcommittee on Single Employer Plans (Excluding ERISA Title IV)
Leroy B. Parks, Jr., Chairman
Jan R. Harrington, Vice Chairman - Legislation
Allan B. Keith, Vice Chairman - Regulations

Jeffrey F. Hartman
Albert L. Hess
Brian W. Kruse
John B. Thompson
Robert D. Thompson
Larry D. Zimpleman
Paul R. Zwilling

STATEMENT 1984-4

February 13, 1984

Mr. Brian Zell
Manager, Auditing Standards Division
American Institute of Certified Public Accountants
1211 Avenue of the Americas
New York, NY 10036-8775

Re: File Reference No. 3140; Preliminary Draft Issues Paper on Accounting for SPDA's

Dear Mr. Zell:

As you know, certain members of the American Academy of Actuaries Committee on Life Insurance Financial Reporting Principles ("The Committee") have been involved in the development and drafting of the proposed paper on SPDA's developed by the AICPA Nonguaranteed-Premium Products Task Force ("The Task Force"). The purpose of this letter is to clarify the relationship of the Committee to this paper and to provide the Committee's preliminary comments on the July 20 draft of the issues paper. We understand that the issues involved are primarily matters of accounting principle, but the proposals contain significant actuarial implications. We have attempted to restrict our comments to those actuarial and related areas which are most affected by the paper's preliminary conclusions.

The Committee's Relationship to the Issues Paper

It is our understanding that your Task Force was initially charged with investigating accounting practices with respect to non-guaranteed premium life policies and, ultimately accounting for universal life. Concurrently, our Committee also was studying these matters and had prepared various papers in this regard. One, that on non-guaranteed premiums, has been adopted by the American Academy of Actuaries as a financial reporting guideline. We understand that it also has been included as a reference in The Task Force's draft issues paper on this subject.

Another Committee paper, a preliminary paper on accounting for SPDA's, served as the original basis for the present SPDA Draft Issues Paper. This original paper was prepared by The Committee as an initial step in its study of the issues related to accounting for universal life and was not intended as a stand-alone paper. The Committee had no plans, and has no current plans, to adopt actuarial guidance with respect to determining GAAP reserves for SPDA's. Thus, while The Task Force has utilized The Committee's original paper with our concurrence, you should understand that it was prepared for a purpose different than is now intended.

The Task Force's use of the paper was accomplished by the overlapping membership with The Committee. Specifically, three members of The Committee have served as Technical Advisors to the Task Force. As the paper originated in The Committee, it was only logical that subsequent

drafting be completed by these same Committee members. However, as a result, while certain Committee members were heavily involved in the preparation of the present Draft Issues Paper, you should be aware that the paper does not agree with the conclusions of the Committee's original paper, nor does it necessarily reflect the consensus of the Committee at this time. The Committee's original paper permitted a much broader range of accounting practices, and it is the purpose of this letter to give you the Committee's specific comments concerning the present Draft Issues Paper.

General Matters

The Draft Issues Paper seeks to narrow the broad range of accounting practices currently being follwed. In addition, it may be intended to present those practices perceived as abusive by the accounting profession. In both instances, the industry's fairly wide knowledge of the paper's conclusions may have already substantially accomplished these objectives. Further benefits to be derived from quickly adopting these conclusions may be minor. In fact, rapid acceptance of these recommendations, without the benefit of a sufficient analysis of their impact on, and relationship to, the accounting practices to be adopted with universal life, could cause considerable difficulties. The Committee believes that, under the circumstances, it is desirable to delay further considerations of these SPDA proposals until comparable progress is made in analyzing the accounting alternatives of the other forms of new products, primarily universal life. This would permit the development of consistent accounting methods for all products and avoid the confusion which could be caused by issuing accounting guidance on a product-by-product basis.

The preliminary conclusion states that the proper accounting for SPDA's should result in no gain or loss at the issuance of the contract (except for the effect of non-deferrable acquisition costs). This conclusion may be shown to be consistent with income recognition principles established by the accounting profession, but it is not necessarily required by actuarial principles or theory. Actuaries routinely estimate the future effects of current transactions, such as the sale of an annuity contract, and determine the related total benefit or cost. From an actuarial perspective, reporting all, or a portion, of the total expected gain or loss at issue may not be inappropriate in certain circumstances, for example, where investment risk has been minimized. As a consequence, it appears unlikely that these proposals can be supported by reference to accepted actuarial methods, procedures, or principles.

The application of actuarial techniques and procedures can result in reporting income in a wide variety of patterns during the lifetime of a block of business. Methods can be used which result in reporting virtually all future profits when the contract is issued. Methods which result in deferring the recognition of all income until the last policy terminates also can be developed, although no one would suggest that such a stream of reporting income is appropriate. Given the remaining range of reasonable income patterns, the preliminary conclusions seem to favor the conservative end of the spectrum.

The proposal seems to ignore the effort required to sell annuity contracts and, in any event, we question the desirability of adopting accounting principles which result in reporting income in an excessively conservative manner.

Finally, the insurance industry markets a tremendous variety of products. No two products, even if they are both "ordinary life", are the same, and each company's sales force, market, administration, investment practices--in fact, every facet of a company's operations--cause their experience to be unique. The existing accounting principles embodied in FASB 60 permit management to exercise a considerable amount of judgment in the application of GAAP to the insurance industry. Appropriately, this permits management to adopt reporting practices which it believes are most consistent with the characteristics and risks of their particular products and operations. The SPDA proposal would eliminate most, if not all, of this managerial perogative. The Committee believes that this result is undesirable and, in fact, unworkable in an environment where product innovations and variations are the rule.

Comments on Specific Matters

Due to the nature of the paper, we have few comments on specific issues. The broader, conceptual concerns are more important and are easily grasped. Nonetheless, we offer the following specific comments for your review and consideration.

First, the paper refers to a "no gain or loss at issue" situation in several instances. It is not always made clear that this situation does not consider the loss related to expensing non-deferrable acquisition costs when incurred. We suggest that all references to "no gain or loss" indicate that this is prior to consideration of non-deferrable acquisition costs.

Paragraphs 16 and 17 discuss certain reasons which support the use of the various accounting practices. As the persistency risk and related capital loss/liquidity risks are significant, we believe that concern about these risks should be added to paragraph 17.

The final paragraph indicates that existing guidance concerning loss recognition remains applicable. In view of the nature of this product and the related risks, we believe that expanded guidance in this area should be considered in those cases where SPDA's are material to a company's operations. Issues which could be addressed include, but may not be limited to, matters such as:

- Whether the SPDA business should be separately identified as a line of business for recoverability and loss recognition purposes.

- Whether the formal or informal segregation or allocation of assets to the product line should be encouraged or required.

- The need to consider completing loss recognition tests more frequently as the effect of adverse experience, even if minor, is more significant and the possibility of favorable experience may be more remote.

Our final comments concern the only two major omissions which we have noted. The first is, how will these conclusions, if adopted, be implemented? Implementation problems would appear to be significant, with neither retrospective nor prospective application particularly appealing. Thus, while it may be unfair to request such guidance, it does appear that a position should be taken.

The second matter concerns disclosure of the practices and procedures which are being used. Whether or not these proposals are adopted, we believe that financial statements would be more meaningful, and that a greater degree of comparability would be achieved, by increasing the disclosures related to SPDA accounting policies. If the proposals are adopted, we believe it would be desirable to clearly disclose all assumptions used in applying the prospective practice. With respect to the retrospective practice, all assumptions used in the determination of the deferred acquisition cost amortization schedule should be disclosed.

The Committee appreciates the close working relationship we have enjoyed with The Task Force in the past and look forward to a continuing relationship. Joint efforts are certainly desirable and are likely to be more productive. Unfortunately, however, the extensive involvement of The Committee members may occasionally impair the ability of The Committee itself to provide its comments. Given the circumstances, we considered it necessary to document our position and hope that The Task Force will accept these comments as the constructive suggestions they were intended to be.

Sincerely,

Virgil D. Wagner

Virgil D. Wagner
Chairman, Committee on Life Insurance
Financial Reporting Principles

STATEMENT 1984-5

COMMENTS OF JEROME A. SCHEIBL, CHAIRMAN
AMERICAN ACADEMY OF ACTUARIES
COMMITTEE ON PROPERTY AND LIABILITY INSURANCE
BEFORE THE NAIC TASK FORCE ON INVESTMENT INCOME
MARCH 7, 1984

My name is Jerry Scheibl. I am appearing on behalf of the Property and Liability Committee of the American Academy of Actuaries which I chair.

The Academy consists of over 7,000 members specializing in all lines of insurance. Its members are employed by insurance organizations, governmental agencies, academic institutions, or as consultants to insurers, insurance buyers and other clients.

The Property and Liability Committee is one of the Academy's public service committees. It is charged with monitoring legislative and regulatory activities in the property and liability area. It also prepares statements on these issues consistent with certain Academy purposes which are:

- To establish, promote and maintain high standards of competence, conduct and practice within the actuarial profession,
- To stimulate and encourage the advancement of the knowledge and the methods of practice in the actuarial profession, and
- To encourage and promote a greater public understanding of the nature and scope of actuarial science.

The integrity of insurance pricing and rate making is among the foremost concerns of professional actuaries. Crucial to such integrity is the realistic anticipation of income from the sale of insurance products. Income can arise in several forms and in some cases, investment income is the key component in the evaluation of anticipated income from all sources.

While total return is a fundamental concern in the proper pricing of insurance products, there are several ways in which such return - both projected and actual - can be reflected in the pricing process. In a well-functioning market, the demands of the marketplace and the need to maintain financial strength are often the most effective controls on the range of total returns anticipated in pricing by each individual insurer.

The role of an insurance rate in determining a policy premium varies by type of insurance and coverage. For some types, premiums are determined directly from manual rates. In other cases - especially in some of the commercial lines - more elaborate methods are followed to determine premiums from manual rates.

Expected total return is a consideration in determining acceptability of risk under both kinds of cases. However, it takes on an additional role as a factor in the process of ascertaining policy premiums from manual rates in many cases where the more elaborate pricing methods apply.

There are a number of ways of reflecting the total return needs of an insurer and, hence, its underwriting and investment income needs in policy

premiums. However, there is no single "best" procedure or method receiving consensus approval within our profession. Perhaps this is because there is no agreement that pricing and rate-making methods should be locked into fixed formulas that ignore the peculiarities of the different lines and types of coverages and the various entrepreneurial risks associated with different markets.

Our committee has not done an in-depth review of this exposure draft. Therefore, this statement is intended as neither an endorsement nor a criticism of any of the specific techniques or analyses presented in this report.

We recognize that regulators should be concerned about their responsibilities under various rating laws. We believe, however, that focus on any particular element of the rate-making process without recognizing its role as only one of the many elements in the ultimate underwriting and pricing of insurance product may only detract from assuring that rates are consistent with the standards set forth in state laws and with the needs of the marketplace.

I am sure I speak for the entire actuarial profession when I say that we stand ready to assist regulators in meeting their statutory obligations in any way we can. I submit that such actuarial assistance is not only desirable but essential.

Thank you for allowing me to express our committee's thoughts on this subject.

STATEMENT 1984-6

March 8, 1984

Mr. Edward A. Densmore
Deputy Director
Human Resources Division
General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Densmore:

The American Academy of Actuaries Committee on Social Insurance recently met to consider the study undertaken by your office entitled "Social Security Actuarial Projections" (GAO/HRD-83-92, September 30, 1983). At their request, I wish to forward to you the Academy's appreciation for GAO's recognition of the importance of actuarial projections in the financing of the Social Security system.

No single actuarial projection utilized for Social Security planning purposes can, by definition, be presumed to be accurate over a 75-year period. However, we believe that the system of providing a range of three or more actuarial projections using assumptions ranging from optimistic to pessimistic has proven to be an effective diagnostic tool for measuring the financial condition of the system. We further believe that the importance of actuarial projections was clearly demonstrated during the Congressional debate leading up to the Social Security Amendments Act of 1983 (P.L. 98-21) and served as a necessary catalyst for the changes eventually enacted into law.

We further believe that independence of the Office of the Actuary within the Social Security Administration is essential if unbiased and professionally responsible actuarial projections are to continue. Without taking a position on whether the Chief Actuary should report independently to Congress or continue to be subject to the Board of Trustees, we must stress that the independence of the actuaries utilized for this purpose is essential to their function. To the extent that the perception of non-independence exists or grows, it constitutes a danger to the credibility of the actuarial projections to the public and to Congress. In view of the need for acceptance by the public and Congress of the reliability of these projections, we believe that independence is a critical matter.

P.L. 98-21 contained a requirement for an actuarial statement of opinion to be included in the annual Trustees Report. Such opinions had been previously included on a voluntary basis since 1981. Although requiring such actuarial opinions by statute is positive in enhancing the independence of the Office of the Actuary, unfortunately the language enacted fell short of what would be appropriate methodology for such actuarial statements of opinion.

In particular, in P.L. 98-21 Congress stated that so-called "economic" assumptions were to be excluded from the actuarial opinion process. We feel that this provision in P.L. 98-21 is unfortunate for the following reasons:

1. It runs counter to the purpose of requiring the actuarial opinion in the first place, i.e. providing an independent actuarial appraisal of the financial condition of the system.

2. It opens the door for future Administrations to superimpose their often unrealistically optimistic "official" economic forecasts on the actuarial estimates.

3. It is vital that all assumptions be internally consistent as a package. It is not true that economic assumptions and demographic assumptions are unrelated. For example, rates of disability and ages at retirement do vary depending upon economic conditions.

4. "Partial" actuarial opinions are of limited value to Congress and the public. By analogy, this situation is similar to asking an accountant to give an opinion on the financial condition of a firm by looking at only the assets and taking someone else's word for the liabilities.

We hope that should the occasion arise, GAO would support attempts to alter the current language and ensure that the current actuarial opinion process be complete and consistent.

Again on behalf of the Academy, please accept our appreciation for your report calling attention to the importance of Social Security actuarial projections.

Sincerely,

A. Norman Crowder, III.
President

STATEMENT 1984-7

March 15, 1984

Mr. Edward F. Lysczek
Executive Secretary
ERISA Advisory Council
Room S-4522
Department of Labor
Third & Constitution Ave., NW
Washington, DC 20216

Re: Advisory Council Meeting 3/15/84

Dear Mr. Lysczek:

This letter sets forth some comments in connection with the meeting of the ERISA Advisory Council on March 15, 1984. We understand that the focus of this meeting is devoted to the "Impact of ERISA and Related Legislation on the Development of Private Retirement Plans."

We regret that we were unable to provide you these comments prior to the stated deadline of March 5, 1984. We greatly appreciate whatever distribution to Advisory Council members and inclusion in the record that is possible under the circumstances.

Statements of the Academy are generally the result of committee deliberations. It has not been possible to go through that procedure in this case in view of the extremely short time available. In preparing this document I have attempted to extract material from a variety of past Academy statements. However, it has not had the benefit of committee review.

The balance of this letter is arranged in rather brief item-by-item format.

A. General Comment on ERISA

ERISA was enacted by Congress nearly ten years ago to mandate certain design features in private pension plans, improve the level of funding for benefit security, strengthen reporting and disclosure requirements, provide termination insurance for plan participants, and eliminate certain abuses that had arisen in connection with the management and investment of pension funds.

In general, ERISA has been successful in achieving these goals, but not without cost. The increase in plan terminations and drop in new plan formations following ERISA, the increased administrative burden and resulting costs of complying with ERISA, and the difficulties in fashioning a workable and affordable plan termination insurance program are indicative of the price that has had to be paid.

In retrospect, certain parts of ERISA might be faulted as having resulted in too large a "cost-benefit ratio." The moral to this story for Congress in considering future pension legislation is to be certain the positives sufficiently outweigh the negatives. There is no free lunch.

B. Need for National Pension Policy

There needs to be a strong and specifically articulated national policy that encourages the formation, continuation, and enhancement of private pension plans. This spirit is missing in ERISA. In view of the future facing Social Security in the next century, the need for a strong and vigorous private pension system is obvious.

C. Stability

There is also a need for more stability from the Federal Government in the legislative, regulatory, and judicial environment affecting private pension plans. ERISA is followed by MEPPAA; which, in turn, is followed by TEFRA. Regulation upon regulation is piled on the system from no fewer than four agencies (DOL, IRS, PBGC, EEOC). The Supreme Court even enters the picture with the Norris decision. Much as this continual turmoil may provide additional work for actuaries, it hardly seems to be in the public interest to make the rules so complex and to change them so often that the typical plan sponsor has no chance of coping.

D. Defined Benefit vs. Defined Contribution

One significant result of ERISA, not intended by Congress, has been to encourage defined contribution plans and to discourage defined benefit plans. The statistics on plan terminations and new plan formations after ERISA clearly bear this out. If the Financial Accounting Standards Board persists in requiring liabilities of defined benefit plans to appear on the balance sheet of plan sponsors, these incentives will be further exacerbated.

Although defined benefit and defined contribution plans both have their place in the private pension system, it is questionable whether the private pension system will fulfill the role it should if there is a major shift from defined benefit plans to defined contribution plans. Only a defined benefit plan can provide a known level of benefits in relation to salary prior to retirement. Furthermore, the entire investment risk in a defined contribution plan is shifted from the employer to the employee. Defined benefit plans provide a certain type of protection to plan participants that defined contribution plans simply cannot provide. In making these comments, we should note that actuaries are not necessarily disinterested in the type of plan chosen by an employer. Defined benefit plans do generate more work for actuaries than defined contribution plans.

E. Actuary/Accountant Relationships

Section 103 of ERISA specifies in considerable detail a division of responsibility in the reports of actuaries and accountants, in which there is virtually no overlap. Further, it indicates that each professional "may rely" on the work of the other. In our opinion, a reasonable interpretation

of the Congressional intent of these words is that each "would rely" on the work of the other under normal circumstances. Close scrutiny of the work of the other would not be the norm, but would arise only in unusual circumstances.

In practice it does not work this way. The literature of the AICPA is written in such a way that routine audits of the enrolled actuary's work product is the norm. It is unclear to us that anyone benefits from this exercise, least of all plan participants. The work of the enrolled actuary is subject to extensive oversight by the IRS and the Joint Board for the Enrollment of Actuaries. When the enrolled actuary signs Form 5500 Schedule B, he assumes personal and professional liability for the quality of his work product. He could not change his numbers under pressure from the auditor. He has already certified that they are his "best estimate."

F. Pension Terminology

The actuarial profession has developed a set of uniform terminology for pensions which would clarify ambiguities and eliminate inconsistencies in existing terminology. This report has been endorsed by the governing boards of all the U.S. actuarial organizations. We would encourage the Advisory Council to support efforts to incorporate the new terminology into ERISA and other pension legislation. This initiative is non-controversial and would benefit everyone by creating a more accurate, less ambiguous lexicon. Copies of the pension terminology report have been widely disseminated and are available from our office on request.

G. Overfunded Plans/Reversions of Excess Assets

Although we recognize that the focus of this Advisory Council meeting is on the effects that past legislation has had and not on the effects that potential future legislation may have, we thought a couple of observations on the issue of reversion of excess assets in overfunded plans might be in order. We understand that this issue is presently receiving considerable attention at the Department of Labor.

This issue has significant actuarial ramifications. One of the major purposes of ERISA was to strengthen the level of funding of private pension plans in order to increase benefit security. Restrictions on reversions of excess assets in overfunded plans could lead to an overall lower level of funding by plan sponsors. This, in turn, could place additional strain on the PBGC. There are also a number of important technical actuarial issues in the design of any potential legislation in this area.

The Pension Committee of the Academy is currently reviewing this issue in some detail. We stress the need to obtain actuarial input on any proposed legislation in this area. The Academy stands ready to be of assistance on this matter.

H. Closing

We hope that these comments are useful to the Advisory Council. We would be happy to expand upon any of these items at your convenience.

Respectfully submitted,

Stephen G. Kellison
Executive Director

STATEMENT 1984-8

March 16, 1984

Mr. Leslie S. Shapiro
Executive Director
Joint Board for the Enrollment of Actuaries
c/o Department of the Treasury
Washington, D.C. 20220

Dear Les:

Enclosed is a copy of a letter I have received from a candidate for enrollment concerning the examination program required to become an enrolled actuary. The candidate raises concerns about the length of the transition arrangement for partial credits under the revised examination program.

I have reviewed the letter and feel that he raises a good point. Although the Academy does not have an official "position" on matters of this type, I have discussed this matter with several individuals within the Academy. In all instances the sense was that allowing only two opportunities to pass a partial segment is quite restrictive.

This is particularly true for an examination in which the percentage of candidates passing is low, as it is with the enrollment examinations. On an examination in which a higher percentage of candidates are successful, allowing only two chances might be more appropriate.

The Society of Actuaries has gone through several examination restructurings over the past two decades since I entered the profession. Typically the transition period for partial credits has been three years.

In another instance, the Academy offered a one-time opportunity to a closed group of health service corporation actuaries to establish their qualifications in that area by passing an examination to demonstrate proficiency. That examination was offered three times.

Thus, a transition period longer than two years would appear to be justifiable in comparison to comparable situations elsewhere within the actuarial profession.

I hope these thoughts are useful to you. Please feel free to distribute them to either the Joint Board or to the Advisory Committee, if you feel that would be appropriate.

Yours truly,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-9

COMMENTS OF THE AMERICAN ACADEMY OF ACTUARIES (AAA) ON THE GENERAL ACCOUNTING OFFICE (GAO) REPORT ON ECONOMIC IMPLICATIONS OF THE FAIR INSURANCE PRACTICES ACT (S372)

Interest of the Academy

The AAA has remained neutral on proposals to prohibit the use of gender as a risk classification factor in the operation of insurance and pension arrangements. We recognize that this issue involves questions of civil rights and public policy which cannot be resolved solely by actuarial analysis. Nevertheless, S372 would have important financial consequences which should be understood before it is enacted. In August, 1980, the House Subcommittee on Consumer Protection and Finance asked the AAA to undertake a study of economic impact of a similar proposal (HR100). That study was completed in the Spring of 1981, and was one of the studies reviewed by the GAO in its report.

General Comments on the GAO Report

The major conclusions of the AAA study are supported by the GAO report. Specifically, if S372 were enacted:

- Women would pay more for life insurance, and men less.
- Unisex health insurance premiums would shift costs from women to men, while mandatory maternity coverage would increase costs for both men and women.
- Automobile insurance premiums would increase for women, and decrease for men.
- Pension plan costs would increase, with some women receiving increased benefits under defined contribution plans and some men receiving increased benefits under defined benefit plans.
- Substantial administrative expenses would be incurred.
- The most severe economic consequences would arise from the Bill's requirement that previously negotiated insurance contracts be altered and previously earned pension benefits be increased.
- The 90 day implementation period would not prove adequate.

The GAO report provides a useful analysis of the potential financial effects of S372. However, we have identified several instances in which the GAO has incorrectly characterized or evaluated our study. These instances are included in the following sections, along with our comments.

Life Insurance

In our 1981 study, we estimated that enactment of S372 would increase annual life insurance costs for women by roughly $360 million, with a corresponding decrease for men. The GAO report has incorrectly characterized this an upper bound estimate because we did not consider the possibility that other rating factors will be introduced in place of sex.

Our $360 million estimate was based on life insurance in force at the beginning of 1980. Even if other rating factors were introduced today, the contracts covered by our estimate would not be affected. Negotiating changes in the guaranteed premium levels, benefits and risk classification structure of these existing contracts would almost certainly prove impractical, and perhaps illegal. Annual premiums for individually purchased ordinary life insurance grew by over 30% between the beginning of 1980 and the beginning of 1983. If we had evaluated the impact of S372 becoming effective in 1983, our estimate would have been significantly higher.

The GAO report speculates that enactment of S372 might stimulate the use of new rating factors reducing the cost shifting impact of the Bill. These new factors would be either legitimate independent risk elements or surrogates for gender, whose predicitive value would depend entirely on their ability to indirectly classify risks by sex. Every workable, legitimate risk factor which has been widely suggested is already being used by some insurance companies. These include smoking habits, physical fitness, occupation, avocations, alcohol/drug usage and health history. The enactment of S372 is not required to motivate insurers to identify and implement useful rating variables. Even if new factors were used, there is no reason to assume they would diminish the impact of gender. In fact, a 1982 article in the American Journal of Epidemiology found that the difference between male and female life expectancy increased when impacts of 16 other factors (smoking, occupation, etc.) were removed. Of course, the use of factors which indirectly segregate risks by sex would reduce the impact of S372. For example, height and weight classifications could be developed which have predictive value only because of their ability to identify male and female applicants without directly asking their gender. Because S372 would prohibit indirect classification by sex, we assumed that insurers would not be permitted to use such surrogate rating factors.

With regard to the impact of S372 on the financial condition of life insurers, the GAO report points out that existing contracts could be brought into compliance through decreases in premiums for men rather than topping up their coverages. The report concludes that this approach would be less likely to impair the insurer's solvency, based on an analysis of one, unidentified company. The relative impact on a company's financial strength of topping up benefits versus cutting premiums is likely to vary widely from company to company, making it risky to evaluate on the basis of one company's situation.

Pensions

In light of the Supreme Court decision in the Norris case, we have not made an in-depth analysis of the numbers in the GAO report concerning the expected financial impact of S372 on pension plans. A brief review leads us to the conclusion that these estimates are reasonable. We agree that the

proposed Act would not have any effect on benefits accrued after August 1, 1983 because of the broad decision in the Norris case. We also agree that the proposed Act would impose a substantial financial burden if future payments of past benefit accruals for active and retired or terminated participants must be topped up.

The GAO report suggests, as did the AAA study, that the redistribution of pension benefits would likely not be to the advantage of female employees.

Health Insurance

As the report indicates, the change to unisex rates will cause prices to increase for men and decrease for women, while the expansion of maternity coverage will increase costs for all consumers. The AAA study reported that the combined effect of these factors would be to increase total cost for both men and women, with the cost increases borne by women being more than offset by additional benefits paid to those who take advantage of the maternity benefits.

The GAO report suggests that our estimates of the redistributive effects of S372 may be reduced by the introduction of alternative factors. As with life insurance, the AAA estimates were based on insurance contracts already in force. Imposing new rating classification on these previously negotiated contracts would likely run into severe legal and administrative barriers, depending on the nature of each contract's structure and rate guarantees. Given the substantial increase in health insurance costs since the Academy report, our 1981 estimates are far more likely to understate, rather than overstate, the redistributive effects of enacting S372 today.

Whether or not S372 is enacted, it is likely that new legitimate rating factors will continue to be introduced to the health insurance marketplace. There is no reason to believe, however, that these new factors will offset the impact of S372. For example, greater use of smoking habits as a pricing variable for health insurance would add to the redistributive pressures created by S372, not reduce them. Of course, the introduction of factors which have no direct predictive value, but tend to separate applicants by sex, could be introduced as surrogates for sex rating and would reduce the impact of S372. Such actions, however, would violate the Bill's prohibition against indirect classification by sex.

The report suggests that we overstated the added cost of the expanded maternity coverage required by S372. This conclusion is based on our assumptions that expenses will increase in proportion to claim costs and that pregnancy disabilities will average 11 weeks. We have reexamined these assumptions and have concluded that they are reasonable and that our estimates of the added costs were not, therefore, overstated.

The GAO report states that only claim costs are expected to increase because of the new benefits. In fact, many of the most significant expenses associated with health insurance vary directly with premium levels, which in turn are affected by claim costs. These expenses include commissions and state premium taxes. Other expenses, such as claims investigation and administration are strongly influenced by the frequency and level of claims. The strong tendency of expenses to grow with direct claim costs is recognized

by state insurance authorities, who typically evaluate the reasonableness of rate changes on the basis of loss ratios (claims/premiums), a method which anticipates that expenses will vary proportionately with direct claim costs. The GAO position that only direct claim costs will be affected by S372 is unrealistic.

The GAO report suggests that a 6-8 week average for maternity related disabilites would be more appropriate than our 11 week assumption. We feel that a 6-8 week assumption would be inadequate, given the tendency for these disabilities to be longer the more generous the insurance coverage. New York State, for example, requires employers to offer at least 10 weeks of maternity benefits. Only limited data are available on the duration of pregnancy disabilites under insurance coverages which impose no special limitation on maternity benefits. After reviewing these data, we continue to feel that our 11 week average was an appropriate assumption taking account of the probable effect of mandatory, unrestricted coverage on policy holder behavior.

The cost of adding maternity coverage to individual health and disability policies may exceed the Academy's original estimate because the frequency of maternity among insured lives will significantly exceed the frequency of maternity for the general U.S. population. The GAO report recognizes that men and women who place little value on maternity coverage may buy less health and disability insurance as a result of S372. The maternity frequency for the remaining purchasers will, therefore, be higher, because they are the people who believe they will use maternity coverage. No allowance was made for that in the Academy's estimates of the cost of adding maternity coverage to existing policies because we don't have a firm estimate of the amount of such anti-selection. Results under limited programs offering maternity coverage have ranged from 130% - 150% of population maternity frequencies. While the GAO recognized this potential understatement in their report, they ignored it in evaluating the Academy's figures.

Automobile Insurance

The GAO report concludes that our estimate of a $700 million annual cost shift from men to women represents an upper bound estimate of the impact of S372. This is not correct. Actually, the growth in total automobile insurance since our 1981 report would result in a much larger shift of costs from young men to young women if the Bill were enacted this year.

One reason cited for our estimate being an upper bound is that the new law might lead to greater use of merit rating and other rating methods in place of sex. In fact, merit rating is currently an integral part of virtually every automobile insurance pricing structure in the United States. Miles driven is also commonly used as a pricing variable. The overwhelming preponderance of statistical evidence confirms that the introduction of other factors, such as miles driven or driving record, would not eliminate the significance of gender as a risk factor. There is no reason to expect that future refinements of automobile insurance risk classification will create cost shifts that offset the impact of S372 or, in fact, that the enactment of S372 would accelerate the development of these refinements. If the discovery of effective substitutes for sex as a rating factor could be triggered simply by mandating unisex

insurance, these substitutes would be in place in the states which already prohibit sex based pricing. This has not happened.

Another reason given for considering the Academy estimate to be an upper bound is that at least one other study has come up with significantly different results. However, the Academy study provides the only estimate of automobile insurance cost shifting under S372 which has not been challenged on the basis of serious methodological flaws. In the 3 years since our report was delivered, the only challenges to it have been based on speculation that alternative rating systems might emerge to replace gender as a rating variable in a manner that undoes the effects of S372. The failure of such a system to emerge in the states already requiring unisex automobile insurance and the absence of an alternative estimate without serious technical flaws suggest that it is inappropriate to classify our results as an upper bound.

Committee on Risk Classification

Robert L. Knowles, Chairman

Marsha Bera-Morris
Alan C. Curry
John G. Larose
John O. Nigh
Andrew M. Perkins
Patricia L. Scahill
Larry L. Schreiber
Robert Shapland
Sanford R. Squires
Eugene R. Strum
Stanley H. Tannenbaum
William K. Tyler
Mavis A. Walters
Claire L. Wolkoff

STATEMENT 1984-10

April 2, 1984

Mr. John J. Salmon
Chief Counsel
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

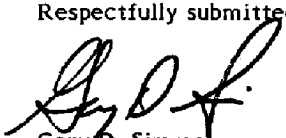
Re: Written Statement for the Record of March 20, 1984
Hearings on the Financial Status of
PBGC Single Employer Insurance Program

Dear Mr. Salmon:

Enclosed are six copies of a statement for the record of the hearing noted above. This statement was prepared by the Subcommittee on PBGC (Single Employer Programs) of the Pension Committee of the American Academy of Actuaries.

If you have any questions about this statement or if you would like any additional information, please direct your inquiry to this office. Academy representatives would be happy to meet with members or staff of the Committee on Ways and Means.

Respectfully submitted,



Gary D. Simms
General Counsel

STATEMENT 1984-10

STATEMENT FOR THE RECORD
AMERICAN ACADEMY OF ACTUARIES
PENSION SUBCOMMITTEE ON PBGC (SINGLE EMPLOYER PLANS)
TO THE SUBCOMMITTEE ON OVERSIGHT
HOUSE COMMITTEE ON WAYS AND MEANS
HEARINGS ON THE FINANCIAL STATUS OF
PBGC SINGLE EMPLOYER INSURANCE PROGRAM
MARCH 20, 1984

The American Academy of Actuaries is a professional organization which includes among its membership more than 7,000 actuaries who work in all areas of actuarial science. Our members are employed by insurance companies, consulting firms, government agencies, academic institutions, and as individual practitioners. A large proportion of our membership is actively involved in pension matters, and are enrolled actuaries under ERISA.

The Academy's Pension Committee is composed of several major subcommittees, and the Subcommittee on PBGC (Single Employer Plans) which is submitting this statement is assigned the responsibility of offering guidance and counsel to governmental bodies on matters which concern the operation of single employer pension plans and the Pension Benefit Guaranty Corporation. As such, it must be stressed that the views expressed herein are those of the Academy subcommittee, and are independent of views which might otherwise be expressed by a particular trade group.

We understand that the Subcommittee on Oversight is considering the propriety of the Administration's proposal to increase the current premium rate charged by the PBGC from $2.60 to $7.00 per year per participant. Our major recommendation in this regard is to urge that the Subcommittee defer consideration of any such increase until such time as proposed changes to the program elements of the single employer program are fully discussed and decided upon. In our view, any insurance program, be it private or public in nature, has a design feature as well as a pricing feature. To the extent that design changes are being considered, we deem it inappropriate to consider price changes until the design changes are settled, because the extent of any price change must necessarily relate to the program design elements.

We recognize that at the present time there is a projected financial deficiency in the PBGC single employer program. We are concerned that the analysis utilized in formulating the PBGC estimates was primarily economic in nature, and was not undertaken through a rigorous actuarial methodology. We would be much more willing to comment on the reasonableness of the estimate (and hence to the premium increase being sought) had a thorough actuarial analysis been performed. In this context, it is useful to note that virtually all insurance company annual valuations which may be required by state law require an actuarial valuation of reserves, anticipated expenditures, and projected revenues. We would therefore urge that Congress seriously consider amending legislative proposals currently being considered (e.g. H.R. 3139) to require an annual actuarial statement on the PBGC's financial reports, together with an actuarial analysis on the propriety of the premium rate.

Our second concern is that, while a premium increase attempts to restore financial stability, this action may have the opposite effect, and further thwart the achievement of national retirement income goals. The increase in premium rate may trigger additional plan terminations from marginally funded plans, causing PBGC's unfunded liabilities to grow beyond predicted levels.

Even soundly funded plans may terminate, in exchange for a less burdensome defined contribution approach. Organizations without existing retirement plans will be dissuaded from establishing defined benefit plans because of the onerous requirements, including the $7.00 premium rate. The end result would be that more, not fewer American workers will be deprived of the guaranteed retirement income levels which only defined benefit plans can provide.

At the present time, as you are aware, many basic changes to the single employer program administered by PBGC are under consideration. We believe that these changes, if enacted, would have a direct impact on the level of premium needed to adequately fund PBGC operations in future years. Hence, we strongly recommend that Congress consider the entire program before taking action in the single area of premium levels.

We thank you for the opportunity of submitting this statement, and offer our assistance in further deliberations on this and related subjects.

Pension Committee

Will ard A. Hartman, Chairman

Subcommittee on PBGC
(Single Employer Plans)

Peter A. Bleyler, Chairman
Marc M. Twinney, Vice Chairman
Robert B. Aglira
Darrel J. Croot
Joseph H. Dittmer
Edward N. Fleischer
Michael J. Gulotta

STATEMENT 1984-11

April 4, 1984

Mr. William M. Lieber
Pension Tax Counsel
Joint Committee on Taxation
1015 Longworth House Office Building
Washington, D.C. 20515

Dear Bill:

A matter of some importance to the actuarial profession in connection with H.R. 4170, The Tax Reform Act of 1984, has come to our attention which we believe merits a technical correction, both to avoid an erroneous misqualification statement regarding actuaries, and to ensure that the intentions of Congress are fully satisfied.

In particular, the House Committee on Ways and Means Report (at page 1279) indicates that, in connection with the valuation of reserves for so-called VEBA's: "The committee expects that Treasury regulations may require the written opinion of an enrolled actuary with respect to the reasonableness of these assumptions."

As you are probably aware, employers utilize VEBA's to provide a wide variety of employee welfare benefits, especially health care and disability payments. As such, while the utilization of actuarial services is entirely appropriate, we seriously question whether enrolled actuaries are necessarily qualified to undertake health and welfare program valuations. Inasmuch as their training and qualifications are tested strictly on pension matters, they may or may not have gained the necessary special expertise involved in undertaking financial valuations of health and welfare plans, such as VEBA's. In short, the fact that they have qualified as enrolled actuaries does not necessarily imply that they are also qualified to undertake the valuations intended here.

We suggest, therefore, that in future committee reports, the language be altered to indicate that the valuations should be undertaken by "qualified actuaries" as opposed to "enrolled actuaries." This would provide Treasury greater latitude in adopting appropriate qualification standards.

The Academy's interest in this matter is primarily to ensure that professional qualifications are properly utilized. We have attempted to delineate the differences entailed in the various actuarial professional qualifications, and we hope that we may head off unnecessary confusion in this regard.

Yours truly,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-12

April 20, 1984

TO: Members of the Senate Committee on Commerce, Science and Transportation

RE: GAO Report on Fair Insurance Practices Act

On April 6, 1984 the General Accounting Office released a report entitled "Economic Implications of the Fair Insurance Practices Act" (GAO/OCE-84-1). The bill embodying this act, S.372, has been referred to your committee.

The Committee on Risk Classification of the American Academy of Actuaries has done an extensive analysis of the economic and other effects of S. 372. The results of this study have been presented to your committee at past hearings (most recently May 19, 1983).

The GAO report refers to the work of the Academy committee in several places. Although the major conclusions of the Academy study are supported by the GAO report, we have identified several instances in which the GAO has incorrectly characterized or evaluated our study.

Accordingly, we are attaching comments on the GAO report prepared by the Academy committee. We commend them to your attention when evaluating the GAO report.

We would be pleased to discuss this matter further with the committee or its staff at your convenience.

Respectfully submitted

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-12

April 20, 1984

TO: Members of the House Committee on Energy and Commerce

RE: GAO Report on Fair Insurance Practices Act

On April 6, 1984 The General Accounting Office released a report entitled "Economic Implications of the Fair Insurance Practices Act" (GAO/OCE-84-1). The corresponding House bill is the Nondiscrimination in Insurance Act, H.R. 100, which has been referred to your committee.

The Committee on Risk Classification of the American Academy of Actuaries has done an extensive analysis of the economic and other effects of H.R. 100. The results of this study have been presented to your committee at past hearings (most recently February 24, 1983).

The GAO report refers to the work of the Academy committee in several places. Although the major conclusions of the Academy study are supported by the GAO report, we have identified several instances in which the GAO has incorrectly characterized or evaluated our study.

Accordingly, we are attaching comments on the GAO report prepared by the Academy committee. We commend them to your attention when evaluating the GAO report.

We would be pleased to discuss this matter further with the committee or its staff at your convenience.

Respectfully submitted

Stephen G. Kellison
Executive Director

STATEMENT 1984-13

To: Members of Life, Accident and Health
Standing Technical Task Force

From: American Academy of Actuaries Health Subcommittee
on Liaison with NAIC Accident and Health (B) Committee

Subject: Progress Report on Revision of Minimum Valuation
Standards for Health Insurance

Date: May 10, 1984

This progress report is intended to bring the Task Force up to date on our subcommittee's progress on the project of revising the existing Minimum Valuation Standards for Health Insurance.

I have received "first round" responses from a number of members of our subcommittee, and this report will summarize the main areas of comment thus far received, in terms of the topics and problems identified and specific items and ideas suggested for consideration.

Our next steps will be: a) to construct a working draft of a revised Minimum Reserve Standards document to be used for further study and discussion purposes, and b) to develop draft discussions or memoranda concerning particular problems or concepts, to clarify how these considerations can best be addressed or embodied in the working document.

This does not necessarily mean that the subcommittee is close to agreement at this stage, nor that we are as yet close to having a proposed document ready to submit to the NAIC. It does mean that we are at the point of getting our working tools functioning so that we can move ahead rapidly and efficiently on this rather complex subject on which many diverse views exist.

In response to this report, and as we proceed, we would greatly value any comments, criticisms or suggestions from any members of the Task Force, so that we will have in mind your views and be aware of all topics and problems that you believe need to be addressed. We would also like to learn which items or concepts mentioned in this or later progress reports, if any, you have problems with or you feel represent wrong directions in which we may be headed.

I. MAJOR TOPICS and ITEMS IDENTIFIED

A. The Basic Purposes and Functions of Reserves.

We have identified three:

1. Measurement of liability, in order to test the solvency of insurers.

2. Measurement of the adequacy of premiums, including the extent to which premium adequacy enables insurers to establish appropriate reserves and maintain sufficient surplus.

3. Reserves using methods that provide for release of reserves having a timely relation to maturation of the obligations they cover.

B. Reserve Methods.

I expect that the subcommittee will devote a great deal of attention to this subject. Among the "methods" identified are:

1. Traditional net premium valuation methods.

2. Alternative retrospective and prospective valuation methods, including gross premium valuation.

3. Loss ratio valuation methods, such as are implied by the retrospective and prospective loss ratio tests incorporated into the existing Rate Filing Guidelines for Individual Health Insurance. The Rate Filing Guidelines themselves, through these tests, have the effect of creating additional insurer liability.

C. Reserve Bases.

Here we are considering such items as these:

1. Morbidity standards, and to what extent it is desirable that these be fixed or formalized (e.g., the 1964 Commissioners' Disability Table), vs. morbidity bases which are more "dynamic" in character.

2. The applicability of dynamic interest rates.

3. The appropriateness of specific mortality standards as compared to the use of specified or dynamic lapse or "termination" rates. There is a real question, for example, as to whether formal mortality tables should be used at all in health valuation, since they appear to serve only to allow insurers to incorporate some degree to minimal termination rates into health reserve valuation.

4. Valuation on a select and ultimate basis.

D. Renewal and Rate Guarantees.

We expect to devote considerable attention to the question of the effect of renewal guarantees on insurer liability and hence on reserve requirements. We will reexamine the question of how and to what extent valuation standards should vary in accordance with renewal and with rate guarantees.

E. The Effect of Actual or Expected Rate Increases on Reserves (related to D, preceding).

We hope to develop practical methods by which rate adjustments, actual or potential, can be reflected in reserve requirements and methods.

F. Nature of the Risk Valued.

Here we have in mind such considerations as how reserve standards should be related to the "stability" or "volatility" of risks, due to vulnerability to inflation, changing health care technology and practice, cost shifting, economic changes, etc.

G. Testing of Reserve Adequacy.

It seems clear there is great need for this. Should this be required periodically such as by gross premium valuation, or other method, every 5th year? Alternatively, can we develop methods that will incorporate "automatic" tests of adequacy, at each valuation?

How effective is the Schedule O test of claim reserves? Should it be amended to incorporate recognition of interest earned on reserves?

How can the responsibility of the valuation actuary for adequacy of reserves be more effectively emphasized and supported, particularly when reserves at levels higher than the "minimum standards" are called for?

II. OTHER SPECIFIC ITEMS IDENTIFIED

Other specific items identified for study or discussion are:

A. Unearned Premiums. Should the existing gross pro-rata unearned premium requirement be kept? Should the test of aggregate reserves vs. aggregate gross pro rata unearned premium reserve be continued?

B. Federal Income Tax Laws and Regulations. To what extent should the standards our committee proposes reflect or be determined by what is known (or presumed) to be acceptable under Federal income tax laws or regulations? To what extent should attempts be made to bring about revision in such laws or regulations where they appear to conflict with sound valuation standards and practice?

C. Proper Determination of Dates of Claim Incurral. We will examine this question, in relation to the establishment of appropriate claim reserves and liabilities. Several of us regard appropriate incurred dating to be a fundamental consideration in establishing proper claim reserves and liabilities.

D. Reserves in Relation to Expenses and Expense Incidence.

1. Should future expenses be provided for? To what extent and how?

2. Preliminary Term Valuation. Is the existing 2 year P.T. minimum reserve method appropriate, in relation to the incidence of expenses and the emergency of margins? If not, what rules should replace it?

It is noted that the new Federal tax law will apparently specifically recognize 2 year P.T. reserves.

E. Similarities and Differences between Health and Life Insurance, in relation to reserve methods and requirements. How can similarities and differences be of guidance in establishing new standards?

Conclusion. The above considerations are among the topics we will be examining and attempting to address as we develop our working draft document.

We welcome comment on any point and at any stage from Task Force members, and in fact URGE that you express your views, criticisms and suggestions to us.

Respectfully submitted

E. Paul Barnhart
Subcommittee Chairman

STATEMENT 1984-14

COMMENTS OF STEPHEN G. KELLISON, EXECUTIVE DIRECTOR
AMERICAN ACADEMY OF ACTUARIES
AT AN OPEN MEETING OF THE
JOINT BOARD ADVISORY COMMITTEE ON ACTUARIAL EXAMINATIONS
MAY 17, 1984

My name is Stephen G. Kellison and I am the Executive Director of the American Academy of Actuaries. I appreciate the opportunity to make a few comments on the issues relating to the jointly administered examination program for enrollment.

Although the Academy is not involved in the implementation of this program on the same basis as the actuarial organizations which offer the examinations, we do retain an active interest in the overall standards for enrollment. This interest results from the fact that according to our Bylaws enrolled actuary status satisfies the education requirement for membership in the Academy.

I would like to offer comments on two of the items appearing on your agenda for this meeting.

The first item is the proposal for open-book examinations. Based on the discussion I have heard here today I sense that nearly everyone agrees that this would be a profound step that would significantly alter the type of examination given and the manner in which candidates prepare themselves. However, I do not yet sense a consensus as to the desirability of taking such a step. I would offer the following thoughts for your consideration:

1. It might be useful to discuss this concept with senior officials responsible for education and examination programs in the other, larger professions. For example, there is a national CPA examination and a national bar examination, both of which are closed-book examinations. It would seem likely that the concept of open-book examinations has arisen in these, and other, professions. Perhaps the deliberations of these other professions on this issue would be enlightening.

2. I sense that certain members are concerned that under an open-book format students will spend time assembling a good "library" rather than studying the material itself. Also, I sense that some members have concerns about equity among students. Finally, I sense some concern over how rigorously any limitations on open-book material could, or would, be enforced. All of these problems can be avoided by gathering together standard reference materials which are available to all candidates and are known beforehand. For example, the Federal Aviation Administration provides a standardized compilation of various reference materials in the back of the examination booklets for written examinations for pilots.

The second item concerns the transition arrangements for partial credits under the revised examination program. I would like to reiterate the comments made in my prior letter of March 16, 1984. Offering the transitional examination for partial credits only two times is restrictive in comparison to comparable situations elsewhere in the actuarial profession.

This is particularly true for an examination in which the percentage of candidates passing is low, as it is with the enrollment examinations. On an examination in which a higher percentage of candidates are successful, allowing only two chances might be more appropriate.

Thank you again for the opportunity to make these comments. I would be happy to answer any questions that you might have.

STATEMENT 1984-15

May 22, 1984

Mr. George A. Fitzsimmons, Secretary
Securities and Exchange Commission
450 Fifth Street, N.W.
Washington, D.C. 20549

RE: FILE NO. S7-9-84
Proposed Rules and Guide for Disclosures Concerning
Reserves for Unpaid Losses and Loss Adjustment Expenses of
Property-Casualty Underwriters

Dear Mr. Fitzsimmons:

The Committee on Property and Liability Insurance Financial Reporting Principles of the American Academy of Actuaries is pleased to have this opportunity to comment on the proposal to require additional disclosure concerning loss and loss expense reserves of property-casualty insurers. The Committee agrees that some additional disclosure in this area would assist investors in understanding companies' reserving practices and their effects and would facilitate comparisons among entities.

We believe that the proposed rules and guides should be designed for a specific target audience, require only that level of detail which is necessary, and yet, say as much as possible about the adequacy of current reserves. Herein, we offer a proposal which would attain the desired objectives in a simple, straightforward, useful, yet less detailed format than is called for in the rules and guides proposed by the SEC. Our comments encompass both an analysis of the proposal as it stands, and the suggested alterative approach which we think would adequately address the Commission's concerns, and we would welcome an opportunity to work with the Commission in order to achieve meaningful improvements in reserve disclosure in a manner which is both understandable and useful to regulators and investors.

Summary

Our proposal provides for a compact and understandable display of what we regard to be the most important and useful information, and which can be compiled by registrants at a reasonable cost on a timely basis. Supplemental information could continue to be made available by registrants to analysts and others who possess the technical background and who will spend the considerable time that would be necessary to use it effectively. For instance, Schedules O and P of the annual statement filed with state regulatory authorities contain all of the data exhibited on pages 8 and 9 of the proposal and, while compiled on the statutory basis of accounting, are in fact, more inclusive. The NAIC annual statement is available to all interested parties since it is a public document; furthermore, we are not aware of any company which would not provide it on request.

STATEMENT 1984-15

Background

Establishing the appropriate provision for losses and loss expenses is generally conceded to be one of the most complex and difficult tasks facing property-casualty insurers. No matter how much care is taken in the process, including the establishment of a proper data base and reporting system and the selection of appropriate actuarial assumptions and techniques, the goal of setting reserves which make "good and sufficient," and yet not excessive or inadequate, provision for the insurer's obligations to its policyholders and claimants, remains much more than a simple exercise in mathematics.

Establishing appropriate reserves requires estimating the effects of certain future events which bear directly on ultimate claim costs. These include:

- the reporting rates of claims not yet reported
- the extent and cost of medical care required by injured parties
- the rate of recovery of injured parties
- the period of time required for certain claims to come to trial
- the outcomes of pending or future trials
- the effects of certain toxic substances on persons and property

In turn, the magnitudes of these events will be affected by many factors, such as:

- changes in reporting patterns, which may be caused by changes in claims processing or by external elements
- changes in rate of growth of volume
- changes in distribution of business by:
    - product line (including entirely new lines of business)
    - geographic region
    - policy limits or deductibles
    - size of risk
    - voluntary vs. involuntary risks
    - other risk characteristics
- changes in state regulations
- legislation or court decisions affecting the tort law or its interpretation
- changes in social climate, which manifest themselves through:
    - claims consciousness
    - incidence of fraudulent claims
    - jury liberality
- public perceptions of insurance and insurers

In general, the longer claims remain open, the higher the likelihood that the final results will differ from those originally estimated. In addition to the "social" inflation referred to above (i.e., judicially, legislatively, and other socially-originated increases in costs), final claim values will be affected by monetary inflation (i.e., changes in wage and price levels). Furthermore, other economic variables, such as unemployment rates or interest rates, may affect the magnitude of the reserve liabilities being estimated.

Thus, reserve adequacy depends very much on the experienced judgement of the reserve technician, and for many coverages the amount of the correct reserve may not be known until years or even decades later, when most of the claims will have been settled.

Analysis of SEC Disclosure Proposal

In general, the proposal focuses on the disclosure of reserving practices, data on past reserving experience, and the publication of considerable additional data pertaining to GAAP loss and loss expense reserve liabilities by NAIC statement line. The proposal would require additional discussion of reserving methodology with emphasis on changes in practices and assumptions, especially as they relate to inflation and discounting. There is a presumption that judgements about current reserve adequacy can be made solely by reviewing a company's track record. There is not necessarily a direct connection between past history and current reserve adequacy; in fact, there may actually be a negative relationship between them. In the case where an insurer strengthens reserves, the development of incurred losses may appear "adverse," when, in reality, the insurer's reserve position has improved.

Nevertheless, we believe that company's historical record with regard to reserves established in previous years is useful information. Our proposal (see Appendix A) would provide this in a relatively simple, understandable way. The theory behind the requirement to publish detailed schedules appears to be that the additional information would allow sophisticated investors to form their own conclusions with respect to current reserve adequacy, i.e., they could apply whatever valuation methods they prefer. For reasons mentioned earlier, we believe that this proposal would not necessarily give enough information to evaluate current reserve levels. Moreover, the publication of GAAP data in the detail specified in the proposal would be disproportionately time-consuming, as well as costly.

The proposed requirements dealing with descriptions and discussions of reserving practices are reasonable, although we would expect the quality and quantity of these descriptions to vary quite widely from company to company. Perhaps a list of areas required to be covered in the Management Discussion and Analysis should be included in the rules and guides. Such areas might include, but not be limited to:

- earnings effects of significant changes in reserves for prior accident years (including any related effects on premiums, etc.)
- the existence and financial statement effects of loss portfolio or other reinsurance
- other unusual transactions

With respect to the disclosure regarding provisions for inflation, it is our experience that most companies do not make separate, explicit provision for either monetary inflation or social inflation. Instead, provision for these elements is subsumed under overall projections of expected claim costs without being specifically identified. Thus, we do not anticipate that this aspect of the proposal would generate much in the way of enlightenment.

Statutory lines may or may not be translatable into segment information, and to move away from regular segment data in this way may be confusing to investors who attempt to reconcile lines of business with segment detail. In addition, lines of business are not defined consistently in foreign jurisdictions, and NAIC line of business reporting for foreign subsidiaries will therefore be either difficult or meaningless in some instances.

The proposed disclosures with regard to discounting extend those now required by FASB 60 to require added detail by line of business.

Finally, the proposed requirement to reconcile GAAP and statutory reserves is not unreasonable, however, providing it by line of business will not be useful to investors.

Application of Proposed Disclosures

The Committee agrees that a materiality standard should be established with respect to unconsolidated subsidiaries as well as for the registrant and its consolidated subsidiaries. The proposed earnings standard, however, may not be entirely appropriate because of the volatility inherent in the property-liability business. We also believe that the inclusion of data from less than 50 percent owned equity investees is simply not feasible under most circumstances, and suggest that this part of the requirement be eliminated entirely.

The inclusion of less than 50 percent owned equity investees poses insuperable practical problems. NAIC statements are required to be filed by March 1 and Form 10-K by March 30 or 31 for registrants who report using the calendar year, as most major insurers do. To compile the proposed data between March 1 and the due date for printing a 10-K for each investee where the registrant does not exercise control would simply be impossible. The inclusion of such data, even if it could be compiled, would say absolutely nothing about the reserving position of the registrant, since the registrant probably has no control over the reserving practices of non-subsidiary investees. In addition, such investees, if SEC registrants, would be filing such information in their own right. We suggest that this part of the requirement should be deleted completely.

As noted earlier, we propose the inclusion of tables as described in Appendix A. These tables display reserve data for all lines combined for the registrant and its consolidated subsidiaries. In addition, a similar schedule would be required for unconsolidated subsidiaries where the total loss and loss expense reserves of such subsidiaries were material.

Again, all parts of the proposal which relate to NAIC statement line of business should be stricken. They may or may not be compatible with industry segment, and in the case of non-U.S. domiciled companies, may simply not be available under any circumstances.

It should be kept in mind that for non-U.S. domiciled companies, accident year detail may not be available. Furthermore, for business written under claims-made policies, where the coverage period is a reporting period rather than an occurrence period, the concept of accident year is meaningless. Therefore, the requirement of accident-year detail should be waived in the case of non-

U.S. domiciled companies which have no local requirement to provide it. Claims-made experience should be included on a report-year basis.

Effective Date

We think that a year-end 1984 implementation date might well be feasible for our proposal. Implementing the SEC proposal as it stands would be difficult.

Recapitulation

The Commission has identified reserving practices and experience of property-casualty underwriters as an area of concern. The Committee shares that concern, and supports the institution of some additional disclosure. We believe that any additional statistical data which would be required under the proposed rules and guides should provide the maximum amount of understandable, useable information encompassed in a reasonable volume of data. We have included a proposal which addresses the Commission's concerns in an informative, efficient format. In addition, we support the idea of some additional disclosure in the Management's Discussion and Analysis portion of required filings, especially as it relates to reserving practices and assumptions, and with regard to reinsurance and other unusual transactions.

We would welcome an opportunity to discuss our proposal further or to participate in further study if that is indicated.

Committee on Property & Liability Financial Reporting Principles
American Academy of Actuaries

Richard H. Snader, Chairman
Linda L. Bell
Vincent P. Connor
James H. Crowley
James A. Faber
James A. Hall, III
Douglas F. Kline
Joseph W. Levin
Stephen P. Lowe
Robert H. McMillen
John D. Nolan

APPENDIX A

Suggested Replacement for SEC Exhibits (Pages 8 & 9)

The attachments display data in a suggested format for replacement of SEC exhibits on pages 8 and 9 of its "Proposed Rules For Disclosure Concerning Reserves," File No. S7-9-84.

The source for all data shown in these exhibits in the NAIC Annual Statement. Exhibit A is designed to communicate information intended by the SEC exhibit on page 8 and Exhibit B is designed to replace the SEC exhibit on page 9 for all available ages of maturity of reserves held at the nine latest year ends (The NAIC Statement will include ten years of data beginning with 1985).

Exhibit A

In the top table, each column represents a calendar year; in the bottom two tables, each column represents an accident year. The upper portion shows the key items shown in the SEC exhibit on page 8: beginning reserve, calendar year incurred, paid and ending reserve. In addition, earned premiums are displayed, so that calendar year or accident year loss ratios may be calculated. The middle portion of Exhibit A shows a track record of accident year incurred estimates and the lower portion shows the accident year paid development. To examine the track record of incurred estimates or the paid development for any one accident year, simply read down the column for that accident year. The reserves for each accident year at any reserve date can be calculated by subtracting the numbers in the bottom table from those in the middle table.

In order to determine impacts on published underwriting results due to changes in reserve adequacy, simply compare the most recent accident year incurred estimate in any column with the calendar year incurred; alternatively, compare the most recent estimate of the accident year loss ratio with the corresponding calendar year loss ratio. It should be kept in mind that if total reserves are equally redundant or equally inadequate at any two succeeding reserve dates, then the earnings for that period are not affected.

The tables include the data necessary for calculating paid to incurred ratios, which can be used to evaluate reserve adequacy. Using this data as an example, about 36 percent of the current incurred for any of the accident years shown is paid in that year, about 60 percent is paid by 24 months after the beginning of the accident year, etc.

Exhibit B

Each column represents a reserve date for the current and all prior accident years combined. The upper portion shows the reserve held, the middle shows a track record of reserve estimates, and the lower shows the paid reserve runoff. To examine the track record or reserve runoff for one particular reserve date, simply read down that column.

Using our example, the 12/31/75 reserve held was $224 million, $246 million has been paid on the 12/31/75 reserve as of 12/31/83 and the 12/31/83 evaluation of the 12/31/75 reserve is $279 million. Thus, the 12/31/75 held reserve is 80% of the current evaluation and 88% of the current evaluation has been paid.

Using this data, it can be demonstrated that this company typically pays about 31% of its full pay reserve in the year following the reserve date with 49% through two years, 62% through three years, etc. . . .

Footnotes

In general, the effects of unusual transactions or circumstances should be explained in footnotes to the proposed tables. For example, if accident year data is not available for certain members of the group, this fact should be disclosed and the total of the reserves excluded should be reported. Other examples where footnotes might be required would include claims-made experience (to be shown separately by report year); accident and health insurance or other lines where runoff data may be distorted by the existence of non-proportional reinsurance arrangements with life companies; any other reinsurance arrangements which might distort runoff data.

LOSS & LOSS EXPENSE

	CALENDAR YEAR							
	1976	1977	1978	1979	1980	1981	1982	1983
Premium Earned	236	288	348	396	437	469	483	500
Beginning Reserve at 1/1	224	260	311	372	437	502	573	636
+ Calendar Year Incurred	191	226	254	282	324	360	388	414
- Paid During Year	155	175	193	217	259	289	325	365
= Ending Reserve at 12/31	260	311	372	437	502	573	636	685

Accident Year (AY) Incurred As Of 12/31:	ACCIDENT YEAR								
	PRIOR	1976	1977	1978	1979	1980	1981	1982	1983
AY	1284	186	210	242	274	319	351	385	415
AY + 1	1289	189	210	237	269	315	347	379	
AY + 2	1302	194	213	238	270	317	348		
AY + 3	1309	196	213	238	269	315			
AY + 4	1317	199	216	239	268				
AY + 5	1323	201	217	239					
AY + 6	1330	202	217						
AY + 7	1333	203							
AY + 8	1339								

Cumulative Accident Year (AY) Paid As Of 12/31:	ACCIDENT YEAR								
	PRIOR	1976	1977	1978	1979	1980	1981	1982	1983
AY	1060	71	76	83	94	115	126	137	158
AY + 1	1144	120	129	141	161	193	214	232	
AY + 2	1194	143	153	169	192	229	255		
AY + 3	1228	159	171	189	215	255			
AY + 4	1253	171	183	203	230				
AY + 5	1272	179	193	213					
AY + 6	1286	185	199						
AY + 7	1297	190							
AY + 8	1306								

AY = Accident Year

EXHIBIT A

LOSS & LOSS EXPENSE

	RESERVE DATE: 12/31								
	1975	1976	1977	1978	1979	1980	1981	1982	1983
Reserve Held	224	260	311	372	437	502	573	636	685
Estimate of Reserve:									
1 year later	229	276	323	380	442	511	576	635	
2 years later	242	288	336	390	455	518	581		
3 years later	249	298	345	402	460	522			
4 years later	257	307	357	408	466				
5 years later	263	316	362	415					
6 years later	270	320	369						
7 years later	273	327							
8 years later	279								
Amount of Reserve Paid:									
1 year later	84	99	110	123	144	163	188	207	
2 years later	134	156	175	200	229	263	300		
3 years later	168	197	224	254	293	334			
4 years later	193	228	258	295	338				
5 years later	212	250	285	325					
6 years later	226	267	305						
7 years later	237	281							
8 years later	246								

EXHIBIT B

STATEMENT 1984-16

COMMENTS OF THE AMERICAN ACADEMY OF ACTUARIES ON THE DRAFT GENERAL ACCOUNTING OFFICE REPORT ENTITLED "INCOMPLETE PARTICIPANT DATA AFFECT RELIABILITY OF VALUES PLACED BY ACTUARIES ON MULTIEMPLOYER PENSION PLANS" (GAO/HRD-84-38) MAY 25, 1984

Background

By letter dated April 16, 1984, Richard L. Fogel, Director of the Human Resources Divison, General Accounting Office (GAO), provided the American Academy of Actuaries ("Academy") with a copy of a draft report to the Congress on the effect of incomplete participant data on the reliability of actuarial valuations for multiemployer pension plans. The Academy was requested to review the draft report and provide comments to the GAO prior to the report's issuance in final form. Having reviewed the document, the comments which appear herein are a compilation of comments received from members of the Academy's Pension Subcommittee on Multiemployer Plans and the Academy's Committee on Pension Actuarial Principles and Practices. While members of these committees are employed by various consulting firms, government agencies, and insurance organizations, the views expressed herein are expressed as members of the Academy, and do not necessarily represent the views of any employer.

Interest of the Academy

The Academy is a professional association of over 7,300 actuaries representing all areas of specialization and types of practice within the actuarial profession. Over 85% of the enrolled actuaries under ERISA are members of the Academy.

The Academy views its role in the government relations arena as offering advice and counsel to the nation's decision-makers, so that when faced with issues of public policy, these decision-makers can proceed with the assistance of an independent and professional actuarial perspective. In this spirit, the following comments and observations regarding the draft report are offered.

Introduction

We commend the GAO for calling attention to the issue of incomplete participant data in multiemployer pension plans. Furthermore, we encourage reasonable efforts to improve the quality of the participant data provided to the actuary. We would note that the quality of the participant data is generally not within the control of the actuary. All parties at interest in multiemployer plans --- participants, unions, employers, and federal regulatory officials --- are well served if uncertainty over the validity of actuarial valuations arising from inadequate participant data can be eliminated.

STATEMENT 1984-16

Data Sufficiency: A Matter of Professional Judgment

We concur with the general conclusion reached by the GAO, that pension plan participant data are crucial in providing the base for an actuarial valuation of a pension plan. We also concur that plan fiduciaries indeed have the legal responsibility for maintaining current, accurate, and complete participant data.

While the Department of Labor has the authority to prescribe regulations for the enforcement of this requirement, it has to date not issued standards concerning the adequacy of participant data. If such regulations are to be issued, a major factor in shaping the specific requirements thereof must, of necessity, involve a definition of what constitutes "complete" data. While a regulatory framework can provide a general yardstick for this definition, in the final analysis the application of such a yardstick to individual multiemployer plans must provide latitude for the exercise of professional actuarial judgment if the regulation is to be effective.

In our opinion, the actuary who is charged with undertaking plan valuations must come to terms with the sufficiency of data made available by plan fiduciaries, and by using professional training and judgment, ascertain whether such data are indeed sufficient for the purposes at hand. In short, we would reject a notion that a regulation can impose a uniform level of data sufficiency which could be applied to all plans, in all industries, and under all sets of circumstances. The universe of multiemployer plans is too diverse and differentiated to be susceptible to such a simplistic approach.

Disclosure of Potential Effects of Incomplete Data

The GAO draft report (p. vii and p. 44) states that practice standards in the Academy recommend, but do not require, disclosure of the effects of incomplete participant data on actuarial valuations. Although this statement technically may be true in an absolute sense, it does overstate the degree of discretion or flexibility available to the actuary.

The professional standard applicable to this situation is Recommendation C: Pension Actuarial Communications (copy attached). Within the Academy's standards of practice literature, a Recommendation has the force of a Generally Accepted Actuarial Principle and Practice, which members are required to observe in their work unless:

1. In their professional judgment, specific facts and circumstances make an alternate practice more appropriate, and

2. The alternate practice is disclosed as an exception to generally accepted standards of practice.

Thus, we feel some softening of the language "but do not require" in the GAO draft report would more accurately describe our current literature for actuarial disclosure on pension plans.

Also, our Committee on Pension Actuarial Principles and Practices is in the process of revising another Recommendation dealing with the measurement of pension obligations. As part of that review, the committee is considering more explicit guidance for the actuary as to what to do when data elements are missing.

Joint Board / Professional Association Standard Development

The GAO draft report recommends that the Joint Board for the Enrollment of Actuaries ("Joint Board") use the information in the report (and other information it can obtain from the Department of Labor and the Internal Revenue Service) to promote action by and work in cooperation with the actuarial profession to develop actuarial disclosure standards for multiemployer pension plans with respect to the adequacy of participant data.

We concur with the primary observation that the development of such standards should rest within the profession itself, both with respect to the adequacy of data and to disclosure of that fact to recipients of actuarial reports. In this regard, the Academy is prepared to be of assistance in this effort, and in fact to undertake a lead role in the development of such standards.

At the same time, the GAO draft report recommends the adoption of new regulations by the Joint Board and the Internal Revenue Service to define and mandate the utilization of complete participant data. We are not convinced that the current regulatory structure of the Joint Board and the Internal Revenue Service are inadequate to accomplish the goals sought in the GAO report. For example, we cite Section 901.20 (f) of the regulations of the Joint Board:

> **"Report or certificate.** An enrolled actuary shall include in any report or certificate stating actuarial costs or liabilities, a statement or reference describing or clearly identifying the data, any material inadequacies therein and the implications thereof (emphasis added), and the actuarial methods and assumptions employed."

We also note that the enrolled actuary when signing Schedule B of Form 5500 certifies that:

> "...the information supplied in this schedule ... is complete and accurate ..."

and that:

> "...the assumptions used ... represent my best estimate of anticipated experience under the plan."

Further, the Instructions to Schedule B of Form 5500 on line 12 (h) in connection with the statement of actuarial assumptions and methods requires that the enrolled actuary:

> "Include also such other information, if any, needed to fully and fairly disclose the actuarial position of the plan."

Thus, we believe that the Joint Board and the Internal Revenue Service already have a sufficient regulatory apparatus in place, if properly enforced, to achieve the goal of adequate actuarial disclosure.

If it is decided that additional regulations are nevertheless required, we would urge that they be deferred until new professionally developed standards can be formulated, inasmuch as the issuance of regulations without consideration of the professional standards which underlie the regulations would be inappropriate and premature.

Other Comments on the Draft Report

This section contains other comments on the GAO draft report. First, the draft report has not addressed the significant marginal costs which may be associated in increasing participant data levels from, for example, 90% to 95% or higher. In some situations, it may well be that the administrative costs associated with this increase in the data base outweigh any benefit which may arise from more complete data utilization.

Second, more attention might be given in the draft report to the fact that industry workforce distribution (by age, years of service, frequency of turnover, mobility, etc.) varies widely in multiemployer plans, and may make the achievement of higher levels of participant data more difficult in one industry than in another. In addition, the geographical differences in plan coverage (from small local plans to immense multistate or national plans) would make the institution of a uniform measure of participant data sufficiency much more burdensome on some plans than on others.

Third, we note that the draft report provides little detail on the sample of plans used other than for the aggregate size of the sample. Given the great diversity in multiemployer plans by size, nature of industry, characteristics of workforce, geographical spread, and other factors, it is important that the report assure readers that a truly representative sample was used for the study.

Conclusions

We commend the GAO for underlining the fact that inadequate participant data has a direct relationship to the validity of actuarial reports for multiemployer plans. We also note that we are in accord with the GAO view that to the extent that the validity of actuarial reports is questioned, the entire regulatory and administrative processing of plan activities may be called into question. Hence, we strongly support the proposition that fiduciaries be required to make available to actuaries as complete a set of participant data as is reasonably possible. But we also note that considerations of administrative feasibility and a cost-benefit analysis must be part of the process utilized in determining the level at which such data is considered "complete." Finally, we believe that it is part of the actuary's role to make a professional judgment as to the sufficiency of participant data and to properly disclose the effects of data inadequacies. While the government can establish general regulatory parameters for the exercise of this discretion, such parameters should be established only with the cooperation of the actuarial profession itself. We stand ready and eager to fulfill our part in the development of such practice standards.

STATEMENT 1984-16

We thank the GAO for offering us the opportunity to comment on this important draft report, and are prepared to cooperate on this and other matters of actuarial concern in the future.

Respectfuly submitted:

American Academy of Actuaries
Pension Subcommittee on
Multiempoyer Plans

Joseph A. Lo Cicero, Chairman

American Academy of Actuaries
Committee on Pension Actuarial
Principles and Practices

Thomas M. Malloy, Chairman

C. PENSION ACTUARIAL COMMUNICATIONS

(Adopted 1983)

1.1 Opinion A-3 of the Committee on Guides to Professional Conduct applies to all written communications by actuaries on actuarial subjects and, unless clearly inapplicable, to oral communications as well.

1.2 Paragraph B of the Opinion states that: "The form and content of any actuarial communication should meet the needs of the particular circumstances, taking into account the knowledge and understanding of the users and the actuary's relationship to the users."

1.3 A pension actuarial communication provides information directed towards plan sponsors, government bodies, employee groups, or other members of the public in connection with the design, revision, valuation, or pricing of employee retirement plans. This Recommendation supplements Opinion A-3 with respect to pension actuarial communications.

1.4 Not all of the items of information set forth in this Recommendation need be presented in every pension actuarial communication; what must be included depends upon the situation. The communication should include, either directly or by reference to accessible prior communications, sufficient information so that:

(a) it would be properly interpreted and applied by the person or persons to whom the communication is directed, and,

(b) another actuary unfamiliar with the situation could form an opinion about the reasonableness of the conclusion.

1.5 RECOMMENDATION C(1): The pension actuarial communication, in addition to including the name of the actuary responsible for its content, should contain, either directly or by reference to accessible prior communications, the following elements, where pertinent:

(a) The name of the person or firm retaining the actuary and the purposes that the communication is intended to serve.

(b) An outline of the benefits being discussed or valued and of any significant benefits not included in the actuarial determinations.

(c) A statement as to the effective date of the calculations, the date as of which the participant and financial data were compiled, and the sources of such data. The statement should include a full description of any material omissions in the data and any assumptions made with respect thereto.

(d) A summary of the participant data, separated into significant categories such as active, retired, and terminated-vested. Actuaries are encouraged to include a detailed display of the characteristics of each category and a reconciliation with prior reported data.

(e) A summary of assets by financial institution or other reporting source and a derivation of the actuarial value of assets. Actuaries are encouraged to include an asset summary by category of investment and a reconciliation with prior reported assets showing total contributions, benefits, investment return, and any other reconciliation items.

(f) A description of the actuarial assumptions and cost method and the asset valuation method. Changes in assumptions and methods from those used in previous communications should be stated and their effects noted.

(g) A statement of the findings, conclusions, or recommendations necessary to satisfy the purpose of the communication and a summary of the actuarial determinations upon which these are based. The communication should include applicable actuarial information regarding statutory minimum funding, tax deductibility, and financial reporting. Actuaries are encouraged to include derivations of the items underlying these actuarial determinations.

(h) A disclosure of (1) any deviations from Generally Accepted Actuarial Principles and Practices in the preparation of the material presented in the communication, and (2) any facts which, if not disclosed, might reasonably be expected to lead to an incomplete understanding of the communication.

STATEMENT 1984-17

May 25, 1984

Mr. Ted Becker
State Board of Insurance
1110 San Jacinto Boulevard
Austin, Texas 78786

Dear Ted:

The American Academy of Actuaries Committee on Life Insurance discussed your request that we prepare a recommendation as to how to modify the proposed 1980 CSO specifications to allow for minor variations such as might result from the use of different computer equipment.

The approach we favor is that which Alan Lauer recommended to you: that as long as the appropriate actuarial methodology is consistently applied, reasonable variations in values should be considered acceptable. I believe that Alan intends to attend the New Orleans meeting of your task force. He was present during our discussion and can communicate to you the sense of our recommendation.

We appreciate the opportunity to contribute to this process.

Best wishes,

Richard S. Robertson /ces

Richard S. Robertson, Chairman
Committee on Life Insurance

STATEMENT 1984-18

May 31, 1984

The Honorable Don Nickles
713 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Nickles:

On behalf of the American Academy of Actuaries Pension Subcommittee on Multiemployer Plans, I submit herewith two (2) copies of a statement for the record in connection with hearings held on May 10 and 17, 1984 concerning S.2329, The Multiemployer Plan Termination Reform Act of 1984. I respectfully request that this statement appear in the record of those proceedings.

Please accept our thanks for providing an opportunity to comment on this significant subject. We are of course prepared to respond to any inquiries you or your staff may have regarding the contents of the statement, and we look forward to working closely with you as you further refine your efforts to obtain a legislative solution to the many problems facing the multiemployer pension plan community in the United States.

Sincerely yours,

Gary D. Simms
General Counsel

STATEMENT 1984-18

STATEMENT FOR THE RECORD
AMERICAN ACADEMY OF ACTUARIES
PENSION SUBCOMMITTEE ON MULTIEMPLOYER PLANS
TO THE SUBCOMMITTEE ON LABOR
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
HEARINGS ON S. 2329
THE MULTIEMPLOYER PLAN TERMINATION REFORM ACT OF 1984
MAY 10 AND 17, 1984

Background

On May 10 and May 17, 1984, the Subcommittee on Labor of the Senate Committee on Labor and Human Resources, chaired by Senator Nickles, conducted hearings on S. 2329, the Multiemployer Plan Termination Reform Act of 1984. The comments below are submitted by the American Academy of Actuaries Pension Subcommittee on Multiemployer Plans. While members of the Academy subcommittee are employed in a variety of capacities, the views expressed herein are made as members of the Academy, and do not necessarily represent the views of any employer.

Interest of the Academy

The Academy is a professional association of over 7,300 actuaries representing all areas of specialization and types of practice within the actuarial profession. Over 85% of the enrolled actuaries under ERISA are members of the Academy. The Academy views its role in the government relations arena as offering advice and counsel to the nation's decision-makers, so that when faced with issues of public policy, these decision-makers can proceed with the assistance of an independent actuarial perspective.

Our comments below on the proposed legislation are therefore confined to issues of an actuarial nature. The comments are not designed to provide the Senate Labor Subcommittee with the view of an advocate, either on behalf of or in opposition to the legislation. Our primary purpose is to assist the Subcommittee by providing actuarial analyses and comment on the potential impact and effect of the proposed legislation.

Furthermore, we take this opportunity to offer an invitation to the Subcommittee to utilize the expertise of the Academy and its Subcommittee on Multiemployer Plans in the further development of multiemployer legislation.

Comments on Bill

The comments set forth below refer to sections enumerated in the proposed legislation.

Sec. 4 Reduction in Employer Withdrawal Liability for Involuntary Withdrawal; Involuntary Withdrawal Payment Fund

The bill proposes to reduce employer withdrawal liability by 90% in circumstances in which withdrawal would be considered involuntary, such as, the death of a principal owner, a natural disaster, etc. Since the unfunded vested liabilities will be funded through other sources, this "no fault"

withdrawal liability proposal will have little direct or immediate impact from an actuarial viewpoint. However, if the same level of benefits is to be maintained (or increased over future years), such withdrawals are likely to require an increase in the contributions from the remaining employers because such a plan will be assessed a risk-related premium to establish and maintain an involuntary withdrawal liability payment fund. This fund will reimburse a plan for 90% of the withdrawal liability in the event of a "no fault" withdrawal. The plans are, in turn, allowed to pass this assessment along to contributing employers. Thus, the end result of this proposal may be that employers incur increased contribution rates in advance of and regardless of whether any employers actually involuntarily withdraw from a plan with unfunded vested liabilities. In addition, an employer's contribution increase in one plan may be used under this system to fund liabilities of withdrawing employers of another plan.

As indicated in our introduction, these comments are not intended to be critical of the involuntary withdrawal liability proposal. We appreciate the policy considerations taken into account in the development of this new concept. Our purpose here and throughout is to point out the areas which require study in order to adequately assess the possible effects of the proposal.

Sec. 5 Exemption from Liability for Withdrawals from Fully Funded Plans; Methods for Determining Unfunded Vested Benefits

Our comments with respect to this proposal do not relate to the proposed rule of no withdrawal liability for fully funded plans. Rather our comments are directed toward a far more significant feature of the proposed Section 5 from an actuarial point of view; that is, the requirement that the Pension Benefit Guaranty Corporation establish actuarial assumptions and procedures for determining the value of unfunded vested benefits and withdrawal liability.

Under current law, the actuary is required to establish assumptions and methods which "in the aggregate, are reasonable ... and which, in combination offer the actuary's best estimate ...." While we are aware that there has been a considerable amount of controversy within the actuarial profession as to the reasonableness of actuarial assumptions for withdrawal liability purposes, at this time we do not believe that multiemployer plans and their beneficiaries will be best served by mandating actuarial assumptions and procedures.

The proposal that the PBGC promulgate such asumptions on a mandatory basis is an infringement on the professional judgment and function of the plan's enrolled actuary. The actuarial community is working towards standards or guidelines as to what is considered generally acceptable practice for the establishment of actuarial assumptions and procedures for withdrawal liability purposes. If the actuarial community cannot resolve the matter, the arbitration process now available under current law will eventually result in a pattern which will form the basis for the acceptable norm or range of reasonableness.

Under current law, PBGC has the authority to establish discretionary guidelines for the purpose of establishing assumptions for withdrawal liability purposes. We believe that discretionary guidelines rather than mandatory procedures would be preferable because of the potential inflexible nature of

mandatory procedures. Nevertheless, regardless of whether the PBGC rules for setting actuarial assumptions for withdrawal liability are voluntary guidelines or mandatory procedures, we strongly believe that the PBGC should be allowed to establish such guidelines and procedures only after considering the recommendations of a committee of enrolled actuaries designated by the PBGC for that purpose. The Academy is prepared to be of assistance in this regard should such a course of action eventually be chosen.

Sec. 9 Additional Charge to Funding Standard Account for Multiemployer Plans Which are Neither Fully Funded nor in Reorganization

Sec. 10 Increase in Vested Benefits Charge in Determining Reorganization Status and Minimum Contribution Requirement

Sec. 11 Minimum Contribution Requirement if Plan Fails to Meet Asset-Benefit Test

The above three proposed sections have a common goal which, broadly stated, is to improve the funded status of multiemployer plans. The Academy strongly supports the premise that pension plans should be funded on a sound basis. The proposals in the above three proposed sections will help meet that goal.

However, the goal of soundly funded pension plans cannot be viewed in a vacuum. There must be a proper balance between contributions and benefits. To the extent that contribution requirements are increased for a particular plan, the current level of benefits that can be provided by that plan may be minimized. The balance in some cases may be a delicate one. The competing forces at work are the plan's desire to maximize benefits and the plan's desire to have a soundly funded plan.

Thus, we are not questioning the wisdom of the rules proposed in Sections 9, 10 and 11. It is our purpose to point out to the Subcommittee that these sections may have the effect, whether intentionally or unintentionally, of minimizing the level of benefits that would have been payable from some plans absent the requirements of these proposed sections.

Other Comments

While the proposed legislation offers a good basis for continuing discussion, we believe that as the Subcommittee continues its deliberations on the complex subject of multiemployer pension issues, several additional subject matters should be included on the agenda for discussion. We highlight several such subjects below which we believe merit consideration by the Subcommittee.

1. The proposed legislation provides many complex rules. As past experience has shown, it is difficult in an area as complex as pensions to anticipate all the ramifications of the proposals at hand. This is not an indictment of Congress, but rather an emphasis on the need to carefully consider the full impact of new rules in the pension area before legislation is enacted.

2. We suggest that the Subcommittee give consideration to a "Technical Corrections Act" with respect to the Multiemployer Pension Plan Amendments Act of 1980. We believe that there are certain provisions in the MEPPAA which are inconsistent with other provisions of the act, contrary to the intent of Congress, or simply inadvertent errors of a purely technical nature. Consideration might be given to scheduling oversight hearings, during which time these difficulties and ambiguities can be aired. If undertaken outside of the scope of major, substantive legislative proposals, such oversight would potentially be of great value.

3. Consideration should be given to the establishment of uniform pension terminology. In 1981, a Joint Committee on Pension Terminology (comprised of representatives of the Academy, the American Society of Pension Actuaries, the Conference of Actuaries in Public Practice, and the Society of Actuaries) issued a final report on pension terminology. The unprecedented unanimity of the pension actuarial profession expressed in this report has gone, to date, unheeded by Congress. The report noted that there are many examples in ERISA and other pension legislation of poorly defined, misleading, or ambiguous terms. We again urge the Congress to adopt uniform standard pension terminology. Such action would lessen misunderstanding and would be beneficial to all concerned in the private pension system. The Academy will be happy to provide assistance on this matter.

4. Consideration should be given to the requirement for a statement of actuarial opinion on the annual financial statement of the PBGC. At the present time, there is no requirement for a statement of actuarial opinion regarding the financial status of PBGC. Such a statement would be particularly valuable in connection with the reserve requirements for future benefit obligations of the PBGC. While we recognize that PBGC is not a private, profit-making institution, nevertheless we believe that a statement of actuarial opinion on its financial status, as part of the annual report, would do much in improving the annual report to Congress. Actuaries frequently provide such reports with respect to annual statements of private insurance companies which are submitted to insurance regulators. The techniques and abilities of actuaries in this regard could be utilized in support of PBGC activities, and we suggest consideration of this requirement in future legislation.

Summation

We recognize the serious public policy concerns which are at the basis of consideration of new legislation in the multiemployer pension area. We note also that changes in funding requirements could have significant impact on the financial condition of multiemployer plans, the contribution levels imposed on employers, and the benefit levels provided to participants. We thank the Subcommittee for providing us with the opportunity of making these comments, and we look forward to working closely with the Subcommittee and its staff as deliberations on this complex area continue.

Pension Committee	Subcommittee on Multiemployer Plans
Willard A. Hartman, Chairman	Joseph A. Lo Cicero, Chairman

STATEMENT 1984-19

REPORT OF THE AMERICAN ACADEMY OF ACTUARIES COMMITTEE ON DIVIDENDS AND OTHER NON-GUARANTEED ELEMENTS

(Submitted to the NAIC Life and Health Actuarial Task Force on June 2, 1984)

The American Academy of Actuaries Committee Report on The American Academy of Actuaries Committee on Dividends and Other Non-Guaranteed Elements has been working closely with its sister Society of Actuaries committee. The Society committee has completed its revision to the guidelines for participating insurance. The Academy committee is currently involved in the following steps:

1) Identifying the changes necessary to create an Academy document instead of a Society document.

2) Clarifying the recommendation for the participating business of stock companies.

3) Developing transition rules for stock company participating business.

4) Analysis of disclosure issues.

It is anticipated that the guidelines for participating business will be exposed to Academy members, along with suggestions regarding disclosure items, late this year.

Regarding non-guaranteed non-par business, the Academy committee's discussions indicate support for Harry Garber's proposals within the Society committee. A joint meeting of the two committees is being considered.

Respectfully submitted,

Claude Thau
Secretary to the Committee

STATEMENT 1984-20

STRATEGY STATEMENT REGARDING THE ACTUARY'S ROLE IN LIFE INSURANCE COMPANY STATUTORY REPORTING

Strategy Statement

1. Propose the following recommendations to the NAIC:

   a. That the board of directors of each life insurance company be required to designate a "valuation actuary" to sign the Statement of Actuarial Opinion covering the actuarial items in the Statutory Statement. To be eligible for such designation the actuary must meet qualifications as specified by the various states.

      In addition to other reasons, this should enhance the perception of the objectivity of the actuary signing the statement.

   b. That the statement of the valuation actuary's opinion be printed in the Statutory convention blank and become a fixed part thereof.

   c. That the statement of actuarial opinion be required to be included in any published financial statement reporting statutory results. In any case where a summary of the statutory financial statement is distributed, the summary would state that a statement of actuarial opinion has been prepared and signed, as required by state regulation, and identify the appointed valuation actuary.

2. Initiate a cooperative effort among the NAIC, the accounting profession, and the Academy to define the respective roles of the valuation actuary and the auditor in those states which require a CPA audit of Statutory financial statements. The roles should be defined to involve as little overlap as possible. The actuary would be responsible for the actuarial items as defined and the auditor would be responsible for the traditional auditing functions, including verification of the in-force or other underlying records.

   The opinion statements of each party would be made without expressed reliance on the work of the other party. A paragraph disclosing the respective role of each party would be provided by management as part of its report or as a note to the financial statements. The qualifcations of each professional would be verified by the other and standard procedures for each function would be developed, accepted by both professions and codified.

3. Request the Academy's Committee on Life Insurance Financial Reporting Principles, and its Committee on Qualifications Standards to review, revise and/or develop standards appropriate for the work product necessary to support the opinion and signature of the valuation actuary. These standards should include defined procedures acceptable to the NAIC and the accounting profession.

STATEMENT 1984-20

OBSERVATIONS, CONCERNS

The following comments and general observations about how these strategies would be implemented are important to consider.

1. (a) On the matter of the appointment of the valuation actuary:

- The clients within the industry and among regulators seem receptive to the concept of the valuation actuary because of Baldwin-United, general asset/liability matching concerns, etc.

- The requirement to designate a valuation actuary would require model legislation or regulation. For example, wording like the following would be needed:

> Where in this insurance code a company is required to attach to its annual statement a report of a valuation actuary, the directors of the company shall by resolution appoint an actuary to be the valuation actuary of the company for the purposes of this section and a certified copy of that resolution and of every subsequent resolution relating to the appointment of a valuatin actuary shall be filed with the Commissioner of Insurance within 15 days of its effective date.

> It is important to obtain broad support for the valuation actuary concept, particularly within the actuarial profession, senior levels within the industry, and the NAIC. The first step is to obtain the endorsement of the Academy's Committee on Relations with Accountants, then the Academy's Executive Committee. The concept will then be taken to the NAIC's Technical Staff Actuarial Group (June 2-3, 1984). Assuming these groups support the general concept, the next step will be to obtain broad support within the profession, the industry and the NAIC.

In order to achieve passage of any model legislation or regulation, it is likely the Academy would need to re-establish grassroot support at the local state level. For example, at the time current life statement of actuarial opinion was introduced, Academy liaison representatives were identified in many states and these individuals worked with the state insurance departments to obtain passage of the needed legislation.

(b) With regard to the opinion being printed in the Blank:

This Recommendation would need to be implemented by the NAIC Blanks Committee.

(c) In the matter of reference to the valuation actuary in statutory summaries:

Model legislation or regulation is likely required. For example, the current Canadian Insurance Company Act contains the following requirement, and illustrates the type of wording required.

> In all financial statements published by the company for presentation to the policyholders, shareholders, or the public showing the financial position of the company at the end of the calendar year... such financial statements shall include a statement of the opinion of the valuation actuary that the reserve makes good and sufficient provision for all obligations guaranteed under the policies in force.

American Academy of Actuaries
Committee of Relations with Accountants
Insurance Subcommittee on Actuary/Auditor Relationships

MAJOR RECOMMENDATIONS OF THE REPORT OF THE JOINT COMMITTEE ON THE ROLE OF THE VALUATION ACTUARY IN THE U.S.

(1) The Valuation Actuary

The Committee recommends that each state enact a statute requiring the directors of a life insurance company licensed in the state to appoint by resolution an actuary to be the Valuation Actuary of the company and to file a certified copy of that resolution and of every subsequent resolution relating to the appointment, dismissal or change of a Valuation Actuary with the appropriate state regulatory authority on a timely basis. Valuation Actuaries who are members of the American Academy of Actuaries would be subject to qualification standards established by the Academy, and accountability would be ensured through the Guides to Professional Conduct and accompanying disciplinary measures. The qualification standards would address the problem of assuring that the Valuation Actuary remain knowledgeable *concerning* current valuation principles and standards of practice.

(2) Principles Underlying the Valuation of Life Insurance Companies for Solvency/Solidity Purposes

The Committee believes that ultimately the Valuation Actuary should be responsible for the selection of assumptions and the establishment of reserves appropriate under the circumstances. Guidelines for selecting the assumptions and making the calculations would be provided in the form of principles contained in actuarial literature and standards of practice promulgated by the actuarial profession. The availability of such principles and standards, along with the qualification standards for

the Valuation Actuary and his relationship to management and regulators, as described in the first recommendation, would provide regulators with the confidence needed to accept the Valuation Actuary's determination of the appropriate reserves.

Until such time as comprehensive valuation principles and standards have been developed, we believe that legal solvency requirements must continue to be defined. The basis of these requirements is the statutory annual statement in which reserves are determined in accordance with the Standard Valuation Law, other statutes and regulations, and statutory accounting principles. These requirements are accepted as being necessary to provide the regulators and the courts with an objective basis for removing the current management of a company failing to meet these requirements.

In addition to the level solvency standard, a Statement of Actuarial Opinion would be required by a qualified designated valuation actuary that (1) the reserves established and the related anticipated insurance and investment cash flows make a good and sufficient provision for all future policy obligations on a reasonably expected basis and (2) that such reserves and additional available appropriated surplus together with the related anticipated cash flow make a good and sufficient provision for all future policy obligations on a basis sufficient to cover future plausible fluctuations from expected assumptions. Documentation of the basis for the opinion would be provided in a Valuation Actuary's report prepared for management and the Board of Directors. This first standard may require reserves to be established which exceed the legal solvency standard. Any portion of surplus required to satisfy the second test described in the actuarial opinion must be recognized by management and the amount, together with the basis of its determination, would be available for review by regulators, but would not be required to be published in financial statements.

In time, when confidence in the protection afforded by actuarial opinion becomes firmly established, the legal solvency standard should be eliminated. The actuary would then be responsible for selecting assumptions for the reserves established which he believes to be appropriate under the circumstances. These assumptions and methods would be fully described in the Valuation Actuary's report to be submitted to regulators on a confidential basis.

SUMMARY OF SUGGESTED PROCEDURE FOR USE BY STATE REGULATORY OFFICIALS FOR THE FILING OF DISCIPLINARY COMPLAINTS AGAINST AAA MEMBERS

I. The Academy is the public interface organization of the actuarial profession in the United States.

- A. Promulgates Guides to Professional Conduct (Guides and Opinions)
- B. Promulgates Standards of Practice (Recommendations and Interpretations)
- C. Operates Discipline system to enforce standards

D. The discipline procedure is aimed at supporting the public interest

II. Interaction with state officials is primarily through submission of insurance company annual statement blanks and associated opinion statements.

III. Overview of Academy's Discipline Process

A. Filing a complaint
B. Investigation
C. Hearing
D. Decision: warn, admonish, reprimand, suspend (public), expel (public)
E. Appellate process

IV. Filing a Complaint

A. May be filed by member, nonmember, actuary, nonactuary
B. May be filed by government official or agency
C. May even be filed anonymously
D. May be filed by Academy committee
E. No format specifically required; but should be sufficient to enable further investigation
F. Filed with the Discipline Committee chairman
G. Process is confidential

V. Basis for Allegations

A. Unethical conduct; conviction of criminal offense evidencing a fraud, dishonesty, or breach of trust, or by knowing filing of false or altered documents
B. Unprofessional work product; disregard or violation of Academy Standards of Practice

VI. Liability for Complainant

A. Discipline process is strictly confidential; AAA Bylaw provision
B. State officials, acting within official capacity, are generally immune from suit; but whether state government will supply an attorney to defend against suit brought for libel is a matter of choice for each state.

VII. Penalties which may result include warning, admonishment, reprimand, suspension, or expulsion (only the last two are public).

VIII. Committee procedure includes necessary due process, with hearing, cross-examination, etc. Final appeal may be made to Board of Directors and membership of the Academy.

IX. Each circumstance is of course unique, and many situations can be resolved through a careful process of examination and consultation. Questions regarding specific matters, and the application of the

Academy's disciplinary procedures, should be submitted to the Chairman of the Discipline Committee.

SUGGESTED PROCEDURE FOR USE BY STATE REGULATORY OFFICIALS FOR THE FILING OF DISCIPLINARY COMPLAINTS AGAINST MEMBERS OF THE AMERICAN ACADEMY OF ACTUARIES

Introduction

The American Academy of Actuaries, the public interface organization of the actuarial profession within the United States, has as one of its basic purposes the establishment, promotion, and maintenance of high standards of competence, conduct and practice within the actuarial profession of this nation. In addition to promulgating specific codes of conduct and standards of practice, the Academy maintains a disciplinary procedure so that allegations of misconduct or unprofessional work product can be initiated, reviewed, and adjudicated. The method by which this takes place requires appropriate emphasis on procedural and substantive due process, fairness, privacy, and protection of the public interest.

The Discipline Committee of the American Academy of Actuaries, which is charged with the responsibility of investigating and adjudicating allegations of unethical conduct or unprofessional work product, views its role as that of a protector of the public interest. To the extent that actuaries do engage in unethical conduct or produce work which fails to meet the standard of generally accepted actuarial principles, the Discipline Committee believes that the profession as a whole suffers, and that the users of actuarial services lose confidence in the profession. Therefore, the efficacious handling of all such allegations is deemed to be within the best interests of the American Academy of Actuaries, the actuarial profession, and the public.

Actuaries and State Regulatory Officials

Commonly, state regulatory officials come into contact with the work product of actuaries through the annual statement blanks filed by insurance companies, to which an actuarial certification is often affixed, pursuant to state law. In some states, actuarial information regarding pension plans is also required, and this may be another area in which the work of actuaries is reviewed by state governmental officials. Rate filings are another focal point for actuarial work vis a vis state insurance departments.

Because of the significance of the actuarial certification, reliance by state regulators on the professionalism of the actuary who undertakes the certification is essential. The American Academy of Actuaries therefore suggests that state governmental officials who have cause to believe that actuarial work product which has been placed before them is somehow lacking in professionalism should bring such matters to the attention of the Chairman of the Academy's Discipline Committee. The Committee is unable to take action to review alleged misconduct or unprofessional work product unless such matters are brought to its attention.

STATEMENT 1984-20

An Overview of the Academy's Discipline Process

The disciplinary procedures of the Academy can be summarized to include the following steps:

1. Filing a complaint
2. Investigation
3. Hearing (if necessary)
4. Disposition by full committee
5. Appeal (if requested)

The Academy's authority to discipline its members is found in its Bylaws, which delegate to the Discipline Committee the authority to review and adjudicate:

> ". . . all questions which may arise as to the conduct of a member of the Academy in the member's relationship to the Academy, or its members or in the member's professional practice, or affecting the interest of the actuarial profession."

It should be noted that the disciplinary process applies only to members of the American Academy of Actuaries, because the Academy lacks any authority to discipline actuaries who are not members of the Academy. However, since the majority of actuaries in the United States are members of the Academy, this disciplinary process is often available to deal with allegations of unethical conduct or unprofessional work product which may appear before state regulatory officials.

Filing a Complaint

As noted above, the Academy's disciplinary process is initiated with the filing of a complaint against an Academy member. Such a complaint may be filed by a fellow member of the Academy, by a nonmember actuary, a governmental agency, a governmental official, or by another person. In addition, the Discipline Committee itself has the authority to initiate the process.

A complaint may be made anonymously, and a complete investigation and hearing may take place arising out of such an anonymous complaint, provided that the investigation undertaken by the Committee finds sufficient grounds to raise a concern that a violation of the Academy's standards of practice or ethical considerations has occurred.

Although no particular form is required for a complaint to be acted upon, the more explicit and detailed the allegations, the quicker and more easily the investigation into the merits of the allegation can be undertaken and completed.

Complaints should be filed with the Chairman of the Discipline Committee of the Academy. If initiated by an actuary, the complainant is urged to specify the particular standards of conduct or professional practice which have allegedly been violated. If applicable, copies of the work which has been questioned should be included with the complaint.

The filing of a complaint does not, of itself, connote guilt. Once a complaint has been received, further investigation and processing becomes the responsibility of the Discipline Committee.

Bases for Allegations

Reference has been made above to unethical conduct and unprofessional work product. Indeed, these are the two bases upon which the disciplinary process operates within the Academy. Unethical conduct can be evidenced by conviction of a criminal offense evidencing a fraud, dishonesty, or breach of trust, or by the knowing filing of false or altered documents. In short, a violation of generally accepted ethical precepts (as embodied in the Academy's Guides to Professional Conduct and supporting Opinions) form one basis for disciplinary action.

Disciplinary actions can also be based on unprofessional work product, which would be work submitted by an actuary which has been undertaken in disregard or in violation of the Academy's Recommendations and Interpretations, or other generally accepted actuarial principles. The Guides, Opinions, Recommendations, and Interpretations are codified in the Academy's Yearbook.

In summary, a complaint about an actuary which is filed by a regulatory agency or regulatory official should:

1. be addressed to the Chairman of the Academy's Discipline Committee;
2. specifically detail the violations of ethical or work practice standards;
3. be accompanied by copies of applicable work product, if any; and,
4. should identify an individual to whom, or source from which, the Academy's investigation can be directed.

Liability for Filing a Complaint

The Academy's disciplinary process is a strictly confidential one, as provided for in the Bylaws. This serves to protect the reputation of the individual under investigation, at least until such time as a public penalty has been imposed (see discussion regarding penalties below). In addition, individuals who wish to retain their anonymity when bringing complaints can be assured of that confidence as well.

In general, state officials who bring complaints to the attention of organizations such as the Academy, when they do so while acting within their official governmental capacity, are immune from suit, based upon the general theory of governmental immunity. However, the law may vary from state to state, as would the willingness of the state government to provide legal representation to the complainant in the event that a suit (for libel or slander) is brought by the defendant/actuary. In this regard, it is suggested that state officials seek legal counsel if deemed necessary.

Penalties

Five different levels of penalties may be imposed by the Academy upon a finding of a violation of either ethical precepts or standards of practice. These include:

1. Warning
2. Admonishment
3. Reprimand
4. Suspension from Membership
5. Expulsion from Membership

Under Academy procedures, a warning, admonishment, or a reprimand are deemed to be internal matters, and hence there is no publication of such penalties when imposed. However, for the more serious penalties of suspension or expulsion, the Academy deems it appropriate that the public be provided notice of the imposition of these measures.

Warnings are generally imposed for unintentional violations, where the offending party could not reasonably have known that the activities complained of were inappropriate. Admonishments are imposed when the offending party unknowingly violated an appropriate standard, but should have been aware that his actions were wrong. Reprimands are imposed when the offending party knowingly committed an impropriety, and continued violations of a similar nature would lead to more severe penalties. A suspension from membership is considered appropriate for a serious, knowing violation, under such circumstances that public censure is deemed appropriate. Expulsion from membership is imposed for a serious, knowing violation of standards which is so severe that, in the opinion of the Academy's Board of Directors, the individual is no longer deemed fit to be a member of the Academy.

Case Processing

Once an allegation is received, the Discipline Committee undertakes an investigation. This initial investigation is designed to ascertain whether there are sufficient grounds to initiate formal charges. If, in the opinion of the Committee, sufficient grounds do exist, the matter will be scheduled for a formal hearing, at which time the actuary/defendant will be offered an opportunity for a full and complete hearing on the allegation. Representation by legal counsel is permitted.

The complainant can have a role to play in the investigation and hearing process, primarily as a witness and resource for additional investigation. The Academy does not, of course, have the power of subpoena, and to the extent that a complainant does not wish to participate in the process, he or she of course can avoid further participation. However, to the extent that the facts and circumstances of a given matter would benefit from the participation of the complainant as a witness, a refusal to participate would certainly render the proceedings more difficult in terms of its ultimate resolution.

Following a full and complete hearing, the Committee will decide whether any of the penalties available are appropriate. For more severe penalties, the Academy's Board of Directors will automatically review the recommendation of the Committee; in all matters, the defendant/actuary has the option of

appealing a Committee decision to the Academy's Board of Directors, and thence to the entire Academy membership, if so desired.

Conclusion

One of the essential concerns of a profession is the fitness of its members to practice. For a profession with public responsibilities, such as the actuarial profession, this concern is considered to be extremely important. Inasmuch as the credibility of actuaries is essential to the public's acceptance of their opinions, the Academy's Discipline Committee views its role with the utmost importance. Further, since state regulatory officials rely upon the work product of actuaries in their own deliberations, the Academy believes that it is appropriate that such officials be aware of and familiar with the process by which the actuarial profession disciplines its members when appropriate and necessary. It is also the belief of the Academy that when regulatory officials are faced with actuarial work product which is submitted in violation of appropriate standards of practice or conduct, that such officials should be encouraged to submit such matters to the Academy for investigation and appropriate action.

Each circumstance is of course unique, and many situations can be resolved through a careful process of examination and consultation. Questions regarding specific matters, and the application of the Academy's disciplinary procedures, should be submitted to the Chairman of the Discipline Committee.

STATEMENT 1984-21

July 20, 1984

Mr. Grey Staples
Counsel
Subcommittee on Commerce, Transportation and Tourism
H2-151 House Office Building
Annex II
Washington, DC 20515

Dear Mr. Staples:

The American Academy of Actuaries has submitted a statement for the record on H.R. 4642, the Fair Insurance Coverage Act. As time was limited, due to the July 20th deadline for submitting the statement, our Committee on Risk Classification was unable to consider this issue. Rather, our statement represents my collaboration with our committee chairman, Robert L. Knowles. I would like to clarify the fact that any further work on this issue would be undertaken by our entire Committee on Risk Classification.

Please notify us if the Academy may be of assistance to the Subcommittee in further consideration of this proposed legislation.

Sincerely,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-21

STATEMENT FOR THE RECORD
AMERICAN ACADEMY OF ACTUARIES
TO THE
SUBCOMMITTEE ON COMMERCE, TRANSPORTATION, AND TOURISM
HOUSE COMMITTEE ON ENERGY AND COMMERCE
HEARINGS ON H.R. 4642
THE FAIR INSURANCE COVERAGE ACT
JUNE 27, 1984

Background

On June 27, 1984, the Subcommittee on Commerce, Transportation, and Tourism of the House Committee on Energy and Commerce conducted hearings on H.R. 4642, the Fair Insurance Coverage Act. The comments below are submitted on behalf of the American Academy of Actuaries for the record of this hearing.

Interest of the Academy

The Academy is a professional association of over 7,300 actuaries representing all areas of specialization and types of practice within the actuarial profession. The Academy views its role in the government relations arena as offering advice and counsel to the nation's decision-makers, so that when faced with issues of public policy, these decision-makers can proceed with the assistance of an independent actuarial perspective.

Our comments below on the proposed legislation are therefore confined to issues of an actuarial nature. The comments are not designed to provide the Subcommitee with the view of an advocate, either on behalf of or in opposition to the legislation. Our primary purpose is to assist the Subcommittee by providing actuarial analysis and comment on the technical difficulties we see in the current proposal which must be overcome if the desired purpose of its sponsor is to be attained in a rational manner.

Comments on the Bill

H.R. 4642, the Fair Insurance Coverage Act, is intended to prohibit discrimination in insurance on the basis of blindness or degree of blindness. Section 3(4) of the proposed bill appears to include within the ambit of the nondiscrimination limitation virtually all forms of individual insurance, including life, health, property and casualty, and annuities.

In several sections, potential exemptions to this broad nondiscrimination requirement seem at first glance to be available. These exemptions would be permitted if what is called "sound actuarial evidence" is found in any particular case. See sections 4(a), 4(b)(2), and 4(c) for examples. The bill appears to indicate that insurers could take blindness into account in setting rates, or in offering coverage, only if the carriers demonstrate "clearly" through "sound actuarial evidence" that the basis for such discrimination is justified.

On closer scrutiny, however, this set of "exemptions" may be difficult to determine in practice. The Academy notes with concern that there is no definition at present of what constitutes "sound actuarial evidence." The

adoption of such an undefined standard would place into federal law this particular standard for the first time. Among actuaries, the determination of whether there is "sound actuarial evidence" is something which can be established only through the application of professional judgment and experience. It is clearly not a standard which can easily be articulated in a statutory framework.

For example, the sponsors of the bill, we assume, would intend to allow automobile insurers the right to deny coverage to drivers whose eyesight has deteriorated beyond a certain point. But under the current language of the bill, it might be difficult for an actuary to demonstrate "clearly" the "sound actuarial evidence" to support the operation of the exemption. This could happen since the number of people who attempt to drive with badly impaired eyesight would be so small in number that any statistical information about them would be too scanty to be "sound" from an actuarial perspective. While common sense would dictate that such drivers could appropriately be denied automobile coverage, common sense alone cannot satisfy the standard of "sound actuarial evidence" which the proposed legislation would require.

Although this example may be a bit artificial and extreme, it does illustrate that the question of statistical credibility is a major factor in the determination of "sound actuarial evidence." Furthermore, not only is statistical credibility dependent upon the volume and quality of data, but also upon what actuaries would call the "level of significance," i.e., the probability that differing results are attributable to true underlying experience differences rather than to random chance. Is it sufficient to say we can recognize experience differentials at only the 51% probability level? Probably not, but how about the 75% level? Or 95%? Or 99%? It is clear that these are very difficult issues to resolve in a statutory framework and that professional actuarial judgment will be required.

Another problem with determining whether "sound actuarial evidence" exists in connection with this kind of determination arises from the fact that blindness is often correlated with other medical conditions which may have an impact upon longevity. For instance, blindness is correlated with diabetes, which has been demonstrated to have a negative impact on life expectancy. In some cases, the statistical evidence necessary to make a sound actuarial determination is simply not available, or is so interwoven with other factors that the segregation of the blindness factor alone becomes illusory.

As noted, the literature of the actuarial profession does not explicitly define "sound actuarial evidence" and therefore the definition of that phrase would under this legislation be developed on an ad hoc basis through case-by-case litigation. The absence of a federal regulatory or enforcement authority would mean, in effect, that the law proposed would be enforced on a state-by-state basis, with the potential for widely differing results. The impact upon the actuarial profession in such an atmosphere should not be ignored. Such a development could have adverse implications for the enforcement of the proposed law itself (through state courts with differing interpretations), and could have negative spillover implications for the actuarial profession in other areas. For example, definitions of "sound actuarial evidence" developed under this statute might well be applied in other areas where the standard was not intended to be utilized.

We would also note that in the model regulation of the National Association of Insurance Commissioners (NAIC) to prohibit unfair discrimination on the basis of blindness or partial blindness, there is a reference to "sound actuarial principles" rather than to "sound actuarial evidence." We are not clear whether these would be essentially the same standard or whether this bill would involve a considerably different standard than the one in the NAIC model.

At the present time, the only generally accepted statement concerning this broad subject matter is the Academy's Risk Classification Statement of Principles (a copy of which is appended to this statement). Despite the generally accepted nature of this document, it falls short of what a court of law would require for a proper judicial analysis of "sound actuarial evidence" in any particular setting.

At the present time, the Academy has embarked upon a significant expansion of standards of practice for actuaries. While, to date, the profession does have a series of standards applicable in a limited number of areas, this new undertaking is designed to furnish the profession with a more complete set of standards, arrived at through a careful and deliberate process utilizing the input of a broad cross section of the profession. Such standards could provide the government and the courts with the kind of guidance and definitions which, in part, the legislation under consideration needs. The Academy is ready, willing, and able to develop appropriate definitions and standards for the term "sound actuarial evidence" should this legislation be enacted. However, we caution that development of such a standard would not be an easy task and would involve considerable time for development, exposure, analysis, and testing.

Conclusion

We recognize the serious public policy concerns which are the basis of consideration of legislation in this area. We note that the bill as currently drafted could create a significant misunderstanding and unnecessary litigation unless the definition of "sound actuarial evidence" is clarified. We offer our cooperation in this effort, and thank the Subcommittee for the opportunity of making these comments.

Respectfully submitted,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

July 30, 1984

Auditing Standards Division
File 3155
AICPA
1211 Avenue of the Americas
New York, New York 10036

Re: Auditing Life Reinsurance

This letter is in response to the AICPA Exposure Draft of a Proposed Statement of Position on Auditing Life Reinsurance dated April 30, 1984. It is being submitted on behalf of the Task Force on Reinsurance Accounting of the American Academy of Actuaries, chaired by Ronald E. Ferguson.

The Academy Task Force commented on an earlier draft of this AICPA paper on March 8, 1983. A copy of these comments is attached.

The Academy Task Force reviewed this latest AICPA Exposure Draft and does not have any additional comments to those previously submitted. We were pleased to note that several of our previous suggestions have been incorporated into the Exposure Draft.

The Academy retains an active interest in the area of reinsurance accounting and intends to comment on future AICPA drafts dealing with the accounting issues which we understand will be considered subsequent to the auditing issues.

Yours truly,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-22

March 8, 1983

Mr. Brian Zell
Auditing Standards Division
American Institute of CPAs
1211 Avenue of the Americas
New York, NY 10036

Re: File Ref. No. 3155

Dear Mr. Zell:

The American Academy of Actuaries Task Force on Reinsurance Accounting is pleased to have the opportunity to review and furnish comments on the current draft discussion paper concerning "Auditing Life Reinsurance."

In general, we find little fault with the current draft. In saying that, it should be kept in mind that the Academy is not necessarily taking a position on whether or not this topic needs to be addressed by the accounting profession. Rather, we have reviewed the work in an effort to spot technical or practical problems.

We have but a few comments to offer:

1. On page 1 at the end of the penultimate sentence of paragraph 2, we assume you mean to use the word "reinsured" rather than "insured."

   More broadly, the statement that "If the policy exceeds the retention limit, a portion of the risk will be reinsured" is confusing. This is true of YRT but would be clearer if it was stated that the excess (not portion) is reinsured. This statement is not true for coinsurance and modified co where generally the insurer cedes a percentage of each policy written.

2. Paragraphs 6a and 6b of the draft leave an incorrect impression about the differences between yearly renewable term and coinsurance. The difference between YRT and coinsurance is not (as implied) that the YRT is a short term proposition and coinsurance long term. Both are long term reinsurance arrangements. In the case of coinsurance, reinsurance is effected on original term basis; in the case of YRT by the series of guaranteed one year term costs.

3. We suggest that paragraph 6a be revised by deleting the first two sentences and adding the following language:

   Yearly renewable term (YRT) involves the purchase of reinsurance on the policyholder's life, on a year by year basis, using a series of one year term costs. Usually these costs, or another table of cost factors, are guaranteed for the life of the contract.

4. We suggest that the first two sentences in paragraph 6b in the draft be deleted and replaced with the following language:

Coinsurance differs from yearly renewable term in that assuming company participates in substantially all aspects of the original policy.

5. The discussion of modified coinsurance on page 4, 6c is incomplete. The statement is made that modified coinsurance differs from coinsurance only in that the assets supporting the reserves remain with the ceding company. It should be noted that the reserves also remain with the ceding company.

6. Although 13c does not address a technical or actuarial point, we would, nevertheless, wish to offer an opinion. While assuming carriers will probably divulge general information about their retrocessional programs, many would be quite uncomfortable about furnishing detailed information. Many assuming carriers would feel that the details of the retrocessional programs fall into a category of privileged or proprietary information.

7. We would again remind the AICPA as we did when the property/liability report was being prepared that we must be careful not to put certain segments of the industry at a disadvantage. This notion most clearly comes to light when reviewing items 22b and 22c. Here it is suggested that the assuming company's independent auditor may need to communicate or visit with the ceding company or its auditors. To the extent that it happens, this is both a nuisance and expense for the ceding company. This may put the U.S. owned audited assuming company at a disadvantage to the foreign owned or mutual reinsurance companies which may not be subject to the same burden on its customers.

We hope these comments will be of some value to you and we look forward to seeing the next draft of "Auditing Life Reinsurance."

Sincerely,

Ronald E. Ferguson

Ronald E. Ferguson, Chairman
AAA Task Force on Reinsurance
Auditing and Accounting

STATEMENT 1984-23

STATEMENT FOR THE RECORD
AMERICAN ACADEMY OF ACTUARIES
TO THE SUBCOMMITTEE ON TAXATION AND DEBT MANAGEMENT
SENATE COMMITTEE ON FINANCE
HEARINGS ON FRINGE BENEFITS
JULY 31, 1984

Background

On July 26, 27, and 30, the Subcommittee on Taxation and Debt Management of the Senate Committee on Finance held hearings on the taxation of fringe benefits. The comments below are submitted for the record of these hearings on behalf of the American Academy of Actuaries ("Academy").

Interest of the Academy

The Academy is a professional association of over 7,600 actuaries involved in all areas of specialization within the actuarial profession. Included within our membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA), as well as comparable percentages of actuaries providing actuarial services for other employee benefit plans such as life, health, and disability programs.

The Academy finds it difficult to comment on tax legislation in general, since we are not advocates on major public policy decisions which are not actuarial in nature. The Academy views its role in the government relations arena as providing information and actuarial analysis to public policy decision-makers, so that policy decisions can be made with informed judgment.

Nevertheless and in spite of the fact that actuarial considerations are unlikely to ever be the driving force behind major decisions on tax policy, actuarial input can be quite useful in shaping and molding tax policy to deal appropriately with the extremely complex, yet vitally important, employee benefits area. For example, the determination of required contribution levels to plans to provide the benefits, setting appropriate reserve levels to meet future obligations, and financial calculations involving the time value of money are all actuarial in nature.

General Comments on Employee Benefit Plans

Employee benefit plans provide an array of insurance and retirement benefits which greatly increase the present and future economic security of millions of Americans. Salary dollars cannot replicate an annuity at retirement that cannot be outlived, life insurance for the family of a deceased worker, the cost of hospitalization in the event of major illness, or income to a disabled worker. Employee benefit plans deliver dollars at the time they are needed most. Moreover, in general, these benefits can be more economically provided on a group basis to an employee workforce than on an individual basis, due to the significant savings in administrative costs and to the stability that comes with a pooling of risks across a broad cross section of employees.

There is no question that the growth of employee benefit plans in the past few decades has been greatly stimulated by tax policy toward those plans. This

tax policy has been the result of deliberate Congressional intent which has been demonstrably successful in fostering the development of employee benefit plans. It would be naive and erroneous to assume that employers would continue to provide the same level of benefits in the event that the favorable tax treatment of certain types of employee benefit plans were significantly curtailed or even eliminated. The pressure from employees with the basic attitude "If I have to pay taxes on it anyway, give it to me in cash" would simply be too great. The end result would be a decline in the level of protection provided by the private sector, inevitably leading to greater demand and strain on governmental programs. Given the financial difficulties facing programs such as Medicare and Social Security, a decline in private sector programs would hardly seem to be in the public interest.

Need for National Policy

We hope these hearings will be useful in focusing attention on the need for a coherent, stable, and strongly articulated public policy toward employee benefit plans by the federal government. The fact that no such policy exists leads to a seemingly endless series of ad hoc changes and confused signals toward employee benefit plans. In the tax area alone in just two short years we have seen the Tax Equity and Fiscal Responsibility Act of 1982 and the Deficit Reduction Act of 1984. And now before this last bill has even been printed into final form, Congress is talking about changing it all around again in 1985.

There is a crying need here for more stability in the tax treatment of employee benefit plans. Pension and insurance plans in particular involve long-term arrangements and commitments. Plan sponsors are finding it increasingly difficult to make rational decisions in such a chaotic environment. Much as this continual turmoil may provide additional work for actuaries, it hardly seems to be in the public interest to make the rules so complex and to change them so often that the typical plan sponsor has no chance of coping. The administrative costs of complying with all the changes being imposed on plans has risen significantly and is increasingly becoming a burden, particularly on small plans.

Tax Exemption vs. Tax Deferral

In some of the debates on tax policy the distinction between tax exemption and tax deferral seems to get lost. Although some employee benefit plans do provide tax exempt benefits, others do not. In particular, the major retirement income programs provide for tax deferral, not tax exemption. Within debates on tax deferral we increasingly hear arguments involving the concept of the "time value of money." This is a concept at the heart of actuarial science.

It is quite true that a dollar to be paid in the future is worth less than a dollar today because of the interest that can be earned in the interim. Translating this into tax policy for the federal government, the argument is heard that $1,000 of taxes today is worth $1,000, but if these $1,000 of taxes can be deferred for ten years their present value is worth only $386 if discounted at a 10% rate of interest. Thus, the argument is made that it is better for the Treasury to get the money now rather than later.

What this analysis overlooks, however, is that in many cases the Treasury will get more than $1,000 at the end of ten years. For example, consider a defined contribution pension plan in which the account balances are growing at a 10% rate of interest. $1,000 in tax deferral will continue to grow in the account and will amount to $2,594, not $1,000, in ten years. The present value of $2,594 discounted for ten years at a 10% rate of interest is exactly $1,000!

In the real world, of course, things are seldom this simple. Differences in value will arise if the rate of accummulation is different than the rate used in computing the present value. Also, there is a question about how the tax rates in ten years which will then apply compared with the tax rates which would apply today. However, the example does clearly illustrate that introducing the concept of the time value of money does not, on its own merits, make a convincing case against tax deferral. It is a valid analytical tool, but must be carefully applied in any analysis to present meaningful comparisons.

Public Sector Programs

If Congress intends to take a comprehensive look at the taxation of employee benefit plans in order to create a more coherent tax policy toward such plans, then it would seem appropriate to consider the tax treatment of public sector programs as part of such a comprehensive review. For example, at the present time the tax treatment of retirement benefits attributable to employer contributions under Social Security is different than for private sector retirement plans. This may or may not be good public policy ---- that is not an actuarial judgment. However, we do urge the Congress to review tax policy toward insurance and pension benefits under government programs as well as private sector programs in any comprehensive review of the taxation of employee benefit plans.

It is also important to consider how private sector and public sector programs fit together. For example, the integration of private pension plans with Social Security has been a controversial tax issue for a number of years. Actuarial considerations are vital in structuring sound integration rules for pensions or other employee benefit plans.

Actuarial Issues

There are six actuarial issues related to the general subject of the taxation of employee benefit plans which we address below.

1. Financial Condition

   The maintenance of a well-run insurance or pension employee benefit plan involves the determination of both an appropriate contribution level to provide the expected benefits and appropriate reserve levels to cover the accrual of benefit obligations. Both of these are actuarial processes.

   Tax policy should recognize the need for these determinations to be made according to sound actuarial principles and practices. Such recognition does exist in the pension area under ERISA. However, that recognition is not as clear in connection with certain insurance programs.

The Academy stands ready to work with Congress and regulatory agencies to define such sound actuarial principles and practices where required. A major priority for the Academy at the present time is the establishment of a structure within our profession to articulate actuarial standards of practice. This structure would be appropriate to deal with issues such as actuarial principles and practices in connection with insurance and pension employee benefit plans. Included in actuarial principles and practices are such matters as disclosure requirements and the content of an actuarial report.

2. Qualifications

Along with a recognition of the need for plans to be operated according to sound actuarial principles and practices there is the need to define the qualifications of the actuaries certifying the plans.

Of course, this need was clearly recognized in ERISA and in that instance Congress chose to create a Joint Board for the Enrollment of Actuaries to examine and license individuals as "enrolled actuaries."

Another example has arisen in the Deficit Reduction Act of 1984. This act provides that in connection with funded welfare benefit plans (including voluntary employees' beneficiary associations (VEBAs) under section 501(c)(9) of IRC) reserves in excess of "safe harbor" limits will be permitted if certified by a "qualified actuary" (to be determined under Treasury regulations).

Academy membership includes actuaries in all areas of practice and serves as the hallmark of a qualified actuary in the United States. However, we recognize that not all actuaries are necessarily qualified for all assignments. Accordingly, our Guides to Professional Conduct contain extensive guidance to ensure that: "The member will bear in mind that the actuary acts as an expert when giving actuarial advice and will give such advice only when qualified to do so."

The Academy has a Committee on Qualifications to address issues such as these. We strongly urge direct participation of the actuarial profession in defining the qualifications of an actuary to engage in any particular assignment. The Academy has a strong commitment to self-regulation and is prepared to work closely with the Treasury if such regulations are to be developed.

3. Actuarial Assumptions

The setting of actuarial assumptions is a key ingredient in any actuarial assignment. The provisions relating to funded welfare benefit plans in the Deficit Reduction Act of 1984 (cited above) require that assumptions be reasonable in the aggregate. This is quite appropriate and follows the precedent set by ERISA in the pension area.

However, the Conference Report goes further and indicates that "in addition to requiring that actuarial assumptions are to be reasonable in the aggregate, Treasury regulations may prescribe specific interest rate and mortality assumptions to be used in all actuarial calculations." Such

a simplistic approach would ignore the fact that experience is different from plan to plan for a variety of reasons (age/sex composition of group, nature of work, geographical area, etc.). Attempting to mandate any set of uniform assumptions will inevitably result in inappropriate assumptions being used for large numbers of plans. Setting appropriate actuarial assumptions requires the application of actuarial judgment to fit the facts and circumstances at hand.

We are concerned at the prospect that the Treasury might attempt to prescribe specific actuarial assumptions for funded welfare benefit plans. We believe the approach used in ERISA for setting actuarial assumptions for pension valuations is much more appropriate.

4. Current Tables

Certain portions of the Internal Revenue Code require the use of actuarial tables promulgated by the Internal Revenue Service. Examples are the tables for the taxation of group term life insurance under Section 79, the tables for the taxation of annuities under Section 72, and the tables used for the taxation of life estates and remainders.

Some of these tables have been allowed to get out-of-date. For example, the uniform premium table for group life insurance under Section 79 was changed in 1983, but the prior table had been in effect since 1966, during which time group term life rates dramatically changed. As another example, the current tables under Section 72 have not been changed since their release in 1954.

The use of actuarial tables to compute certain values required in the IRC is quite appropriate, but may appear arcane or even obscure to many taxpayers. Maximum credibility will be achieved if taxpayers perceive that the tables are based on current interest and mortality factors rather than ones that may appear obsolete. Such credibility should be an objective of tax policy.

5. Design Aspects

On occasion, actuarial insights on design aspects of certain tax proposals may be useful. For example, in the Academy testimony to the Senate Committee on Finance on June 22, 1983 on proposals for a health insurance tax cap, our Committee on Health Insurance pointed out some technical flaws with the proposal to base the tax cap on premiums. The Committee went on to suggest basing it on the richness of coverage provided as an alternative which would avoid these flaws.

(Note: The Academy neither supports nor opposes such a tax cap. This is a public policy decision up to Congress and is not an actuarial issue. However, we are concerned with the technical details of any such proposals and their full ramifications.)

6. Adverse Selection

A rather subtle, but potentially quite important, actuarial concept is the notion of "adverse selection." There is a natural tendency for any person

covered, or potentially covered, by an insurance or pension plan to exercise any options available to his or her apparent advantage, i.e. to select against the plan. Within limits, the cost of such adverse selection can be absorbed by a plan. For example, in pension plans with lump-sum options, retirees in poor health will tend to elect lump sums, while those in good health will tend to elect life annuities. In such a case, the plan sponsor has been willing to assume any extra costs involved in allowing such options.

In some cases, however, adverse selection could present more serious problems. For example, consider a voluntary health insurance program with substantial employee contributions required (either directly through payroll deduction or indirectly through a health insurance tax cap). Younger, healthier employees will tend to opt out of the program if they do not perceive they are receiving adequate value for their contributions. If this happens, the group left behind will increasingly consist of older or less healthy employees, and costs would increase significantly. In extreme cases, this could result in a vicious cycle of further defections of healthy employees as costs rise and spiralling cost increases for remaining participants, until the entire financial structure of the plan is undermined.

Although the collapse of a plan due to adverse selection alone may appear a bit far-fetched, it is not impossible. On a lesser scale, adverse selection can and does increase the costs of certain plans.

Congress should be careful in structuring tax policy toward employee benefit plans to be aware of such subtle possibilites and not inadvertently undercut the financial strength of plans to pay benefits which have been promised.

Summary

In summary, we encourage Congress to proceed carefully in structuring a rational tax policy for employee benefit plans. To the extent that revenue enhancement is the objective, Congress must weigh this "gain" against the costs if private sector plans are discouraged, and less economic security is thereby provided by the private sector. To the extent that elimination of real or perceived tax abuse is the objective, we strongly encourage Congress to use the scalpel and not the meat ax, since the large majority of benefits under employee benefit plans are not being provided with tax avoidance as the primary motivation.

We appreciate the opportunity to present these comments for the record. The Academy is available to offer an actuarial perspective on the taxation of employee benefit plans in future considerations of such policy. We would be happy to answer any questions or provide further information for the Subcommittee upon request.

Respectfully submitted,

Stephen G. Kellison
Executive Director

STATEMENT 1984-24

August 22, 1984

Mr. Brian Zell
Technical Manager of Auditing Standards
AICPA
1211 Avenue of the Americas
New York, NY 10036

Reference: File No. 3155

Dear Mr. Zell:

The American Academy of Actuaries Task Force on Reinsurance Accounting appreciates the opportunity to review and comment on the AICPA's discussion paper on "Accounting for Loss Portfolio Transfers That Are Financing Arrangements". Due to the relatively short lead time given us, coupled with the fact that the vacation season is upon us, meant that some members of our Task Force did not have an opportunity to participate fully in the preparation of the response. I am not aware of (nor do I expect) any dissenting views or minority opinions, but should any arise, I will forward them to you.

Perhaps the most basic and helpful question we can pose is, "Why does the AICPA feel that a statement on this issue is required?" Put another way, it is not apparent why the Accounting profession needs to deal separately with loss portfolio risk transfer issues in place of a reliance on the general and relevant language found in FASB No. 5, Paragraph 44, and FASB 60, Paragraph 40. These paragraphs would appear to cover the ground adequately and one wonders why further statements are required. Citing these prior FASB statements does not necessarily mean that the various members of our Task Force agree with the form and substance of those paragraphs, but rather, our view is merely a reflection that these statements have been promulgated and presumably are currently used by the Accounting profession.

Responding more narrowly to the discussion paper, we would challenge the notion that failure to meet one or more of the four conditions starting in the middle of Page 1 and continuing through the top third of Page 2 defeats risk transfer. Our Task Force respectfully recommends that the AICPA Reinsurance Accounting and Auditing Task Force think further about the various types of risks that are associated with the insurance and reinsurance transactions. To this end, a review of the work of the Society of Actuaries and an evaluation of related problems would be enlightening. In particular, it would appear that the AICPA Task Force is giving short shrift to the risks that the Society of Actuaries Committee and others in the business have come to call C1, C3 risks and a sub-set of the so-called C2 Risk.

Responding on an even narrower basis, it is not at all clear why the second and fourth tests are relevant to your considerations. It is not apparent why the AICPA feels that an "additional consideration" defeats the transfer of risk. If the additional consideration is finite and/or, in any event, properly accrued, there would appear to be no basis on which to argue that it has any relevance at all in determining or judging of the transference of risk. Similarly, the fourth condition concerning cancellation apears to be misguided. While an

argument could be made that a reinsurer should not have the unilaterial right to cancellations, there would appear to be no basis for the AICPA to suggest that the ceding company should not have a unilateral right of cancellation.

In summary, the AAA Task Force agrees that auditors and companies need guidelines on the proper accounting for the loss portfolio transfers, whether they are judged to be risk transfers or financing arrangements. It should be noted that the AICPA Draft, focusing as it does on financing arrangements, neglects the need for a statement on accounting guidelines for the risk transfer case. As noted in this letter, our Task Force does not feel that the AICPA Task Force has properly defined financing arrangements and, in any event, the need of such definition is not apparent in light of long-standing and well-understood FASB promulgations.

Sincerely,

Ronald E. Ferguson

Ronald E. Ferguson

P.S. We are not too sure how to interpret the first sentence of the paragraph starting in the middle of Page 2. It reads in part..."or if for any reason the agreement does not provide for the indemnification of the ceding company against loss or liability". We presume, but can not be certain, that it is not your intention to use this particular language to challenge an agreement simply because the loss or liability is, by contract, limited. For example, it is not uncommon in contemporary reinsurance treaties to limit or define the liability to exclude contractual obligations.

STATEMENT 1984-25

August 29, 1984

Mr. Kenneth W. Smith
Deputy Director, CPCU
Property and Casualty Division
Department of Insurance
State of Illinois
320 West Washington
Springfield, IL 62767

RE: Report of the NAIC Accounting Practices and Procedures Task Force Study Group on Loss Reserve Discounting

Dear Mr. Smith:

The captioned report was called to the attention of the American Academy of Actuaries' Committee on Property and Liability Financial Reporting Principles and was reviewed at a recent meeting.

In general, committee members felt the Study Group did a thorough and effective job of dealing with a difficult subject and reached an appropriate conclusion in specifying more detailed disclosure requirements. Two minor points are called to your attention.

- Long term disability claims arising from guaranteed renewable or non-cancellable disability policies and reserved in accordance with a standard table, such as the 1964 Commissioners Disability Table, should be treated the same way as Workers' Compensation annuity claims.

- Reserves assumed from certain underwriting pools and associations may present problems in compliance if they are discounted and the amount of discount is not reported to pool participants.

Thank you for your consideration. Your Study Group should be congratulated for its complete and professional work product.

Yours truly,

Richard H. Snader

Richard H. Snader, Chairman
Committee on Property and Liability
Financial Reporting Principles

STATEMENT 1984-26

COMMENTS BY
THE AMERICAN ACADEMY OF ACTUARIES
BEFORE THE
DEPARTMENT OF LABOR
NATIONAL PENSION FORUM

SEPTEMBER 12, 1984

The American Academy of Actuaries appreciates the opportunity to present this statement to the National Pension Forum. The Academy is a professional organization of actuaries and consists of members who work daily with the Employee Retirement Income Security Act of 1974 (ERISA) and the private pension system in general. Included within our membership are approximately 87% of the enrolled actuaries certified under ERISA. Appendix A provides some background information on the Academy.

Introduction

In establishing the National Pension Forum, Secretary of Labor Donovan called for the development of a "comprehensive set of recommendations for future administrative and legislative changes in the areas of regulation, enforcement, research and jurisprudence" under Title I of ERISA. In presenting its comments and recommendations, the Academy notes that its membership includes actuaries with a diverse range of views on current pension issues; furthermore, certain of these issues are not primarily actuarial in nature. Accordingly, this statement is limited to a discussion of pension issues having actuarial implications.

The Problem of Statutory Overkill

ERISA was enacted by Congress ten years ago to mandate certain design features in private pension plans, improve the level of funding for benefit security, strengthen reporting and disclosure requirements, provide termination insurance for plan participants, and eliminate certain abuses that had arisen in connection with the management and investment of pension funds.

In general, ERISA has been successful in achieving these goals, but not without cost. Not all of the intentions of the drafters of the legislation have been realized, and in some instances have actually been frustrated. The increase in plan terminations and drop in new plan formations following ERISA, the increased administrative burden and resulting costs of complying with ERISA, and the difficulties in fashioning a workable and affordable plan termination insurance program are indicative of the price that has been paid. One of the lessons of ERISA has been that efforts to close perceived loopholes and prevent potential abuses also create complexity and extra costs. Thus, certain complex requirements which do not have major significance for most plans often create more negative than positive results, even though conceptually the requirements may appear desirable.

Ensuing legislation has created additional complexity and costs. ERISA was followed by MEPPAA, which in turn was followed by TEFRA, and now the Deficit Reduction Act of 1984 (DEFRA) adds yet another twist to the maze.

Regulation upon regulation has been piled on the system by no fewer than four agencies (DOL, IRS, PBGC, EEOC). The Supreme Court even enters the picture with the Norris decision. Much as this continual turmoil may provide additional work for actuaries, it hardly seems to be in the public interest to make the rules so complex and to change them so often that the typical plan sponsor has no chance of coping. The administrative costs of complying with all the changes being imposed on plans has risen significantly and is increasingly becoming a burden, particularly on small plans.

We believe that the time has come for a change in attitude on the part of the regulators of the private retirement system. Instead of prescribing over-specific statutory and regulatory requirements and mandates, the regulators should increase their reliance upon the private sector, and upon the professional organizations which are prepared to fill the void effectively. For example, the actuarial profession has embarked on a newly expanded program of articulating professional standards of practice for actuaries. These standards will provide the practitioner with the guidance of his peers in performing his duties.

In setting forth such standards, we believe that the profession itself is better suited for authoritative, informal rule-making than the federal establishment in many areas. As an example, we note that the General Accounting Office recommended that the Joint Board for the Enrollment of Actuaries seek the input and assistance of the actuarial profession in drafting appropriate standards for the determination of data sufficiency with regards to multiemployer plans. This is a fine example of government/private sector cooperation, and we look forward to participating both in this particular endeavor and in others which will follow.

The Need for a National Pension Policy

The fact that no national coherent, stable, and strongly articulated public policy toward employee pension and benefit plans exists in the federal government leads to a seemingly endless series of ad hoc changes and confused signals. There needs to be a strong and specifically articulated national policy that encourages the formation, continuation, and enhancement of private pension plans. Should the private system fail to satisfy the national needs for retirement security, the federal sector will inevitably be faced with increased demands on its already limited resources. In view of the future facing Social Security in the next century, the need for a strong and vigorous private pension system is obvious.

The need for a national policy transcends ERISA, of course, and must address other matters such as Social Security, health care, as well as matters of tax policy. It is dangerous to deal with one facet of this universe without careful consideration for the impact of a particular change on the other dimensions of the private retirement system as a whole. For example, changes in tax treatment of certain employee benefits may have significant impact on private retirement systems, Social Security, and other parts of the overall system. The need for a broad-reaching policy is essential.

Not only has there been no clear articulation of national pension policy, but in several areas where there is some statutory guidance, the intentions which were articulated have, in fact, been frustrated by inadequate consideration of

the potential impact of the statute itself on the real world decision-making of plan sponsors. For example, while ERISA was specifically intended to enhance the role and growth of defined benefit plans, the act, as applied, has actually encouraged the growth of defined contribution plans and has discouraged defined benefit plans. The statistics on plan terminations and new plan formations after ERISA clearly bear this out. If the Financial Accounting Standards Board persists in requiring liabilities of defined benefit plans to appear on the balance sheet of plan sponsors, these incentives will be further exacerbated.

Although defined benefit and defined contribution plans both have their place in the private pension system, it is questionable whether the private pension system will fulfill its role should there be a major shift from defined benefit plans to defined contribution plans. Only a defined benefit plan can provide a known level of benefits in relation to salary prior to retirement. Furthermore, the entire investment risk in a defined contribution plan is shifted from the employer to the employee. Defined benefit plans provide a certain type of protection to plan participants that defined contribution plans simply cannot provide. In making these comments, we should note that actuaries are not necessarily disinterested in the type of plan chosen by an employer. Defined benefit plans do generate more work for actuaries than defined contribution plans.

The Need for Technical Improvements

The relationship between actuaries and accountants under ERISA has given rise to an unresolved problem in the auditing area. Section 103 of ERISA specifies in considerable detail a division of responsibility in the reports of actuaries and accountants, in which there is virtually no overlap. Further, it indicates that each professional "may rely" on the work of the other. In our opinion, a reasonable interpretation of the Congressional intent of these words is that each "would rely" on the work of the other under normal circumstances. Close scrutiny of the work of the other should not be the norm, but should arise only in unusual circumstances.

In practice it does not work this way. The literature of the American Institute of Certified Public Accountants (AICPA) is written in such a way that routine audits of the enrolled actuary's work product is the norm. It is unclear to us that anyone benefits from this exercise, least of all plan participants. The work of the enrolled actuary is subject to extensive oversight by the Internal Revenue Service and the Joint Board for the Enrollment of Actuaries. When the enrolled actuary signs Form 5500 Schedule B, he assumes personal and professional liability for the quality of his work product. He could not change his numbers under pressure from the auditor. He has already certified that they are his "best estimate."

Ten years after the enactment of ERISA, uniform pension terminology does not exist. There are numerous examples in pension literature of multiple terms having the same meaning, one term having multiple meanings, and terms with ambiguous meanings. In fact, the terminology appearing in ERISA contains inconsistencies. The actuarial profession has developed a set of uniform terminology for pensions which would clarify ambiguities and eliminate inconsistencies in existing terminology. This report has been endorsed by the governing boards of all the U.S. actuarial organizations. We

would encourage the Department of Labor to support efforts to incorporate the new terminology into ERISA and other pension legislation. This initiative is non-controversial and would benefit everyone by creating a more accurate, less ambiguous lexicon. Copies of the pension terminology report have been widely disseminated and are available from our office on request.

The issue of reversion of excess assets in overfunded plans has significant actuarial ramifications. One of the major purposes of ERISA was to strengthen the level of funding of private pension plans in order to increase benefit security. Restrictions on reversions of excess assets in overfunded plans could lead to an overall lower level of funding by plan sponsors. This, in turn, could place additional strain on the PBGC. There are also a number of important technical actuarial issues in the design of any potential legislation in this area. The Academy stands ready to provide actuarial input on any proposed legislation dealing with reversions of excess assets in overfunded plans.

The Need for Improved Regulatory Supervision

As was pointed out above, the costs associated with regulatory compliance under ERISA are large, and are especially burdensome to small plan sponsors. To the extent that the paperwork burden on small and large plans alike can be eased, the beneficiaries will gain. We applaud the steps taken to date by the regulatory agencies in this area to comply with the requirements of the Paperwork Reduction Act, and urge continuing efforts to reduce the complexity and length of reporting forms under ERISA.

To enhance appropriate administration by the federal government, we believe that it is necessary for the Department of Labor (as well as IRS and PBGC) to have a staff of capable and qualified actuaries. Through the use of qualified in-house actuarial support, we believe that the regulatory agencies can better cope with the real-world problems facing plan sponsors and administrators.

The concept of a single agency to oversee the regulatory framework for ERISA is intuitively appealing. The Academy does not take a position, either for or against such a proposal, inasumuch as bureaucratic structure is not an actuarial issue. We would note, however, that from the perspective of the practicing actuary, there is an overriding need for close cooperation and coordination between the various regulatory bodies which have a part in the overall process. It is important to remember that each time one of the major regulatory bodies decides that a change is appropriate, a modification of the plan is often necessary. This drives up the costs of operation and provides another disincentive for employers to maintain their plans. If changes are necessary, we suggest that the DOL, PBGC, and IRS should attempt to consolidate them so that the number of plan document revisions which are required, even if not limited, can at the least be effectuated simultaneously.

Conclusions

A review of ten years of experience under ERISA shows mixed results. While the growth in pension plan funds in the private sector has increased substantially, and while the number of employees who can safely anticipate retirement security has increased significantly, the problems which have developed must be faced before the entire structure becomes too

burdensome. We have already seen evidence of plan sponsors who, when faced with continued changes and additional administrative costs, have decided to convert their plans from defined benefit to defined contribution, or to eliminate their plans entirely.

We believe, therefore, that substantial progress has been made, but that future prospects for continued growth are clouded by regulatory and statutory overkill, and by the need for both technical and regulatory changes. We believe that the articulation of professional standards of practice by the actuarial profession can be of assistance in ensuring that the goals of the private pension system are met.

The Academy appreciates the opportunity to present these views, and we look forward to continued close cooperation with the Department of Labor in the future.

APPENDIX A
BACKGROUND INFORMATION ON THE AMERICAN ACADEMY OF ACTUARIES

The American Academy of Actuaries is a professional association of actuaries which was formed in 1965 to bring together into one organization all qualified actuaries in the United States and to seek accreditation and greater public recognition for the profession. The Academy includes members of three founding organizations - Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

The Academy serves the entire profession. Its main focus is the social, economic, and public policy environment in which the actuarial profession functions. Its primary activities include liaison with federal and state governments, relations with other professions, public information about the actuarial profession and issues that affect it, and the development of standards of professional conduct and practice.

Over 7,500 actuaries in all areas of specialization belong to the Academy. These members are employed by insurance companies, consulting actuarial firms, government, academic institutions, and a growing number of industries. Actuarial science involves the evaluation of the probabilities and financial impact that uncertain future events - birth, marriage, sickness, accident, retirement, and death - have on insurance and other benefit plans.

Membership requirements can be summarized under two broad headings: education and experience. At present, the education requirements can be satisfied either by passing certain professional examinations sponsored by the Casualty Actuarial Society or the Society of Actuaries, or by becoming an enrolled actuary under the Employees Retirement Income Security Act of 1974 (ERISA). The experience requirement consists of three years of responsible actuarial work.

STATEMENT 1984-27

STATEMENT TO THE SUBCOMMITTEE ON HEALTH OF THE HOUSE COMMITTEE ON WAYS AND MEANS ON THE DECEMBER 1983 REPORT OF THE ADVISORY COUNCIL ON SOCIAL SECURITY

BY ROBERT H. DOBSON, ON BEHALF OF THE COMMITTEE ON HEALTH OF THE AMERICAN ACADEMY OF ACTUARIES

SEPTEMBER 13, 1984

Introduction

The American Academy of Actuaries is a professional association representing actuaries in all aspects of actuarial practice. Members of the Committee on Social Insurance and the Committee on Health who jointly prepared this statement are employed in a variety of capacities. For purposes of this statement, however, we speak as professional actuaries and not on behalf of our clients or employers.

As a professional association, the Academy neither supports nor opposes specific legislation to change the Medicare programs. We do, however, have a major concern that the sizeable deficit projected for the Hospital Insurance program be addressed adequately and that the way in which it is addressed be actuarially sound.

The rising cost of the Hospital Insurance program, expressed as a percentage of taxable payroll, can be attributed primarily to a combination of: (1) increases in the cost of health care for the Medicare population which are more rapid than increases in wages subject to taxation, and (2) demographic changes, resulting in an increase in the number of Medicare eligibles relative to the number of workers in covered employment. An actuarially sound, long-term solution to the financing of the Hospital Insurance program requires a leveling of program costs, relative to taxable payroll. With the magnitude of the projected deficit, such an accomplishment is likely to require some combination of actions:

- reduced benefits
- reduced rate of increase in the cost of health care
- eligibility changes
- increased revenue

A comparable set of considerations applies to the Supplementary Medical Insurance program, where the financial burden is borne out of general revenue funds and beneficiary premiums.

The following comments reflect our thinking on those recommendations of the Advisory Council on Social Security (offered on December 15, 1983) which we believe have significant actuarial implications. Our comments are limited to an analysis, from an actuarial perspective, of the implications that the recommendations of the Advisory Council might have on the effective long-range operation of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs. We earnestly hope that our comments will be of assistance to Congress as it begins careful consideration of various proposals for reform of the HI and SMI programs.

STATEMENT 1984-27

Program Financing Recommendations

Recommendation 1.

The Advisory Council has identified the most critical problem facing Medicare: the HI Trust Fund faces insolvency prior to the end of the 1980's unless steps are taken to improve the financial condition of the fund. We commend the council for recognizing that a crisis exists, and for urging appropriate consideration and action by Congress while time remains for corrective action.

Recommendation 3.

The Academy endorses the Advisory Council's recommendation to fund each of the Social Security programs Old Age and Survivors Insurance (OASI), Disability Insurance (DI), and Hospital Insurance (HI) separately and on a sufficient basis. We believe that in order to accomplish this, the Social Security Administration and the Health Care Financing Administration should continue to make short - and long-term actuarial projections using a range of assumptions in regard to future economic, demographic and other factors.

Recommendation 4.

Regarding the Advisory Council's recommendation to increase the revenues of the HI Trust Fund by earmarking funds from a new tax on employer-paid health insurance, the Academy neither supports nor opposes such a proposal. However, we do have a major concern with the technical design of the proposal being considered. That is, we believe that if there is to be a tax-free limit it should not be based on premiums, but rather on coverage provided.

Health coverage is not a commodity. It does not have a price as such. Many cases are self-insured and have no known price until months or even years after the experience period. Even in cases that are fully underwritten by an insurance company, the price charged per member of the group is often more a function of the make-up of the group than of the coverage level. We do not believe it is equitable to base the amount of tax which a person has to pay on the content of the group of which he is a member.

For example, employees who work for small employers (who cannot obtain the lower insurance premium rates available to larger employers) will be taxed simply because they work for a small employer. Similarly, higher taxable premiums for the same coverage can be caused by the demographic make-up of the employee group. For example, for the same coverage, a group of employees whose average age is thirty-five may incur no tax while a group whose average age is fifty would be taxed.

A clear precedent for basing such taxes on coverage exists in the current taxation of employer-provided life insurance coverage above $50,000. In this instance the tax is based on the value of insurance coverage received, which bears no necessary relationship to the price paid for the coverage. We would be pleased to offer assistance to Congress and to the Internal Revenue Service in developing standard tables should Congress decide that taxation of employer-paid health insurance should be based on the level of coverage provided rather than on premium cost.

Recommendation 7.

With regard to the diversion of projected surplus OASDI revenues, we note that according to Social Security Administration projections, no long-term surplus will exist in the OASDI fund (despite the fact that in the short-term, due to various factors, a surplus will emerge). Therefore, we believe that any reallocation of payroll taxes from OASDI to HI will tend to place the actuarial balance of the OASDI fund in jeopardy. In order to rationally evaluate proposals to alleviate the HI deficit by diverting contributions from the OASDI fund, short- and long-range actuarial projections of costs and funding of both programs are especially important.

Program Eligibility Requirements

Recommendation 8.

As we noted at the outset, demographic changes are one of the main reasons for the financial problems facing the Medicare system. These changes primarily affect the long-term solvency of the program. Actuarial projections indicate that while 3.2 workers now support each beneficiary, once the "baby boom" generation retires, only 2 workers are expected to support each beneficiary.

Increases in life expectancy also contribute to this problem, since benefits are paid over a longer period of time. Dramatic improvements in life expectancy have already occurred, and actuarial studies show that people who are now age 71 have the same life expectancy as those age 65 when that age was chosen in 1935 as the age to commence retirement benefits. The projections by Social Security actuaries forecast that age 74 will be the equivalent age by the year 2000.

The Advisory Council has recommended an incremental increase in the age of eligibility for Medicare benefits from age 65 to 67 and a subsequent indexation of the age of eligibility to increases in life expectancy. As the Academy previously testified to Congress in 1983 in connection with Social Security financing, we believe that indexation of the retirement age would add more stability to the financial structure of the system.

However, it is important to note that the Advisory Council is proposing a different pattern of retirement age increases for HI than those enacted by Congress in 1983 for OASDI. Differing eligibility dates in the two systems would create significant problems for beneficiaries in setting retirement dates and obtaining health insurance coverage for themselves and their spouses between retirement and eligibility for Medicare benefits. Although these problems already exist to a limited extent (since eligibility for Social Security retirement benefits begins at age 62), they would become more pronounced if eligibility dates different from those for OASDI are enacted.

Many workers who will retire before age 67 will do so involuntarily, under the pressure of medical conditions and other factors beyond their control. It is not necessarily desirable that such persons remain in the work force. Congress should carefully evaluate the problems faced by this age group in obtaining and affording health insurance coverage, and consider a disability related entitlement for persons unable to work for health or related reasons.

STATEMENT 1984-27

Recommendation 9.

As the Advisory Council correctly points out, universal coverage would contribute to the financial stability the HI program. We support the principle that Social Security and Medicare should be universal to the extent possible. Accordingly, the Academy is supportive of efforts to achieve universal coverage, while recognizing the constitutional issues which must be resolved with respect to state and local government employees. To the extent that this approach is not feasible in the short-term, other steps might be taken to improve the cost picture by eliminating, to the extent possible, the windfalls which many persons employed in non-covered groups currently receive.

Benefit Structure Recommendations

General Commentary

We believe that the success of the Social Security and Medicare programs represents a long-term social contract. While Congress legally has the right to change the program (and even terminate it without notice if it desires), in principle, changes should not deprive covered persons of benefits they are currently receiving or can expect to receive upon retirement. If benefit reductions are necessary, they should be made in a way which will distribute the burden of such changes as equitably as possible. Furthermore, if changes are major in nature, substantial lead time should be provided before such changes become effective, so that those affected have time to make appropriate changes in their own financial planning.

Recommendation 11.

The Advisory Council has recommended a restructuring of benefits under the Medicare programs. The changes recommended for the HI program can be expected to result in a modest net reduction (less than 1%) in program costs, with some specific changes increasing costs and some decreasing costs.

The changes recommended by the council for the SMI program involve three significant changes in the scope of Medicare. First, the enhancement of benefits under the HI program (to be made an integral part of the SMI beneficiary coverage election) serves to liberalize HI, i.e., increase benefit costs.

Second, and perhaps most important, the HI enhancement under SMI introduces premium payment into HI on a broad scale (since nearly all HI beneficiaries historically have elected SMI coverage). Part of this premium is intended to pay for the HI enhancement, and part is intended to support the program generally.

Third, the offering of enhanced SMI benefits, on an optional basis, to enrolled beneficiaries represents an extension of the scope of coverage into areas currently covered privately through Medicare-supplement policies or self-payments. Adverse selection must always be considered as a possibility in situaions where individuals may elect alternative levels of benefits. However, the widespread purchase of Medicare-supplement policies by beneficiaries would suggest that a large majority would elect the proposed SMI enhancement, adding to existing coverage.

Recommendation 14.

While the Academy supports measures to introduce competition into the provision of services in the Medicare program, we must point out a number of technical problems with proposals to use vouchers in the Medicare program.

The most important technical problem is presented by possible adverse selection (or "skimming"). Insurers may design their policies or market them in a manner that appeals more to healthier individuals. To the extent they are successful in enrolling healthier than average individuals, payment of an average amount for persons of the same age, sex, and so on -- as occurs with the adjusted average per capita cost (AAPCC) -- may overcompensate such insurers, and may result in higher outlays by the Medicare program. (Adjustment of the voucher for differences in the average cost of Medicare enrollees by age, as done by the AAPCC, only partially corrects for biased selection.) The present state of the art of actuarial classification is not adequate to prevent such selection from occurring.

The feasibility of a voucher program depends on the development of an index like the AAPCC which also takes into account the health of enrollees joining a particular plan. Although this is also a significant technical problem for paying HMOs based on 95% of the AAPCC, the potential for adverse selection is greatly augmented in the context of vouchers for insurance plans designed specifically to attract Medicare enrollees.

An additional problem is that Medicare enjoys a substantial cost advantage in purchasing hospital services. Unless insurers offering alternatives to Medicare paid the same hospital rates, the premiums could not be competitive.

Recommendation 15.

The Advisory Council has recommended that the SMI deductible be indexed to the CPI. Under current law, the SMI annual deductible is fixed at a level of $75. Over time, inflation and utilization increases will erode the effect of the $75 deductible, resulting in an increase in SMI costs which is greater than the underlying rate of increase in the cost of covered services. With appropriate indexing, the deductible can be expected to represent a constant percentage of the total cost of covered services. We support, in principle, efforts such as this to stabilize the growth rate of the SMI program. We would note, however, that the CPI may not be the most technically appropriate index for making annual changes in the deductible, since it does not reflect cost increase patterns specific to medical services.

Program Reimbursement Recommendations

Recommendation 16.

The Advisory Council endorses the use of a prospective payment system for hospital services based on diagnosis related groups (DRG), and cautions that the annual rate of growth in DRG rates must be limited.

The rising cost of the HI program, expressed as a percentage of taxable payroll, can be attributed primarily to a combination of: (1) increases in the

cost of health care which are more rapid than increases in wages subject to taxation, and (2) demographic changes, resulting in an increase in the number of Medicare eligibles, relative to the number of workers in covered employment. The Advisory Council recommendation reflects one means of attempting to close the gap between health cost increses and average wage increases. We support, in principle, efforts to do so.

The council has recognized that the allowed rate of increase in the DRG rates will have a significant impact on the cost of the HI program. It has recommended that the Secretary of Health and Human Services (HHS) limit this increase to the rate of the change in the hospital input price index.

Future increases in the DRG rates will determine to a large extent, the stability of the cost of the HI program, expressed as a percent of taxable payroll. If such increses exceed the annual rates of increase in average wages in covered employment, HI costs can be expected to continue to grow as a percent of taxable payroll. This has been the case historically. The limitation of future DRG rate changes to those indicated by the hospital input price index will not assure level HI costs, as a percent of taxable payroll. This differential may be widened by increases in admission rates and by changes in the mix of diagnoses. However, a more severe limitation may impair the quality of and access to medical services, retard the development of continued medical technology advances, and result in substantial cost shifting to other payors.

We concur with the Advisory Council recommendation that HHS exert care to limit the rate of growth in DRG rates. We recommend, however, that an appropriate balance be maintained, and we caution against excessive reliance on this initiative as the overriding means of solving the HI financing deficiency.

Recommendation 18.

Physician reimbursement is a complex issue. The Advisory Council's recommendation of reimbursement based on fee schedules represents a significant departure from current practice and should not be adopted prior to careful technical (as well as policy) analysis. Any fee schedule adopted would have to be set at fee allowances well below the current Medicare "prevailing fee" levels, in order to avoid an increase in program costs. In addition, program cost increases due to causes other than rising fees -- utilization of services, mix of services, billing practices, technology -- are equally important. In the past, efforts to restrict fee increases to less than industry patterns have typically been offset by increases attributable to these causes.

Recommendation 19.

Finally, the Academy supports, in principle, the Advisory Council's recommendation for a statutory revision to the current Medicare assignment system, with incentives for physicians to participate, because of the recommendation's potential for cost savings.

Conclusion

We appreciate being given this opportunity to testify. We hope our testimony will be helpful, and we would welcome the opportunity to be of further assistance as you procede with your important deliberations.

Respectfully submitted by:

American Academy of Actuaries

Committee on Social Insurance

Preston C. Bassett, Chairman
Francis M. Schauer, Jr.,
Vice Chairman
George E. Bell, III
Thomas P. Bleakney
Michael H. Gersie
Howard J. Levin
John B. McQuade
Cecil J. Nesbitt
Frederick Seltzer
Samuel E. Shaw, III
James R. Swenson
James O. Webb

Committee on Health

Robert H. Dobson, Chairman
E. Paul Barnhart,
Vice Chairman
J. Martin Dickler
Ronald G. Harris
Richard H. Hoffman
W. Duncan MacKeen
Lloyd F. Mathwick
Thomas G. Nelson
Allen J. Sorbo
Margaret Wilkinson Tiller
Gordon R. Trapnell
Edward J. Wojick
Ronald M. Wolf

STATEMENT 1984-28

STATEMENT FOR THE RECORD
AMERICAN ACADEMY OF ACTUARIES
TO THE SUBCOMMITTEE ON SOCIAL SECURITY AND
SUBCOMMITTEE ON SELECT REVENUE MEASURES
HOUSE COMMITTEE ON WAYS AND MEANS
HEARINGS ON FRINGE BENEFITS
SEPTEMBER 17 AND 18, 1984

Background

On September 17 and 18, the Subcommittees on Social Security and Select Revenue Measures of the House Committee on Ways and Means held hearings on the taxation of fringe benefits. The comments below are submitted for the record of these hearings on behalf of the American Academy of Actuaries ("Academy").

Interest of the Academy

The Academy is a professional association of over 7,600 actuaries involved in all areas of specialization within the actuarial profession. Included within our membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA), as well as comparable percentages of actuaries providing actuarial services for other employee benefit plans such as life, health, and disability programs.

The Academy finds it difficult to comment on tax legislation in general, since we are not advocates on major public policy decisions which are not actuarial in nature. The Academy views its role in the government relations arena as providing information and actuarial analysis to public policy decision-makers, so that policy decisions can be made with informed judgment.

Nevertheless and in spite of the fact that actuarial considerations are unlikely to ever be the driving force behind major decisions on tax policy, actuarial input can be quite useful in shaping and molding tax policy to deal appropriately with the extremely complex, yet vitally important, employee benefits area. For example, the determination of required contribution levels to plans to provide the benefits, setting appropriate reserve levels to meet future obligations, and financial calculations involving the time value of money are all actuarial in nature.

General Comments on Employee Benefit Plans

Employee benefit plans provide an array of insurance and retirement benefits which greatly increase the present and future economic security of millions of Americans. Salary dollars cannot replicate an annuity at retirement that cannot be outlived, life insurance for the family of a deceased worker, the cost of hospitalization in the event of major illness, or income to a disabled worker. Employee benefit plans deliver dollars at the time they are needed most. Moreover, in general, these benefits can be more economically provided on a group basis to an employee workforce than on an individual basis, due to the significant savings in administrative costs and to the stability that comes with a pooling of risks across a broad cross section of employees.

There is no question that the growth of employee benefit plans in the past few decades has been greatly stimulated by tax policy toward those plans. This tax policy has been the result of deliberate Congressional intent which has been demonstrably successful in fostering the development of employee benefit plans. It would be naive and erroneous to assume that employers would continue to provide the same level of benefits in the event that the favorable tax treatment of certain types of employee benefit plans were significantly curtailed or even eliminated. The pressure from employees with the basic attitude "If I have to pay taxes on it anyway, give it to me in cash" would simply be too great. The end result would be a decline in the level of protection provided by the private sector, inevitably leading to greater demand and strain on governmental programs. Given the financial difficulties facing programs such as Medicare and Social Security, a decline in private sector programs would hardly seem to be in the public interest.

Need for National Policy

We hope these hearings will be useful in focusing attention on the need for a coherent, stable, and strongly articulated public policy toward employee benefit plans by the federal government. The fact that no such policy exists leads to a seemingly endless series of ad hoc changes and confused signals toward employee benefit plans. In the tax area alone in just two short years we have seen the Tax Equity and Fiscal Responsibility Act of 1982 and the Deficit Reduction Act of 1984. And now before this last bill has even been printed into final form, Congress is talking about changing it all around again in 1985.

There is a crying need here for more stability in the tax treatment of employee benefit plans. Pension and insurance plans in particular involve long-term arrangements and commitments. Plan sponsors are finding it increasingly difficult to make rational decisions in such a chaotic environment. Much as this continual turmoil may provide additional work for actuaries, it hardly seems to be in the public interest to make the rules so complex and to change them so often that the typical plan sponsor has no chance of coping. The administrative costs of complying with all the changes being imposed on plans has risen significantly and is increasingly becoming a burden, particularly on small plans.

Tax Exemption vs. Tax Deferral

In some of the debates on tax policy the distinction between tax exemption and tax deferral seems to get lost. Although some employee benefit plans do provide tax exempt benefits, others do not. In particular, the major retirement income programs provide for tax deferral, not tax exemption. Within debates on tax deferral we increasingly hear arguments involving the concept of the "time value of money." This is a concept at the heart of actuarial science.

It is quite true that a dollar to be paid in the future is worth less than a dollar today because of the interest that can be earned in the interim. Translating this into tax policy for the federal government, the argument is heard that $1,000 of taxes today is worth $1,000, but if these $1,000 of taxes can be deferred for ten years their present value is worth only $386 if discounted at a

10% rate of interest. Thus, the argument is made that it is better for the Treasury to get the money now rather than later.

What this analysis overlooks, however, is that in many cases the Treasury will get more than $1,000 at the end of ten years. For example, consider a defined contribution pension plan in which the account balances are growing at a 10% rate of interest. $1,000 in tax deferral will continue to grow in the account and will amount to $2,594, not $1,000, in ten years. The present value of $2,594 discounted for ten years at a 10% rate of interest is exactly $1,000!

In the real world, of course, things are seldom this simple. Differences in value will arise if the rate of accummulation is different than the rate used in computing the present value. Also, there is a question about how the tax rates in ten years which will then apply compare with the tax rates which would apply today. However, the example does clearly illustrate that introducing the concept of the time value of money does not, on its own merits, make a convincing case against tax deferral. It is a valid analytical tool, but must be carefully applied in any analysis to present meaningful comparisons.

Public Sector Programs

If Congress intends to take a comprehensive look at the taxation of employee benefit plans in order to create a more coherent tax policy toward such plans, then it would seem appropriate to consider the tax treatment of public sector programs as part of such a comprehensive review. For example, at the present time the tax treatment of retirement benefits attributable to employer contributions under Social Security is different than for private sector retirement plans. This may or may not be good public policy ---- that is not an actuarial judgment. However, we do urge the Congress to review tax policy toward insurance and pension benefits under government programs as well as private sector programs in any comprehensive review of the taxation of employee benefit plans.

It is also important to consider how private sector and public sector programs fit together. For example, the integration of private pension plans with Social Security has been a controversial tax issue for a number of years. Actuarial considerations are vital in structuring sound integration rules for pensions or other employee benefit plans.

Actuarial Issues

There are six actuarial issues related to the general subject of the taxation of employee benefit plans which we address below.

1. Financial Condition

   The maintenance of a well-run insurance or pension employee benefit plan involves the determination of both an appropriate contribution level to provide the expected benefits and appropriate reserve levels to cover the accrual of benefit obligations. Both of these are actuarial processes.

   Tax policy should recognize the need for these determinations to be made according to sound actuarial principles and practices. Such recognition

does exist in the pension area under ERISA. However, that recognition is not as clear in connection with certain insurance programs.

The Academy stands ready to work with Congress and regulatory agencies to define such sound actuarial principles and practices where required. A major priority for the Academy at the present time is the establishment of a structure within our profession to articulate actuarial standards of practice. This structure would be appropriate to deal with issues such as actuarial principles and practices in connection with insurance and pension employee benefit plans. Included in actuarial principles and practices are such matters as disclosure requirements and the content of an actuarial report.

2. Qualifications

Along with a recognition of the need for plans to be operated according to sound actuarial principles and practices there is the need to define the qualifications of the actuaries certifying the plans.

Of course, this need was clearly recognized in ERISA and in that instance Congress chose to create a Joint Board for the Enrollment of Actuaries to examine and license individuals as "enrolled actuaries."

Another example has arisen in the Deficit Reduction Act of 1984. This act provides that in connection with funded welfare benefit plans (including voluntary employees' beneficiary associations (VEBAs) under section 501(c)(9) of IRC) reserves in excess of "safe harbor" limits will be permitted if certified by a "qualified actuary" (to be determined under Treasury regulations).

Academy membership includes actuaries in all areas of practice and serves as the hallmark of a qualified actuary in the United States. However, we recognize that not all actuaries are necessarily qualified for all assignments. Accordingly, our Guides to Professional Conduct contain extensive guidance to ensure that: "The member will bear in mind that the actuary acts as an expert when giving actuarial advice and will give such advice only when qualified to do so."

The Academy has a Committee on Qualifications to address issues such as these. We strongly urge direct participation of the actuarial profession in defining the qualifications of an actuary to engage in any particular assignment. The Academy has a strong commitment to self-regulation and is prepared to work closely with the Treasury if such regulations are to be developed.

3. Actuarial Assumptions

The setting of actuarial assumptions is a key ingredient in any actuarial assignment. The provisions relating to funded welfare benefit plans in the Deficit Reduction Act of 1984 (cited above) require that assumptions be reasonable in the aggregate. This is quite appropriate and follows the precedent set by ERISA in the pension area.

However, the Conference Report goes further and indicates that "in addition to requiring that actuarial assumptions are to be reasonable in the aggregate, Treasury regulations may prescribe specific interest rate and mortality assumptions to be used in all actuarial calculations." Such a simplistic approach would ignore the fact that experience is different from plan to plan for a variety of reasons (age/sex composition of group, nature of work, geographical area, etc.). Attempting to mandate any set of uniform assumptions will inevitably result in inappropriate assumptions being used for large numbers of plans. Setting appropriate actuarial assumptions requires the application of actuarial judgment to fit the facts and circumstances at hand.

We are concerned at the prospect that the Treasury might attempt to prescribe specific actuarial assumptions for funded welfare benefit plans. We believe the approach used in ERISA for setting actuarial assumptions for pension valuations is much more appropriate.

4. Current Tables

Certain portions of the Internal Revenue Code require the use of actuarial tables promulgated by the Internal Revenue Service. Examples are the tables for the taxation of group term life insurance under Section 79, the tables for the taxation of annuities under Section 72, and the tables used for the taxation of life estates and remainders.

Some of these tables have been allowed to get out-of-date. For example, the uniform premium table for group life insurance under Section 79 was changed in 1983, but the prior table had been in effect since 1966, during which time group term life rates dramatically changed. As another example, the current tables under Section 72 have not been changed since their release in 1954.

The use of actuarial tables to compute certain values required in the IRC is quite appropriate, but may appear arcane or even obscure to many taxpayers. Maximum credibility will be achieved if taxpayers perceive that the tables are based on current interest and mortality factors rather than ones that may appear obsolete. Such credibility should be an objective of tax policy.

5. Design Aspects

On occasion, actuarial insights on design aspects of certain tax proposals may be useful. For example, in the Academy testimony to the Senate Committee on Finance on June 22, 1983 on proposals for a health insurance tax cap, our Committee on Health Insurance pointed out some technical flaws with the proposal to base the tax cap on premiums. The Committee went on to suggest basing it on the richness of coverage provided as an alternative which would avoid these flaws.

(Note: The Academy neither supports nor opposes such a tax cap. This is a public policy decision up to Congress and is not an actuarial issue. However, we are concerned with the technical details of any such proposals and their full ramifications.)

6. Adverse Selection

A rather subtle, but potentially quite important, actuarial concept is the notion of "adverse selection." There is a natural tendency for any person covered, or potentially covered, by an insurance or pension plan to exercise any options available to his or her apparent advantage, i.e. to select against the plan. Within limits, the cost of such adverse selection can be absorbed by a plan. For example, in pension plans with lump-sum options, retirees in poor health will tend to elect lump sums, while those in good health will tend to elect life annuities. In such a case, the plan sponsor has been willing to assume any extra costs involved in allowing such options.

In some cases, however, adverse selection could present more serious problems. For example, consider a voluntary health insurance program with substantial employee contributions required (either directly through payroll deduction or indirectly through a health insurance tax cap). Younger, healthier employees will tend to opt out of the program if they do not perceive they are receiving adequate value for their contributions. If this happens, the group left behind will increasingly consist of older or less healthy employees, and costs would increase significantly. In extreme cases, this could result in a vicious cycle of further defections of healthy employees as costs rise and spiralling cost increases for remaining particpants, until the entire financial structure of the plan is undermined.

Although the collapse of a plan due to adverse selection alone may appear a bit far-fetched, it is not impossible. On a lesser scale, adverse selection can and does increase the costs of certain plans.

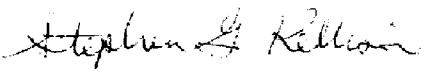
Congress should be careful in structuring tax policy toward employee benefit plans to be aware of such subtle possibilites and not inadvertently undercut the financial strength of plans to pay benefits which have been promised.

Summary

In summary, we encourage Congress to proceed carefully in structuring a rational tax policy for employee benefit plans. To the extent that revenue enhancement is the objective, Congress must weigh this "gain" against the costs if private sector plans are discouraged, and less economic security is thereby provided by the private sector. To the extent that elimination of real or perceived tax abuse is the objective, we strongly encourage Congress to use the scalpel and not the meat ax, since the large majority of benefits under employee benefit plans are not being provided with tax avoidance as the primary motivation.

We appreciate the opportunity to present these comments for the record. The Academy is available to offer an actuarial perspective on the taxation of employee benefit plans in future considerations of such policy. We would be happy to answer any questions or provide further information for the Subcommittee upon request.

Respectfully submitted,



Stephen G. Kellison
Executive Director

STATEMENT 1984-29

September 20, 1984

The Honorable William L. Clay, Chairman
Subcommittee on Labor-Management Relations
Committee on Education and Labor
United States House of Representatives
Washington, D.C. 20510

Re: September 5, 1984 hearing on post-retirement accruals

Dear Mr. Clay:

Enclosed is a statement on behalf of the American Academy of Actuaries for the record of the September 5, 1984 hearing on post-retirement accruals.

Much of the material contained in this statement has been drawn from the Academy submission on November 14, 1983 to the EEOC in response to its Request for Comments. This submission was developed by the Academy Pension Subcommittee on Single Employer Plans (Excluding Title IV), chaired by Leroy B. Parks, Jr.

The Academy would be happy to answer any questions about this statement or to provide further information on request. We appreciate the opportunity to submit this statement for the record.

Respectfully submitted,

Stephen G. Kellison

Stephen G. Kellison
Executive Director

STATEMENT 1984-29

STATEMENT FOR THE RECORD
BY THE AMERICAN ACADEMY OF ACTUARIES
TO THE SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS
COMMITTEE ON EDUCATION AND LABOR
HEARING ON POST-RETIREMENT ACCRUALS
SEPTEMBER 5, 1984

The American Academy of Actuaries appreciates the opportunity to submit comments on the issue of requiring employers to continue making pension contributions and crediting service under ERISA for employees who work beyond normal retirement age. The Academy is a professional association representing over 7,600 actuaries in all areas of specialization. Membership includes 85% of the total number of enrolled actuaries who are qualified under ERISA.

The Academy does not advocate a particular position regarding post-retirement age benefit increases under pension plans. We recognize that there are several possible views of this issue and we hope to provide information and informed opinions on matters that should be considered in any discussion of it. The Academy has submitted a similiar statement to the Equal Employment Opportunity Commission (EEOC) in response to that agency's request for comments on the possible revision of rules under the Age Discrimination in Employment Act (ADEA).

PLAN COSTS FOR POST-65 ACCRUALS

The impact on the actuarial costs of a pension plan due to deferred retirement is significantly affected by the choice of actuarial assumptions and cost method. In a great many instances, the impact of working beyond age 65 is typically not isolated in the actuarial computations because it would not be significant in the context of the operation of the plan as a whole. This is not to say that it would be insignificant if there was in the future a major shift in ages at which individuals actually retire.

Actuarial Value of Plan Benefits

The impact on the actuarial present value of benefits, for various methods of adjusting plan benefits is outlined briefly below. For a plan which provides a benefit equal to a percentage of final five year average salary for each year of service, the following generalizations may be made with respect to an employee who has completed twenty-five years of service:

1. If there is no additional service credit granted, the actuarial present value of the benefit payable from the plan decreases at a rate of approximately 10% - 12% per year during the period that the employee defers retirement.

2. If there is additional service credit granted but average salary is not allowed to increase, then the actuarial present value of the benefit declines at a rate of approximately 7% - 10% per year.

3. If additional service credit is granted and average salaries are allowed to increase, then the actuarial present value of the plan benefits declines at a rate of 2% - 4% per year.

4. If benefits are simply allowed to grow "actuarially", then there is no increase or decease in the actuarial present value of the benefits.

5. If the employee's benefit is allowed to grow with (a) actuarial increases, (b) additional service credit, and (c) increases in average salary, then the actuarial present value of benefits will grow at a rate of approximately 8% - 12% for each year of deferral.

All of the above are based upon investment return and salary increase assumptions which are well within the range of assumptions in common use. It is important to note, however, that the impact will vary according to the plan's assumptions, and can vary to a major extent based upon an employee's service and his or her actual growth of earnings in situations where average earnings are allowed to increase after age 65. Similarly, the plan of benefits can have an important impact on changes in costs.

Actuarial Assumptions Relating to Retirement Age

Actuaries have over the years tended to base the funding of most pension plan retirement benefits upon the assumption that employees will retire at age 65, the normal retirement age for most private plans. A major exception is often found in the funding of plans which allow earlier commencement of pensions on a basis which is financially favorable to employees. In these situations, an assumption concerning early retirements is often found. This is so because if the actuary were to ignore the existence of (for example) unreduced benefits at an earlier age, such as 62, this could lead to systematic underfunding and underestimation of the long term costs of the plan.

Another exception to assuming that retirement occurs at age 65 is found in the assumptions for those plans where there is an established history of a significant proportion of the employees working beyond age 65. In that instance the actuary might assume that a certain proportion of employees would work until an older age than the "normal retirement age." Ordinarily, however, caution would be used in selecting the retirement assumption if it materially reduced recommended funding levels relative to assuming employees will retire at age 65.

The 1978 Amendments to the Age Discrimination in Employment Act (ADEA) increased from 65 to 70 the age at which most employees can be required to retire. For a variety of reasons the impact on actual retirement patterns may have been minor to date, and the pattern of retirement which will emerge in the future is not clear. What is known is that for most private pension plans the funding of plan benefits based upon assumed retirement ages greater than age 65 would reduce plan funding requirements. We believe that many (if not most) actuaries would be reluctant to recommend reduced plan funding based upon an assumption that employees will work beyond age 65 without some evidence that this is in fact a reasonable expectation.

Added Costs of Post-Age 65 Benefit Adjustments

The analysis described above focuses on changes in pension costs relative to retirement at age 65. Another valid approach to this issue is to examine the opposite view -- what is the actual added cost of changing present requirements for pension plan design. That is, it would be the view of some that there is now no requirement that benefits be adjusted for work beyond age 65, and that the imposition of any requirements in this area necessarily adds to costs. This would be so because the cost of a plan which provides larger benefits must be greater than otherwise. Here it is important to distinguish between (a) actuarial costs which are based upon actuarial estimates, and (b) actual costs of providing benefits. The former refers to the costs that the sponsor currently recognizes each year based upon actuarial valuations, and which often coincides with actual cash contributions to the plan.

These actuarial costs are dependent upon the actuary's assumptions. From this perspective, for example, actuarial adjustments to benefits have no effect on "costs" if the actuary assumes employees retire at age 65. Each time an employee works beyond 65, the actuarial adjustment to his or her benefits prevents the occurrence of an actuarial gain which would otherwise have reduced future funding requirements, but the "cost" is not identified.

The opposing view is that a change in interpretation of the act and its legislative history which would require benefit increases of any kind necessarily adds to the true cost of the plan. From this perspective the actuarial cost of a pension plan is recognized for what it actually represents -- an estimate that provides a reasonable and rational manner of budgeting for actual costs which cannot be known in advance.

While we express no opinion on the appropriateness of requiring benefit increases for service beyond age 65, we feel it is important to point out that a policy change which required the payment of larger benefits necessarily involves greater costs for the sponsor.

PENSION BENEFIT DESIGN ISSUES

Defined Benefit Pension Plans-Two Views

1. Deferred Compensation Viewpoint

   At one extreme there is the view that defined benefit pension plan benefits are in all material respects deferred compensation plans. According to this view, an employee who works beyond age 65 should not "lose" any of the value that accrued to him or her before the plan's normal retirement age, and in fact he or she should be allowed to accrue further service credit beyond age 65 in addition to the full value of benefits "earned" before that age.

   According to this view, the lump sum actuarial value of the employee's accrued benefit determined at age 65 (or possibly some earlier age when unreduced benefits are available) should be treated as if it belonged to the employee. This lump sum should then accumulate with interest to be

converted to a larger retirement income at a later date of the employee's choosing.

Furthermore, it may be asserted that the employee should be entitled to earn further plan benefits while continuing to work.

2. Income Replacement/Protection Concept

At the other extreme, defined benefit pension plans are viewed as a form of income replacement protection for employees who retire after having met certain criteria -- attained a certain age (whether it be 55, 60, 62, 65, etc.) and completed certain service requirements. According to this view, the employer should be able to design his plan to provide that level of income replacement which the sponsor desires. ERISA and IRS regulations place certain constraints on benefit design; however, those rules do not prohibit the sponsor from providing the same level of retirement benefit across a wide range of ages -- for example, all ages from 65 to 70.

According to this view, an employee who does not elect to retire has no claim to foregone benefits he or she might have received upon retirement. If the "protection" viewpoint is adopted, the situation can be considered analogous to a health insurance plan which makes no provision to pay amounts to individuals who do not incur covered medical expenses, a life insurance program that pays no benefits other than upon an employee's death, and a disability plan which pays benefits to only those who become disabled.

Issues raised by these two divergent views of defined benefit plans are not readily resolved. It has been common practice for employers to adopt (or maintain) the second view (or to assume its validity), and it appears to many to be permitted by the legislative history and current interpretations of the 1978 Amendments to the ADEA. Adoption by the EEOC of the first view (or of some intermediate position) would necessarily seem to be a repudiation of the validity of the second view with possible consequences beyond the seemingly simple question of whether or not retirement benefits must be increased for periods worked between age 65 and 70. For example, will identical reasoning be applied to plans which pay unreduced retirement benefits at age 62 or 60 or 55? Will this reasoning apply to benefits not customarily considered part of the "basic plan benefit" -- for example, temporary retirement income benefits payable between retirement and age 62 (or age 65) which are designed such that total retirement income benefits, including Social Security, are more nearly level?

Currently pension accruals are permitted (by ERISA) which are greater in the early years of employment and lesser in the later years. This approach is commonplace and permits employees to have greater security at an earlier age than would be the case if uniform accruals were mandatory. This enables a mobile workforce to have deferred vested pensions which in total may be larger and this can help offset for inflationary erosion.

Many pension plans provide for a lower benefit accrual rate after 20 or 30 years of service, and may in fact provide for no credit beyond that point. This point frequently occurs within the 40 to 65 age range, and therefore many

plan participants protected by the ADEA do not accrue benefits. If sponsors were required to provide a uniform accrual at all ages, one possible consequence is the prospective reduction of accruals at younger ages rather than larger benefits for older employees. If the EEOC contemplates requirements for benefit accruals among employees in the protected ages then we believe that this issue needs to be addressed.

We do not offer answers to the questions raised above because we do not believe that objective answers exist. The answers decided upon by individual sponsors are found in the manner in which their plans operate -- some have adopted the first view, some have partially adopted the first view (for example for basic benefits, but not "supplemental" benefits), and most employers have adopted an approach which is consistent with the second view.

Defined Contribution Plans

Similar arguments may be developed concerning contributions to defined contribution plans. One view is that there is no justification for stopping contributions at a particular age when the cost is the same as for a younger employee at the same salary or wage level. The opposing view is that the employer may establish retirement income goals for the plan, and contributions are structured based upon actuarial estimates to meet the sponsor's goals by a certain age (usually age 65). According to the second view the employer is justified in stopping contributions at that age even if the employee continues to work.

If the Income Replacement/Protection viewpoint relating to defined benefit plans is accepted by the EEOC, then should this second view of defined contribution plans be found unacceptable? If so, will sponsors of defined contribution plans reduce contributions for all participants to meet retirement income targets at an older age?

We do not feel it appropriate for the Academy to offer answers to these questions; however, we do believe it appropriate to raise the issues so that consideration can be given to the many issues that are involved in areas being addressed by the Commission.

Additional Comments on Special Early Retirement Benefits

Many pension plans enable employees who have met certain requirements to retire before reaching age 65 and to receive benefits which have a greater value than the accrued plan benefit payable at age 65. Examples include plans which allow employees to retire with unreduced benefits at age 60 or 62 provided certain service requirements have been met (10 years, 20 years, 30 years, etc.). If the employee continues to work beyond that age, there may or may not be additional service credit earned.

We wish to call this situation to the attention of the Subcommittee because discussions about the application of the ADEA to pension plans tend to focus upon the issues related to benefit accruals (or lack of them) after age 65. For those plans which do offer benefit commencement before age 65, the same issues appear to be relevant from an earlier age. That is, if a plan allows an employee to retire at age 62 (or 60, 55, etc.) with unreduced benefits, and the employee chooses to retire at age 65 with a benefit which has a lesser value

(due to the shorter period over which it will be paid) the sponsor will also need to be advised whether this will be considered a discriminatory practice under the ADEA.

We also wish to call to the attention of the Subcommittee the fact that special early retirement benefits may be contingent upon employer actions such as reductions in work force, plant closing, etc., and may not be available to an employee under normal circumstances. Thus, if some special pension accrual and/or actuarial adjustment requirements are adopted by the EEOC, it will be helpful to sponsors to know whether a distinction will be allowed for benefits payable to employees whose early retirement benefits are contingent upon events not fully within the individual employee's control.

STATEMENT 1984-30

September 20, 1984

Financial Accounting Standards Board
High Ridge Park, P.O. Box 3821
Stamford, Connecticut 06905-0821

Re: Exposure Draft: Disclosure of Postretirement Health Care and Life Insurance Benefits Information

Board Members:

The purpose of this letter is to reply to the Board's recently-published Exposure Draft on the disclosure of postretirement benefits information. I am writing on behalf of the American Academy of Actuaries as its Chairman of the Subcommittee on Health and Welfare Plans.

While the proposals contained in the Exposure Draft are not perceived by us to be actuarial in nature, we do wish to take the opportunity afforded by the Board's comment period to offer to the FASB the services of the Academy's Subcommittee on Health and Welfare Plans during the remainder of the project on accounting for non-pension postemployment benefits. Prior to the separation of the pension and other postemployment (OPE) topics into two distinct FASB projects, the Academy's Pension Committee was responsible for such interface. As a result of the division in February of this year of the prior project into two independent projects, the Subcommittee on Health and Welfare Plans has assumed that responsibility.

The liability and expense accrual considerations of the OPE project involve complex actuarial calculations as well as difficult accounting questions. The complexity stems from the interrelationships of a myriad of variables, including the measurement techniques available, benefit types and designs, demographics, the effects of such influences as dependent coverage, government -sponsored programs, anticipated inflation and utilization changes, etc. Our Subcommittee's goal is to avail the Board of an informed actuarial viewpoint, in addition to providing all pertinent information at our disposal.

We look forward to the opportunity of assisting the Board wherever possible.

Sincerely,

Tom Nelson

Thomas G. Nelson
Chairman
Subcommittee on Health and Welfare Plans

STATEMENT TO THE SUBCOMMITTEE ON LABOR-MANAGEMENT RELATIONS OF THE HOUSE COMMITTEE ON EDUCATION AND LABOR BY THOMAS G. NELSON ON BEHALF OF THE SUBCOMMITTEE ON HEALTH AND WELFARE PLANS OF THE AMERICAN ACADEMY OF ACTUARIES

HEARINGS ON EMPLOYEE WELFARE BENEFIT PLANS SEPTEMBER 26, 1984

On September 26, 1984 the Subcommittee on Labor-Management Relations of the House Commmittee on Education and Labor held hearings on the need for extending participation, vesting and funding standards to employee welfare benefit plans. The attached comments are submitted for the record of those hearings.

PURPOSE

In recognition of the studies being undertaken of various aspects of employee welfare benefit plans, the actuarial profession, as represented by the American Academy of Actuaries (Academy), wishes to indicate its readiness to assist those governmental bodies which are conducting the studies. In this document both the general comments, and those specifically relating to participation, vesting and funding, are meant to provide insights into the status of, and current practices in, employee welfare benefit programs in the United States.

BACKGROUND

The American Academy of Actuaries is a professional association of over 7,600 actuaries involved in all areas of specialization within the actuarial profession. Included within our membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA), as well as comparable percentages of actuaries specializing in actuarial services for other employee coverages such as life, health and disability programs. As a national organization of actuaries, the Academy is unique in that its members have expertise in all areas of actuarial specialization.

The Academy is active in the development of guides to professional conduct and standards of practice required of members in their professional practice. The Academy is also active in government relations, in liaisons with other professions and in public relations.

With respect to government relations, the Academy views its role as a provider of information and actuarial analysis in order that policy decisions may be made with informed judgement. It is our belief that the training and experience of Academy members allow a unique understanding of current practices in employee benefits. Our intention is to communicate that understanding in ways that assist policy decision-makers.

STATEMENT 1984-31

EMPLOYEE WELFARE BENEFIT PLANS

General

Employee welfare benefit plans provide an array of benefits which greatly increase the present and future economic security of millions of Americans. The financial risk to employees and dependents is greatly decreased due to payments from sources such as life isnraunce proceeds for the family of a deceased worker, payment of the cost of hospitalization in the event of major illness, or provision of income continuation to a disabled worker. Employee benefit plans deliver financial protection at the time it is most needed. Moreover, these benefits can generally be more economically provided on a group basis to an employee workforce than on a individual basis, due to the significant savings in administrative costs and to the stability that stems from a pooling of risks across a broad cross-section of employees.

As Congress is mandating studies of employee welfare benefit plans, a great deal of change is taking place, particularly in the health care industry. In order to stress cost-efficiency, funding approaches for providing group health coverage in recent years have moved from predominantly fully-insured arrangements toward more self-insurance by employers. Also, more recently, continued inflationary pressure has driven the medical plan costs of many employers to the point where medical plans have become the most expensive employee benefit, surpassing pensions. As a result, cost containment activities have increased greatly at all levels of the health care market, including the purchasers, insurers, and providers of health care. The Federal government, as a purchaser of such care, has moved steadily in a similar direction in recent years, implementing programs such as prospective hospital payments, and making Medicare payments secondary to employer-provided plans in the case of workers and their spouses who are aged 65 and older.

Several significant points should be recognized about the special position of employee welfare benefit plans in our society today.

- Public policy toward employee benefits has attempted in the past to balance the competing objectives of 1) providing fair, worthwhile, and available financial protection to employees, with 2) reasonable financial incentives that do not overly-erode the nation's tax base.

- Today several types of welfare benefit plans are virtually universal in availability to American workers during their active years. Examples are coverages that protect against the financial difficulties caused by death, disability or medical problems. Substantial proportions of those workers are provided postretirement life insurance and/or medical benefits as well.

- Current tax laws prohibit unfair discrimination in employee benefit welfare plans in favor of key employees. In fact, the vast majority of welfare benefit coverage is provided to low and middle income workers and their families, often on a basis that is commensurate with the benefits of key employees.

- Existing legislation and regulation (primarily from individual states), together with competition, have provided extended protection in times of heightened need for workers and dependents. Some of these employee-protective provisions include:

  - The right for terminating employees to convert to individual life and medical insurance plans

  - The extension of medical coverage for terminated, disabled employees for periods ranging from a few months to 1-2 years; life coverage for disabled individuals is also usually extended in some fashion for considerably longer periods of time, often to or beyond normal retirement age

  - The frequent extension of dependent medical coverage in the event of death of an employee

  - The transfer of an employer's group coverage between insurers on a basis which in general has no adverse coverage impact on incumbent employees who have on-going medical conditions

  - The availability of protection for unemployed or laid-off workers in most states

Participation, Vesting and Funding

No precise legal definitions currently exist for the terms "participation", "vesting", and "funding" as they relate to employee welfare benefit plans. The closest available parallels are found in the pension benefit area, and are provided primarily by ERISA and its regulations. However, very important differences exist between pension and welfare benefits, resulting in difficulties in applying the concepts and terminology of one to the other.

- The timing of benefit payments is different between welfare and pension programs. The majority of health and welfare benefits are provided to active employees and their dependents. Since these plan costs (with the exception of certain disability coverages) are generally linked to actual present payments, most welfare benefits are generally considered to be "current" benefits. Pension benefits are more properly termed "future" benefits since the service life-times of employees result in a provision of benefits years later, after retirement.

- Minimum pension participation rules have been established by law to be administratively efficient, excluding very new and young employees due to the anticipation of excessive costs associated with their expected high turnover. Mandated participation rules do not exist for employee welfare plans. However, competition for employees has dictated the availability of nearly universal and immediate death, disability and medical coverage for active workers. Employers use various approaches to postretirement welfare benefit eligibility, frequently relating it to an individual's retirement and receipt of a pension from the employer. Additionally, employers often require that the most recent years of service were with that employer.

- Pensions benefits are generally provided in accordance with a service-related formula. Upon retirement both the employer and employee understand what the anticipated benefit will be. In contrast, employee welfare benefits such as medical coverage are usually based upon the cost of services provided, making future benefits subject to increasing costs due to inflationary pressures, as well as changes in utilization patterns, in government-sponsored programs such as Medicare, and in technological innovation. The lack of service-based formulas for health and welfare benefits makes those programs more difficult to relate to service; this in turn makes the accrual of benefits and any meaningful vesting schedules more difficult and arbitrary.

- Employer obligations to retirees under welfare plans are less certain in comparison to the obligations of pension plans. Often, welfare plan provisions stating management's prerogatives (to continue, alter or cease to provide postretirement benefits) exist with no mandated vesting of benefits for workers and retirees. Partial vesting (for example, 50% of full benefits) can easily and sensibly exist for pension benefits, while the administration of such a concept for welfare (especially medical) benefits would require study and coordination. Similar examination would be needed in cases where an individual has obtained vested welfare benefits through more than one employer.

- The Deficit Reduction Act of 1984 has placed maximum tax-deductible funding limits on postretirement benefits provided through voluntary employee beneficiary associations (VEBA's). Under the Act's provisions, increases in claim costs dues to any source such as inflation, changes in utilization patterns, etc. could only be funded each year after the increase has occurred, rather than through advanced funding. The net effect is that these limits in general will be substantially below the full, level cost of the benefits promised. This provision effectively discourages employers who wish to fund retiree welfare benefits as they do pension plans.

  The accounting profession is currently studying reporting requirements for postemployment welfare benefits, with a strong possibility of including benefit liabilities and accruals in financial statements. This study is likely to lead to more frequent pre-funding of retiree programs, reversing the pay-as-you-go approaches of most employers today. More frequent pre-funding by employers would better secure benefits for retirees. However, the recently-enacted tax law is at cross-purposes with that support since contributions for full funding would not be fully tax-deductible. Unrelated business income tax penalties will also be assessed in cases where advanced funding exceeds mandated levels, further discouraging full funding. By comparison, pension funding currently allows a corridor of possible funding levels ranging from minimum to maximum levels. This flexible approach has generally permitted the full funding of pension benefits on a sound actuarial basis.

- As in any actuarial assignment, the setting of assumptions is a key ingredient in establishing funding levels. The provisions relating to welfare benefit plans funded through VEBA's in the Deficit Reduction Act of 1984 require that assumptions be reasonable in the aggregate. This is quite appropriate and follows the precedent set by ERISA in the

pension area. However, the Conference Report goes further and indicates that "in addition to requiring that actuarial assumptions are to be reasonable in the aggregate, Treasury regulations may prescribe specific interest rate and mortality assumptions to be used in all actuarial calculations." Such a simplistic appraoch would ignore the fact that experience is different from plan to plan for a variety of reasons (age/sex composition and benefit utilization tendencies of group, nature of work, geographical area, etc.). Attempting to mandate any set of uniform assumptions will inevitably result in inappropriate assumptions being used for large numbers of plans. Setting appropriate actuarial assumptions requires the application of actuarial judgement to fit the facts and circumstances at hand.

We are concerned at the prospect that specific actuarial assumptions might be prescribed for funded welfare benefit plans. We believe the approach used in ERISA for setting actuarial assumptions for pension valuations is much more appropriate.

Any significant federal legislation or regulation relating to employee welfare benefit plans will have a dramatic impact on future benefits. We believe that actuaries who are familiar with these plans and their financial structures are able to make a unique and necessary contribution to the evaluation of potential legislation or regulation.

Actuarial analysis of employee welfare benefit plans demands the expertise of specialists in welfare plans, employing actuarially-sound methods which reflect characteristics unique to those particular welfare plans; included are characteristics such as the analysis of past health care utilization, adjustments to reflect the changes in plan design or demographics, assessments of claim liabilities, analysis of claim trends (including inflation and utilization patterns) and projections of financial experience. Only actuaries specializing in these programs are properly qualified to so examine employer welfare benefit plans. We strongly urge that direct participation of the actuarial profession be allowed in defining necessary qualifications for actuarial services to these plans. The Academy has a strong commitment to self-regulation and is prepared to work closely with the government if regulations regarding actuarial qualifications are to be developed.

SUMMARY

The actuarial profession, as represented by the American Academy of Actuaries, appreciates the opportunity to present our testimony and wishes to offer any possible assistance to the governmental bodies involved in studying employee welfare benefit plans. Because we understand past and present practices in this area, we believe that we can assist in identifying and weighing the merits of employee benefit plan alternatives for the future.

STATEMENT 1984-32

AMERICAN ACADEMY OF ACTUARIES
ACCOUNTING FOR UNIVERSAL LIFE
DISCUSSION MEMORANDUM
SEPTEMBER 27, 1984

Table of Contents

STATEMENT 1984-32

SUMMARY

This Discussion Memorandum represents the current thinking of the American Academy of Actuaries' Life Insurance Financial Reporting Principles Committee on the matter of accounting for Universal Life. This paper is the product of a task force of the Committee and has been approved for exposure for comment to Academy members and other interested parties. This paper is the result of a request by the American Institute of Certified Public Accountants' Task Force on Non-Guaranteed Premium Products to assist them in analyzing the applicability of existing GAAP to certain important new products, most notably those referred to as Universal Life. As these issues are expected to materially affect the financial reporting of many life insurance companies, the Committee believes that this working relationship with the AICPA Task Force is appropriate and desirable and will allow input to be provided at the early stages of the analysis process, thereby assuring that technical and professional actuarial issues are adequately addressed.

Nonetheless, the Committee understands that it has neither the authority nor the responsibility to establish GAAP for Universal Life or any other product. This document simply represents its efforts to assist those who have such authority and responsibility. In this regard, the Committee does not now believe that this document will be developed into a formal Financial Reporting Recommendation or Interpretation. In the event that the Committee believes that the development of such a Recommendation or Interpretation is necessary, the normal required exposure and approval processes will be adhered to.

As indicated, the purpose of this Memorandum is to provide recommendations with respect to the accounting for Universal Life products. In order to achieve these objectives, the Memorandum first defines those products to which this guidance would apply. In this respect, the NAIC definitions contained in the model Universal Life regulation have been adopted. The paper further reviews and comments on the applicability of current actuarial and accounting principles to Universal Life products. Illustrations have been included to clarify alternate practices. Finally, recommendations concerning several key accounting issues are presented, including:

- Accounting for contracts with lump-sum premiums.
- Accounting for Universal Life contracts issued in exchange or existing contracts of the same company (internal replacement).
- Basic accounting issues related to Universal Life policies other than those with lump-sum premiums or those issued in exchange for existing contracts of the same company.

The difficulties of defining premiums which are subsequently identified as lump-sum amounts have led the Committee to address the first issue in a generalized fashion. Lump-sums are defined as those amounts which are in excess of those premiums which may be expected to be received on a continuing basis. Thus, considerable professional judgment must be exercised in identifying and handling lump-sum amounts. In the extreme case, a contract may not be reasonably expected to result in any future premiums. In such single premium Universal Life cases, it has been recommended that

a"full margin" or a "full release from risk" approach be taken, wherein no earnings would be released on receipt of the single premium. Rather, all income would be reported over the life of the contract through the interest, mortality, withdrawal, and possibly other risk elements of the contract. Other contracts are likely to have lump-sum premiums paid early in the contract's history or may result in lump sums being paid significantly after issue. In such cases, the accounting for the amounts identified as lump sums is to be consistent with the procedures adopted with respect to single premiums. The remainder of the contract is to be accounted for using the accounting principles recommended for basic contracts.

Contracts which are not expected to contain lump-sum amounts and the remainder of lump-sum contracts are to be accounted for in the following fashion. A "balanced approach" is to be used wherein assumptions are selected so as to allocate earnings to major performance and risk elements of the contract. Significant performance and risk elements have been identified as premium receipt, mortality, investment, withdrawal, and possibly other elements. In some circumstances, premium receipt is not likely to be a significant factor in the performance or profitability of the contract and in such cases either the "full margin" or the "full release from risk" approach can be utilized. Both methods will result in no earnings emerging as premiums are received, but may produce annual earnings patterns which are different from one another. Under these approaches, all earnings would emerge during the life of the contract in proportion to the inherent margins built into the product (the "full margin" approach) or in proportion to the conservatism included in experience assumptions (the "full release from risk" approach).

In other cases, basic contracts may contain significant performance and risk elements related to the premium receipt function. In such circumstances, assumptions are to be selected so as to allocate expected future profits to premium, mortality, interest, and other elements in proportion to the risks assumed and performance provided under the contracts. In most cases, it is not expected that the premium receipt function will be predominant. Therefore, it is expected that assumptions will be selected which will result in a total "balanced" valuation premium in excess of the valuation premium defined by most likely assumptions plus normal provisions for adverse deviation.

Contracts arising from internal replacement transactions are to be accounted for in a manner consistent with the guidance provided with respect to lump-sum and basic contracts. The net cost associated with the replacement transaction is to be considered for redeferral against the new Universal Life contract, subject to tests for recoverability. Guidance is included with respect to the definition of the block of business to use in the recoverability test, as are comments with respect to setting assumptions for contracts arising from internal replacement transactions.

This Discussion Memorandum is being made available to the Academy membership for comment and also has been provided to the AICPA Non-Guaranteed Premium Products Task Force for their review and analysis. The Academy Committee is continuing to work closely with the AICPA Task Force in this regard and intends to continue to provide our assistance in developing recommended guidance for accounting for Universal Life products.

STATEMENT 1984-32

INTRODUCTION

During the last several years many life insurance products have been introduced which incorporate policy provisions and design features and characteristics which differ significantly from traditional permanent and term life insurance contracts. The development and pricing of these products have often required major changes in methods and procedures and a new approach to fundamental actuarial and management issues such as setting profit criteria and goals, establishing experience assumptions, handling replacement considerations, compensation programs, and adequately addressing the increased importance of investment performance. In these circumstances, reporting the results of operations has received considerable attention as management continues to develop an understanding of the economics of these new products and to evaluate results on a timely basis.

Reporting by stock life companies is performed on both statutory and GAAP bases. Statutory valuation principles and accounting practices are set forth by law and regulation and reserving procedures and methods are selected by interpreting the meaning and intent of this guidance. GAAP valuation principles are contained in FASB 60, which superceded the Audit Guide, previously the most authoritative source for life insurance accounting principles on a GAAP basis. These statutory and GAAP valuation principles require considerable interpretation and the exercise of professional actuarial judgment when specific valuation practices and techniques are selected.

The applicability of existing statutory standards to new products, the development of new standards, and the general evolution of statutory valuation principles are generally addressed by various industry and actuarial groups, including the NAIC, the ACLI, the Society of Actuaries, and other actuarial technical groups. This Task Force is not charged with reviewing or commenting on these matters.

Similar functions with respect to GAAP valuation matters also require the participation of several professional bodies. Ultimately, FASB has the final authority and responsibility to establish GAAP. The AICPA, through its Insurance Companies Committee and related Task Forces, often completes the necessary background study, analysis, and evaluation of issues, providing recommendations to FASB for further consideration.

The actuarial profession's role in the process includes commenting on preliminary AICPA positions, discussing alternatives, and providing additional technical assistance as requested. Also, the Academy is charged with providing specific actuarial guidance to assist in the interpretation and application of the rules promulgated by the accounting profession to valuation and other actuarial matters. In recent years, the actuarial profession, through this Committee of the Academy, has been represented on key AICPA Task Forces charged with developing guidance for the reporting of new products on a GAAP basis. Thus, input is provided at the earliest stages of the process, assuring that technical and professional actuarial issues are adequately addressed.

This working relationship with the AICPA's Insurance Companies Committee's Task Force on Nonguaranteed Premium Products has led to a request that this Academy Task Force complete an analysis of the applicability of existing

GAAP to certain important new products, most notably those referred to as Universal Life. Earlier, the Academy provided GAAP valuation guidance with respect to nonguaranteed or indeterminate premium products and assisted the AICPA Task Force study the accounting alternatives for annuity products. The purpose of this Discussion Memorandum is to present a summary of our analysis with respect to Universal Life.

While FASB 60 generally defines the manner in which life insurance products are to be accounted for on a GAAP basis, considerable discussion has arisen within the actuarial and accounting professions concerning the applicability of FASB 60 to products such as Universal Life. Some of the issues which have led to this reevaluation of the applicability of FASB 60 include:

1. FASB 60, in paragraph 69, specifically states that "this statement does not address issues that currently are being studied by the insurance industry and the accounting and actuarial professions. Some of those issues include...how should Universal Life insurance contracts and similar products that have been developed since the AICPA insurance industry related Guides and SOPs were originally issued be accounted for?" This paper is part of this study of the applicability of FASB 60 to such products.

2. The unbundling of the investment and insurance aspects of the product suggest to some that accounting policies for each element should be considered separately.

3. The nature and extent of the mortality and interest guarantees (i.e., the nonguaranteed nature of the eventual costs and benefits of the contract) suggest to some that GAAP for guaranteed cost contracts (which FASB 60 primarily addresses) may not be applicable.

4. The continual nature of the underwriting and investment management services (i.e., the constant repricing of existing business through mortality charges and interest credits) suggest to some that complete reliance on gross premium income to measure and reflect the level of services or functions performed by the insurer may be inappropriate.

5. The diversity of accounting policies being followed in practice is substantial, which may suggest that significantly different viewpoints exist with respect to the pattern in which pre-tax GAAP earnings should emerge.

6. The AICPA is considering additional accounting guidance with respect to SPDA's, which some believe may be relevant to Universal Life products.

The Task Force understands that it has neither the authority nor the responsibility to establish GAAP for Universal Life or any other product. However, the Task Force believes that the actuarial issues and concerns related to accounting for Universal Life are such that professional actuarial involvement is both necessary and valuable. Thus, in responding to the request for assistance, the Task Force has established the following objectives:

1. To define those products to which this actuarial and accounting guidance would apply.

2. To review and comment on the applicability of current actuarial and accounting principles and methods to Universal Life products.

3. To identify, summarize, and evaluate the various Universal Life accounting practices being used throughout the industry.

4. To identify, discuss, and present preliminary suggestions on the manner in which key Universal Life actuarial and accounting issues should be handled.

5. To present and support a tentative position with respect to actuarial and accounting principles for Universal Life products.

In addition, the Task Force believes that it is desirable to adopt Universal Life actuarial and accounting procedures which are not inconsistent with the manner in which existing literature addresses other life and annuity products. Thus, the Task Force believes that a separate AICPA project should study the relationship between the Universal Life recommendations contained in this memorandum and the actuarial and accounting practices followed for other products. In the event they differ materially, the effects of applying these conclusions to other products should be considered and reconciled.

APPLICABILITY

The primary purpose of this memorandum is to study actuarial and GAAP accounting alternatives for Universal Life products and to make tentative recommendations in this regard. While the term "Universal Life" is generally understood, it is necessary to define, as precisely as possible, those products to which this guidance is relevant. It is not intended that the suggestions contained herein be considered with respect to any other life, health, or annuity product. To avoid increasing the level of confusion already present, the Task Force has adopted the product definitions included in the NAIC model regulation which addresses, in addition to other issues, valuation and nonforfeiture guidelines. This regulation describes the relevant products in Article III: Definitions.

This Article defines the general Universal Life policy and separately describes both fixed and flexible premium contracts. The proposed guidance contained in this memorandum is intended to be applicable to both fixed and flexible premium policy forms. The relevant definitions are as follows:

Universal Life Insurance Policy

"Universal life insurance policy" means any individual life insurance policy under the provisions of which separately identified interest credits (other than in connection with dividend accumulations, premium deposit funds, or other supplementary accounts) and mortality and expense charges are made to the policy. A universal life insurance policy may provide for other credits and charges, such as charges for the cost of benefits provided by rider.

(Note: This regulation is specifically designed for individual life insurance policies. It is not intended, however, to prohibit the issuance of group universal life insurance policies. States are free to adopt whatever portions of this regulation which are appropriate for group insurance and which are in accordance with State law.

Unlike the unitary nature of traditional whole life insurance, a distinguishing feature of universal life insurance is the existence of an indeterminate policy value from which specific periodic charges are deducted and to which specified periodic interest is credited at a rate not determined at issue. This indeterminate policy value feature with separately identified charges and credits may or may not have a premium pattern predetermined by the insurer at issue. Valuation and nonforfeiture treatment of these products varies depending upon the nature of the premium pattern. To distinguish these treatments, a definitional distinction has been made between "flexible" and "fixed" premium policy forms.)

Flexible Premium Universal Life Insurance Policy

> "Flexible premium universal life insurance policy" means a universal life insurance policy which permits the policyowner to vary, independently of each other, the amount or timing of one of more premium payments or the amount of insurance.

Fixed Premium Universal Life Insurance Policy

> "Fixed premium universal life insurance policy" means a universal life insurance policy other than a flexible premium universal life insurance policy.

While group contracts are not specifically included in this regulation, this tentative guidance is considered applicable to both group and individual forms. It is also intended that this tentative guidance be applicable to contracts which are both indexed and nonindexed Universal Life policies. The NAIC model regulation defines an indexed contract as "any Universal Life insurance policy where the interest credits are linked to an external referent."

OVERVIEW OF PRESENT ACCOUNTING PRINCIPLES

In 1972, the AICPA introduced an industry audit guide entitled Audits of Stock Life Insurance Companies. The guide described generally accepted accounting principles for all types of life insurance then known to the industry.

The guide addressed key issues related to the incidence of earnings of a life insurance enterprise and concluded that:

1. There should be a matching of policy benefits and expenses with policy revenues.

2. There should be included in the experience assumptions margins for adverse deviation to minimize the probability of future losses.

Thus, the incidence of revenues determines the incidence of costs and, therefore, income. The guide considered various ways to determine the

incidence of the recognition of revenues and concluded that for insurance contracts, generally:

> "Premium revenue should be recognized over the life of the contract in proportion to performance under the contract...In general, the committee agreed that if performance could be measured by one or more of the predominant functions or services, premium revenues should be recognized in direct proportion to such functions or services..."

Several functions and services were considered as bases for recognizing premium revenue, costs and income. These included premium collection, incurred costs, invested funds, gross and net amounts at risk, and insurance in force.

At the time the guide was being drafted, traditional whole life was the primary product being considered and analyzed. The revenue recognition concepts applicable to most other products were based on the example of whole life. For whole life, the drafters of the guide determined that "there was no predominant function or service which provided a measure of the composite of all functions and services" under such contracts. Therefore, they concluded that level recognition of premiums as revenues over the lives of the contracts was appropriate.

The concept of provisions for adverse deviation was introduced to further assure that income would be recognized over the life of the contracts as services other than premium collection were performed and to assure the presence of some conservatism. The result is that premiums are recorded as revenue and income is recognized as the premium collection, investment, protection, and other functions and services are performed. Thus, income will be recognized periodically over the same term that premiums become due and as the provisions for adverse deviation included in the assumptions are released.

While premium revenue became the primary factor determining the manner in which earnings emerge, it was recognized that the use of premium income as the sole measure of performance was inappropriate for some contracts. Thus, alternate accounting practices were adopted with respect to products where the pattern of premiums was clearly unrelated to either the insurer's performance or the risks assumed under the policies--single premium plans. The most significant single premium products at the time were credit insurance and single premium immediate annuities.

In the case of credit insurance, it was understood that releasing all, or a substantial portion of income when the contract was written and the premium received was neither desirable nor reasonable. The use of the unearned premium reserve to alter the pattern of earned premium was introduced and resulted in earned premium which was generally in proportion to the expected benefits of the contracts. This result was achieved by the guide's requirement that "gross premium revenues on such contracts should be recognized in proportion to the amounts of insurance in force." In this way, revenue (earned premium) was in proportion to performance and risk (providing life or disability benefits) and the resulting income followed the same pattern. This

accomplished the guide's goal of recognizing revenue, and thus income, "over the life of the contract in proportion to performance under the contract."

A similar approach was taken with respect to single premium immediate annuities. Here the guide states that "a reserve... should be provided in an amount approximating the consideration less acquisition costs." This forces all income to emerge over the life of the contract as the mortality and interest margins inherent in the reserve are released. This, too, appears consistent with the guide's basic objectives.

Inherent in this process of income recognition is the accrual of reserves for future policy benefits and the capitalization of deferrable acquisition costs and their amortization in direct proportion to the recognition of revenue. Further, the guide anticipated that the assumptions considered appropriate at the time the contract was issued would continue to be used ("locked-in") during the periods that reserves are accrued and deferred acquisition costs are written off.

In June 1982, the Financial Accounting Standards Board released Statement Number 60, Accounting and Reporting by Insurance Enterprises. FASB 60 represents the extraction of specialized principles and practices relating to insurance enterprises from the AICPA Insurance Audit Guides and Statement of Position without significant change. It did not undertake a comprehensive reconsideration of the accounting issues related to Universal Life and other new products. In fact, FASB 60, in paragraph 69, stated that it did not address issues raised by Universal Life and certain other new products, as guidance in these areas was being developed. Some progress has been made in this effort and before reviewing present accounting practices for Universal Life, proposed accounting guidelines for two new products, indeterminate premium life insurance (IPL) and single premium deferred annuities (SPDA), which have been developed since the adoption of FASB 60, should be reviewed.

An IPL policy permits the issuing company to modify the gross premium charged from time to time based on current and prospective actuarial assumptions. Normally, the policy form specifies the maximum premium that can be charged by the company. In 1982, the American Academy of Actuaries adopted Interpretation 1-I: Nonparticipating Guaranteed Renewable Life and Accident and Health Insurance Policies. The interpretation offers the practicing actuary guidance in determining what actuarial assumptions should be used for GAAP reporting at a gross-premium-change-date. It is notable that the interpretation provides for the adoption of current actuarial assumptions subsequent to a gross-premium-change-date to reflect current and projected experience. However, the amounts of the policy benefit and expense reserves and deferred acquisition cost assets should remain unchanged as of the date of change of actuarial assumptions. Thus, the revised assumptions should apply only to policy durations subsequent to the gross-premium-change-date. The AICPA Task Force has expressed agreement with this interpretation.

The AICPA Task Force also prepared a draft issues paper entitled Accounting for Single Premium Deferred Annuities. Its purpose is to identify issues, explore alternatives, and provide a basis for accounting guidance for SPDAS. A preface to the draft noted that the draft's conclusions are tentative and subject to change due to further consideration of the issues as they relate to

other insurance products, including universal life insurance. One of the key preliminary conclusions regarding SPDAs is that no gain or loss should be reported when the contracts are issued. Rather, profits should be recognized over the term of the contract using the method described in the draft.

One procedure, the prospective practice, results in a net reserve equal to the present value of future benefits and expenses. Such present values would be based upon a "break-even interest rate" and assumptions as to mortality, withdrawal, and contract interest credits, all of which include an adequate provision for adverse deviation. Income reported in each period would be based on the variation between actual experience and the "break-even interest rate" and other basic reserve assumptions.

The second practice, the retrospective approach, defines the reserve as an amount equal to the gross accumulated contract value before adjustment for any contractual surrender charges. Also, deferrable acquisition costs in excess of front-end loads are capitalized and amortized in relation to reasonably anticipated future investment margins and surrender charges. Thus, investment income in excess of interest credited to the policy is recognized in the period realized to the extent that it exceeds the amortization of deferred costs.

The significance of the IPL and SPDA accounting guidelines described above is that they may be seen as incorporating concepts which deviate to some extent from the provisions of the industry audit guide. The IPL guidance provides for periodic adoption of new actuarial assumptions in an effort to maintain the desired consistency between pricing and reserve assumptions. The SPDA draft recommendations include an implicit modification of the revenue stream, which results in income patterns (before the effects of the provisions for adverse deviation) unrelated to premium income. In this respect, it is similar to the guide's treatment of credit insurance and single premium immediate annuities. As both the IPL and SPDA products exhibit characteristics common to the Universal Life products offered today, this guidance should be carefully considered. In addition, the arguments and rationale which underly and support these guidelines can also be used to justify some of the present practices used to account for Universal Life.

PRESENT ACCOUNTING PRACTICES

Present industry accounting practices for Universal Life vary substantially. In part, this is due to the absence of specific authoritative guidance. Also, it is the result of the wide variety of contract designs and differing investment, marketing and underwriting philosophies.

The spectrum of practices include the following specific methodologies:

- the "traditional" approach, which defines premium as revenue and allows income to emerge as a level percentage of premium income (prior to the release of provisions for adverse deviation).

- the "full margin" approach, which defines revenue as the inherent interest, mortality, expense and withdrawal margins designed into the product and allows income to emerge in proportion to the annual emergence of these revenue margins.

- the "full release from risk" approach, which defines revenue as the differences between the benefit, expense, and interest costs based on most likely experience assumptions and those costs based on conservative experience assumptions. The conservative experience assumptions are selected so that the resulting GAAP valuation premium is equal to the gross premium. Earnings under this approach will emerge as the conservatism in the experience elements is released.

- the "balanced" approach, which defines revenue as, in part, premium income, and, in part, the differences in the benefit, expense, and interest costs based on most likely experience assumptions and those costs based on conservative experience assumptions. Here, the conservative experience assumptions are selected so that the resulting GAAP valuation premium is equal to that portion of the gross premium not included in revenue (i.e., the conservative assumptions result in a GAAP valuation premium less than the gross premium, but greater than the GAAP valuation premium derived under the Traditional approach). Earnings under this approach will emerge, in part, in proportion to premium income and, in part, as the conservation in the experience elements is released.

As noted, the Traditional approach defines premium as revenue and allows income to emerge as a level percentage of gross premium income prior to the release of provisions for adverse deviation. The Full Margin and the Full Release From Risk approaches adopt a modified revenue definition and are supported by those who believe premium income is not the best measure of the insurer's performance or risk under a Universal Life policy. The Full Release From Risk method increases the loadings included in each major assumption so that the resulting GAAP net premium equals the expected gross premium. Under the Full Margin method, the gross fund values are maintained as reserves. Deferred acquisition costs are amortized in proportion to a modified revenue stream which consists of margins inherent in the interest, mortality, expense load, and surrender charge elements of the contract.

Both approaches are described below. In addition, other approaches are discussed, including the Balanced approach. Finally, various other practical approaches which are used in some instances when the adjustment is not material also are reviewed.

Traditional Approach

This accounting model is based on the premise that Universal Life is an evolutionary extension of traditional life insurance products. Thus, the traditional accounting model becomes the most appropriate accounting model for Universal Life. The previous section, "Overview of Present Accounting Principles", reviews these basic concepts.

In summary, under this accounting model, Universal Life premium income is defined as revenue. Estimates of future premiums, benefits, and expenses are made based on assumptions with respect to interest, contract charges, contract and payment persistency, benefits, expense levels, and other factors. Such assumptions should contain suitable margin for adverse deviation. Policy benefits and expenses are matched with premium revenues

through the calculation of benefit and expense reserves. While the nature of the contract and the lack of fixed relationships between premium, face amount, and cash value provisions normally requires the use of special valuation procedures, reserves and DAC are developed following traditional GAAP reserve and present value concepts. The result is that income, except for the effects of experience varying from assumptions (with respect to both policy parameters and experience) and the release of provisions for adverse deviation emerges substantially in proportion to premium income.

Full Margin Approach

As indicated, the Full Margin approach is based on the margins inherent in the interest, mortality, net expense loads, and withdrawal elements of the contract.

This method employs the gross fund value as the reserve and provides for the amortization of capitalized expenses in proportion to revenue margins consisting of interest margins, mortality margins, net expense loads, and surrender charges.

The gross fund value represents the accumulation of actual transactions and is a function of gross premiums (net of front-end loads, if any), expense charges, mortality charges, and interest credits. Therefore, the determination of the benefit reserve, which is equal to the gross fund value, does not require any assumptions as to future experience. Since the gross premium less any expense loads is credited to the fund, the use of the gross fund value as the reserve dampens the effect on earnings of fluctuations in premium payments for flexible premium Universal Life policies. Thus, for flexible premium Universal Life policies, earnings would not normally change abruptly when large amounts are deposited or when premium payments are suspended.

Deferred acquisition costs consist of the difference between (a) excess first year costs (excluding nondeferrable acquisition costs) and (b) excess first year front-end policy loads. Deferral of this difference, whether positive or negative, spreads this first year net cost (the usual case) or benefit over the life of the policy in proportion to the revenue margins. Also, exclusion of FASB 60 nondeferrable costs results in their recognition in income as incurred.

The margins used to amortize capitalized expenses consist of the expected future income from differences between assumed experience and amounts credited or charged to the policy. All assumptions as to future experience would include provision for adverse deviation. Also, since these revenue margins are dependent on the level of the fund, assumptions with respect to the rate of credited interest, mortality, lapse, and the pattern of gross premium payments are required.

The interest margin is the difference between earned interest and credited interest. This margin may be determined by applying the excess of the assumed earned rate over the assumed credited rate to the gross fund value. Alternatively, this margin may be calculated by estimating net investment income on cash flow and subtracting the amount of assumed credited interest. In this latter method, assumptions must be made to determine cash flows.

The mortality margin is the excess of the mortality charge made against the fund over the assumed mortality experience. The assumed amount at risk is developed from the aforementioned assumptions.

Surrender charges, if any, are back-end loads that represent the amount charged against the gross fund value on surrender. In addition to the aforementioned assumptions, an assumption of an average surrender charge may be required.

Net expense loads are the difference between policy expense charges, which may be in the form of a percentage of gross premiums paid, a flat dollar amount per policy, or an amount per thousand of insurance, and assumed expenses, other than excess first-year charges and expenses which have been included in the deferred acquisition cost calculation. These loads represent revenue to the extent they exceed commissions and expenses, including both deferrable acquisition and maintenance expenses not included in the deferred acquisition cost calculation described above. The assumed pattern of gross premium payments is of particular importance if these loads are a percentage of premium.

It is important to understand that the incidence of revenue and income under the Full Margin approach is dependent on the specific design of the insurance contract. That is, revenue is defined to consist of the differences between assumed experience and corresponding amounts credited or charged to the policy. Thus, the margins reflect the specific characteristics of the contract and, for a given scenario of interest, mortality, withdrawal, and expense experience, the specific mortality charges, expense loads, expected credited interest, and surrender charges designed into the product will determine the pattern of income emergence. Some believe that this reliance on the specific contract design, i.e., the level of interest credited, the mortality charges, the expense loads, and the surrender charges, is not desirable as the resulting margins may not bear a direct relationship to the risks assumed under the contract.

The tables at the end of this section illustrate the application of this approach using the Universal Life contract described earlier and used to demonstrate the Traditional approach in the same table.

Full Release From Risk Approach

This approach is based on selecting the valuation assumptions so as to achieve a GAAP valuation premium substantially equal to the gross premium. This is achieved by loading the most likely experience assumptions with margins similar to those for adverse deviation, generally through an iterative testing process. Income will then emerge as actual experience varies from these loaded assumptions.

This method is generally implemented by combining the benefit reserve and expense asset components and working with the resulting total GAAP premium. While a net reserve (benefit less expense) is obtained from these procedures, it is customarily allocated to separate liability and asset elements for financial reporting purposes.

This particular approach does not lead to an immediate or single conclusion concerning the pattern of emerging profits. The assumptions and conservatism included therein will determine the expected pattern. A level investment return margin may tend to defer profit recognition, while heavily loaded early termination assumptions may move profit recognition to early policy years. The use of level termination rates combined with level or increasing investment return margins may defer profit recognition, and may even result in losses in early years. Such drastic assumptions will seldom be found in a competitive environment and would be justified only when serious question exists as to whether the product is self-supporting.

The tables at the end of this section also illustrate the application of this approach.

Balanced Approach

This method allows a portion of earnings to emerge as a level percentage of gross premiums, while all other earnings emerge in proportion to revenue margins. Thus, the method represents a blend between the Traditional method and the Full Release From Risk method. Earnings emerge in proportion to a composite revenue basis reflective of the performance under the contract and in relation to the risks assumed, as opposed to the single basis of premium income under the Traditional method. Unlike the Full Release From Risk method, however, premium income may be included as a component of such composite revenue basis.

The composite revenue basis may vary by plan, depending on the relative importance of each function or service being performed (i.e., sales, premium collection, protection, investment, conservation), and the magnitude of the related risks. For example, the composite revenue basis for a Universal Life plan expected to result in an endowment at age 95 plan and containing a balanced emphasis on protection and savings might be based on a reasonably uniform weighting of each of these functions (protection and savings) and the premium receipt function or service. A plan expected to contain a lesser savings element, such as a term contract, would place more weight on the protection function and less weight on the savings function.

Earnings emerge in proportion to the composite revenue basis and can be accomplished by the use of larger-than-normal margins for the risk of adverse deviation. The additional margins, however, should not be viewed as margins for adverse deviation, but rather as margins forming part of the revenue basis. Nonetheless, the additional margins would have the same effect on earnings emergence as do the margins for adverse deviation. The protection service and mortality risk assumed, for example, are recognized in the revenue basis by incorporating an additional margin in the mortality assumption.

A portion of earnings would then be expected to emerge in relation to the net amount of risk. Similarly, investment risks and functions are recognized by placing an additional margin in the investment yield assumption, thereby causing some profits to emerge in relation to invested funds.

The portion of the composite revenue basis which is assigned to premium income is represented by the difference between the gross premium and the

GAAP valuation premium, where such GAAP valuation premium has been determined on a basis that includes the aforementioned margins. This suggests that the basic actuarial calculations do not initially separate the benefit and expense reserve elements, which is similar to the unitary reserve approach used in the Full Release From Risk approach. The selection of assumptions and the evaluation of the appropriateness and reasonableness of the resulting implied composite revenue basis is normally done in this manner. Subsequent to the identification of final assumptions, the total GAAP valuation premium and reserve (benefit reserve less expense asset) are then split into separate benefit and expense components, both based on the same final policy and experience assumptions.

Sources of earnings under the Balanced method consist of:

1. Earnings emerging in proportion to the composite revenue basis--a portion as a level percent of gross premium, where appropriate, and a portion arising from the release of the additional margins forming part of the revenue basis.

2. Earnings arising from the release of normal margins for the risk of adverse deviation.

3. Gains or losses arising from differences between actual and expected experience.

As would be the case under any method, earnings allocated to the revenue basis must not be at the expense of providing sufficient provision for the risk of adverse deviation. The tables at the end of this section illustrate the earnings pattern obtained when the balanced approach is implemented.

Implementation of this method requires a full set of assumptions regarding expected future experience--interest, mortality, withdrawal and expense, as well as the expected pattern of premiums. In addition, assumptions must be made regarding the rate of interest to be credited and the cost of insurance and expense loads to be charged to determine projected gross fund values (before surrender charges, if any) and cash surrender values (after surrender charges, if any). Also, the death benefit pattern must be determined.

The following steps are generally followed when setting the assumptions and related additional margins (excluding the normal margins for adverse deviation) when the Balanced method is adopted:

1. Set assumptions regarding expected, or most likely, future experience.

2. Add margins for the risk of adverse deviation.

3. Calculate a total GAAP premium based on the above assumptions and compare it to the gross premium.

4. If the total GAAP premium is greater than the gross premium, reduce the margins for adverse deviation so as to cause the total GAAP premium to equal the gross premium. If the total GAAP premium with all margins for adverse deviation eliminated is still greater than the

gross premium, reduce deferred acquisition costs enough to cause the total GAAP premium to equal the gross premium.

5. If the total GAAP premium (including normal provisions for adverse deviation) is less than the gross premium, proceed with developing the composite revenue basis by placing additional margins in the assumptions which are reflective of the functions and services being performed and the risks assumed. The difference between the gross premium and the resulting total GAAP premium represents the portion of earnings expected to emerge as a level percent of premium income.

An iterative process may be involved in solving for the additional margins necessary to achieve the desired composition of the revenue basis. In no event should provisions for adverse deviation be impaired unless the GAAP premium excluding additional margins exceeds the gross premium.

Special valuation procedures are normally required and two alternative approaches for implementing the prospective version of the Balanced method are commonly used. While other procedures can be used, these two techniques are described below.

The first approach develops benefit reserves based on the application of ratios of net level benefit reserve factors and projected gross fund value factors to the actual gross fund value inventory on an issue age and duration basis. The acquisition expense asset also is based on this technique. Here, ratios of net level acquisition expense asset factors to projected gross fund value factors are applied to the actual gross fund value inventory on an issue age and duration specific basis. Maintenance expense reserves, if needed, are based on ratios of net level maintenance expense reserve factors to projected gross fund value factors applied to the actual gross fund value inventory on an issue age and duration specific basis.

The second valuation technique develops benefit reserves based on the application of ratios of modified preliminary term (MPT) benefit reserve factors and projected gross fund value factors to the actual gross fund value inventory on an issue age and duration specific basis. The MPT benefit reserve factors reflect a first-year expense allowance equal to any excess first-year expense load charged under the policy. If no excess first-year expense load is present, the reserve factors revert to net level. Use of an MPT basis puts the benefit reserve factors on a comparable basis with the build-up of gross fund values, and thus, produces better-behaved ratios by duration.

The acquisition expense asset consists of any excess first-year expenses less ultimate commissions. This amount is capitalized and amortized as a level percent of gross premium via a work sheet schedule using the loaded assumptions and is dynamically adjusted based on "experience" premium in force.

Maintenance expense reserves, if needed, are based on the application of ratios of net level maintenance expense reserve factors to projected gross fund value factors to the actual gross fund value inventory on an issue age and duration specific basis.

Both approaches relate the reserve factors to gross fund values rather than units of insurance to better adjust for the flexible nature of premiums and benefits of these products. This allows the method to respond to substantial variations in actual and expected experience.

Other Approaches

The approaches discussed above represent different views as to what constitutes revenue. All methods require a considerable amount of effort to achieve accurate results.

In the absence of authoritative statements concerning which method is appropriate, many companies have chosen methods which are relatively easy to implement. Their rationale is that, as long as the simple methods produce results which are comparable to one of the theoretical methods, such methods are justified. Usually, the expected incidence of earnings under these simpler approaches lies within the range derived from the above methods and, thus, might be regarded as reasonable. Such an approach may be justified at this time as it may be unreasonable to expect companies to expend a great deal of effort to develop a method which may be declared inappropriate. In addition, Universal Life is still a fairly small proportion of in-force business for many companies, so that the choice of GAAP method often does not affect overall earnings significantly. Thus, materiality considerations are an important factor supporting the use of these simpler methods.

Gross Fund Values as Reserves with Independent Amortization Schedules

The most common simplified method being used by companies is to hold the gross fund value as the benefit reserve and to amortize deferred acquisition expenses in some manner. Generally, acquisition costs are reduced by any first-year expense loads. If such costs were amortized in proportion to income margins, the method would be the Full Margin approach method described above. The actual items being used by companies to amortize acquisition costs include premiums (ignoring any additional first-year premium), cost of insurance rates for a level net amount at risk, and the minimum premiums required to keep the policy in force.

Amortizing in Proportion to Premium:

Amortizing costs in proportion to premiums has considerable appeal for companies seeking a simplified method. It is similar to methods used for traditional products and for companies using the work sheet method of acquisition cost amortization, the mechanics are identical to those used for other plans. The company needs only to determine an assumed lapse rate and a premium pattern for in-force policies, although level premiums per in-force policy are generally assumed. First-year premiums in excess of the "target" premiums may be ignored in order to avoid heavy first-year amortization. While this approach may be described as being based on premium revenue, the simplified premium assumptions result in amortization in proportion to in-force volume.

Amortization in Proportion to Cost of Insurance Rates:

This method is based on the concept that the cost of insurance rates consitutute the major source of predictable revenue and that most or all interest margins should be recognized only when earned. A criticism of this method is that the profits in the cost of insurance rates (the difference between the charges and actual mortality) follow a different pattern than the insurance rates themselves. If the cost of insurance rates are used to amortize acquisition costs, then an adjustment should be made to the benefit reserves, which is not done in all cases. Since cost of insurance rates increase by attained age, the amortization of acquisition costs is often low in the early durations, especially if a level net amount at risk is assumed.

Amortizing in Proportion to Minimum Premiums:

This is similar to amortizing costs in proportion to cost of insurance rates, except that the first-year minimum premium may be high for products with a first-year load. In this case, the first-year GAAP earnings may be low (possibly even negative), but the pattern for years two and later is the same as that produced by amortizing acquisition costs in proportion to the cost of insurance rates. If the company defers total acquisition costs (instead of the excess of the acquisition cost over the first-year load), there is a large first-year GAAP earnings under this metod. However, this practice is generally considered inappropriate.

Adjusted Gross Fund Values as Reserves With Independent Amortization Schedules

With this method, acquisition costs are amortized using an independent schedule, and the increase in benefit reserves is solved for in order to achieve a "reasonable" income result, usually expressed as a percentage of premium. This "reasonable" percentage of premium is typically based on pricing studies. For example, if pricing studies indicated an expected profit of 15% of premiums, then the company might choose 10% of premium as a "reasonable" first-year income result. An adjustment is made for nondeferrable acquisition expenses, so that, in the above example, the first-year profit would be 10% of premium less these nondeferrable acquisition expenses. A smaller percentage of premium, possible zero, may be used for collected premiums in excess of anticipated premiums.

A variation of this method is to solve for a "reasonable" percentage of premium profit assuming no profits from excess interest. Income would then be increased (by reducing the benefit reserve increase) by an amount equal to the actual excess interest earned during the year.

Methods such as these are intended to be interim procedures, used until a permanent method is developed. These techniques generally would not be considered appropriate if the effects were material to income. Also, inaccuracies will develop as, if the intended margin is 15% and a 10% margin is used to report income, distortions ultimately will occur, even if anticipated experience is realized. In actual practice, anticipated experience never is realized and this method does not allow for such differences to be recognized. While it is possible to estimate the differences between actual and anticipated mortality, maintenance expenses, interest income, and other

factors and to reflect these differences in income, this involves a considerable effort and defeats the primary objective of this method, which is its simplicity.

Illustrative Income Patterns

To illustrate the general patterns of income which could be derived from the various accounting approaches, certain examples have been prepared. Appendix A contains detailed product descriptions, presents the assumptions used in the calculations, and shows the resulting reserve and income computations. Income illustrations have been prepared for two product/assumption scenarios in an effort to provide information which may be useful in reaching an understanding of those product features and assumptions which may significantly impact the level and pattern of reported income.

Both products contain front-end expense loads and do not contain surrender charges. In other respects, the products are identical, except for the mortality charges. Product I mortality charges are 100% of 1958 CSO rates, while Product II charges are graded from 60% to 79% (over twenty years) of the 1958 CSO mortality rates. Mortality, withdrawals, and earned investment income experience are the same for both products and all income illustrations.

The following table summarizes the results of the calculations for Product I.

Illustrative Income
Product I

Policy Year	Traditional	Full Release Balanced	From Risk	Full Margin
1	$111.32	$ 56.03	$ 28.90	$ 52.91
2	88.97	52.04	34.11	45.41
3	79.98	53.88	41.37	45.78
4	75.89	58.63	50.54	50.23
5	71.98	63.11	59.17	55.12
6	68.26	67.32	67.28	60.56
7	64.72	71.39	75.06	66.18
8	61.35	75.28	82.47	71.84
9	58.13	79.07	89.61	77.59
10	55.06	82.69	96.41	83.45
15	41.71	98.84	125.99	114.82
20	31.08	98.82	129.44	155.25
Present Value	509.47	509.47	509.47	509.47

These results may not be self-explanatory and certain comments may be helpful. First, the exclusion of provision for adverse deviations effects certain approaches more than others. Generally, however, the inclusion of such provisions would defer the recognition of income. Also, the inclusion of reasonable provisions for adverse deviation would cause the Traditional income pattern to be shifted toward the Balanced approach. In this respect, the exclusion of such provisions exaggerates the yearly income differences which would be likely to occur in practice.

The Balanced approach contains additional conservatism in the assumptions used to compute the reserves and deferred acquisition costs. This conservatism was added so that the present value of the income related to premium, interest, and mortality elements were equal. This results in a reduction of income as a percentage of premium from 9.9% under the Traditional approach to 3.3% under the Balanced approach. Different relative levels of conservatism could be included in the assumptions and different annual income patterns would be obtained. Also, the introduction of additional conservatism in maintenance expense and withdrawal assumptions would affect the reported income patterns.

The Full Release From Risk illustration is based on the inclusion of conservatism in the interest and mortality experience assumptions sufficient to cause the GAAP premium to equal the gross premium. This example includes conservatism in each element to an extent needed to cause the present value of the income related to these two elements to be equal at issue. Other relative levels of conservatism, or including conservatism in maintenance expense or withdrawal assumptions, would result in different income patterns. This is further illustrated in the examples completed with respect to Product II.

Some may be surprised at the level of income produced by the Full Margin approach in the early policy years, especially as compared to the Full Release From Risk approach. The relatively high level of income in these years is primarily due to the pattern of mortality charges (1958 CSO) compared to the expected mortality experience (1965-70 Select and Ultimate). Due to the aggregate nature of the charges and the select pattern of the experience, high mortality margins are reported in income. As shown in the Product II illustration, other product designs will produce different annual income results under the Full Margin approach.

Other illustrations also have been prepared for Product II. The principal difference in the two products is the selected nature of the mortality charges in Product II. The following table presents the annual incomes which could be derived by the application of the various accounting approaches to Product II.

STATEMENT 1984-32

Illustrative Income
Product II

			Full Release From Risk			
Policy	Traditional	Balanced	75% Mortality	50% Mortality	25% Mortality	Full Margin
1	$111.09	$ 57.14	$ 45.20	$ 30.62	$ 15.90	$ 29.40
2	88.78	53.00	47.08	35.60	24.02	28.95
3	79.81	54.76	52.30	42.74	33.12	33.46
4	75.73	59.47	59.87	51.84	43.78	41.09
5	71.83	63.91	66.70	60.41	54.12	49.21
6	68.12	68.08	72.79	68.46	64.18	57.89
7	64.58	72.11	78.40	76.19	74.07	66.85
8	61.22	75.96	83.44	83.54	83.78	76.01
9	58.01	79.11	88.06	90.63	93.39	85.40
10	54.95	83.30	92.12	97.37	102.87	95.04
15	41.63	98.98	103.76	126.28	149.06	147.86
20	31.01	96.99	66.34	126.79	185.43	216.30
Present Value	496.33	496.33	496.33	496.33	496.33	496.33

The accounting approaches illustrated are the same as presented for Product I. However, the Full Release From Risk approach has been demonstrated using different relative levels of conservatism in interest and mortality elements. In each case, the GAAP premium equals the gross premium, but was obtained with different degrees of conservatism in the two elements. The percentages shown are the portion of the present value of profits allocated to the mortality function. The 50% allocation is the same as the Full Release from Risk illustration for Product I.

Note that the present value of profits for Product II is nearly the same as Product I. As a result, despite the product design differences, the Traditional, Balanced, and Full Release From Risk (for Product II, the 50% mortality example) annual incomes are generally comparable. This indicates that these accounting methods are primarily influenced by the overall economics of the product, not the specific contract design.

In this regard, note that the Full Margin income results for Product II are substantially different than those for Product I. This suggests that, even though the overall incomes are substantially equal, the specific product design (mortality charge levels, in this example) can materially affect the incidence of reported income.

VIEWS ON PRESENT PRACTICES

Generally, those using the Traditional approach believe that current literature is sufficient to account for Universal Life since:

a. Ordinary Life is a special case of Universal Life and the same accounting theory should apply as the same functions are performed under both types of contracts.

b. Premiums continue to represent a good and reasonable measure of performance under the Universal Life contract.

c. Use of another method implies that current accounting for Ordinary Life is inappropriate, since these products could be unbundled as well. Until accounting is changed for Ordinary Life products, Universal Life accounting should be consistent with current literature.

d. The Traditional approach is fully proven and in place throughout the industry for other products.

e. The financial impact of the accounting method is not as material for an annual premium product as it is with single premium products. Hence, concerns which have surfaced with respect to SPDAs do not apply to Universal Life to the same degree and could be resolved with minor modifications to existing principles.

Generally, those supporting the Full Margin or the Full Release From Risk approach believe that changes from current guidelines are indicated since:

a. The "unbundling" of services and other product differences between Universal Life and Ordinary Life cause current literature to be inapplicable, as well as insufficient, for Universal Life. These major product differences include partial withdrawals, premium discontinuances, flexible face amounts and funds based on current mortality and interest elements.

b. The variable nature of the mortality and interest elements of the contract suggest that current GAAP accounting for guaranteed cost contracts is inappropriate.

c. Current practice for nonguaranteed premium products and SPDAs differs from FASB 60, indicating that this document is not necessarily applicable to all products.

d. Performance under the Universal Life contract is best measured by investment functions, mortality risk spreading, the assumption of expense risks, and sales efforts. Hence, matching of costs to an unpredictable premium stream would be distortive and not an appropriate measure of performance under the contract.

e. These methods produce a smooth flow of income over the life of the contract and do not distort income materially if policy parameter assumptions, especially with respect to premium income, are not realized.

f. Universal Life can be viewed as a series of short-term contracts reflecting the lack of guarantees and should not be accounted for utilizing long-term contract methodology.

g. Significant practical implementation problems would exist if the traditional approach were used. Therefore, a reasonable and practical alternative is sought.

Those favoring the Full Margin approach further believe that the gross revenue margins designed into the contract are the best indicator of the level of service provided under the contract. They believe that such margins should be reflected in income in the period in which the policy is actually credited or charged for the service, i.e., when mortality charges, expense loads, and surrender charges are assessed and when interest is credited.

Those favoring the Full Release From Risk approach believe that, while income should not be determined by the receipt of premium, it also should not be based on the specific design of each contract. Rather, it should be related to the passage of, and release from, risks assumed under the contract. This concept is considered consistent with FASB 60 and the need to include provisions for adverse deviation in experience assumptions. Thus, the definition of revenue under this method, unlike that used under the Full Margin approach, differs from FASB 60 only in the degree to which premium income is included in revenue.

Generally, those supporting the Balanced approach believe that it is a reasonable approach which eliminates the objections of the other approaches. In addition, it is considered a desirable alternative since:

a. It identifies the relative importance of the various functions provided under the Universal Life contract and attempts to match profit recognition on a composite revenue basis.

b. The current diversity of accounting practices indicates that different approaches are reasonable depending on product and market specifics and company philosophies. The Balanced approach directly allows for these differences by incorporating the elements directly.

c. The Balanced approach produces a reasonable pattern of earnings. The pattern is reasonable and appropriate considering the services performed, the risks assumed, and the contract features.

RECOMMENDATIONS REGARDING THE BASIC ACCOUNTING ISSUE

The Committee believes that contracts meeting the definition of Universal Life policies as presented herein should be accounted for using a methodology consistent with the fundamental concepts embodied in the Balanced approach. This general approach is considered appropriate principally because it allows the direct recognition of the relative importance of the primary functions performed and risks assumed by the insurer. This permits revenue (for income allocation purposes) and income to be recognized in proportion to services performed during the life of the contract, which is the basic objective of the audit guide and FASB 60.

In addition, other factors supporting adoption of the Balanced concepts include the following:

- By itself, premium income does not represent a good and reasonable measure of performance for contracts with undefined premium and benefit structures, which are offered through varying marketing

methods to widely differing markets to satisfy virtually any combination of financial and insurance needs.

- The absence of significant guarantees as to the contract's ultimate cost, in conjunction with its basic flexibility, suggests that procedures appropriate for long-term contract accounting for guaranteed cost policies is not appropriate for Universal Life.

- While the contract may be "unbundled", product pricing often follows a prospective and integrated approach to overall profitability, implying the continued interrelationship of product elements and the need to rely on premium income for profitability. This indicates the importance of the receipt of premium, suggesting that some income may be permitted to emerge in relation to that event.

In this context, the Balanced approach can be considered an extension of existing GAAP concepts regarding revenue recognition and income emergence. Specifically, proper application of the Balanced approach, which is defined more fully below, should result in the emergence of income in proportion to the relative importance of the services and functions performed and risks assumed by the insurer under the terms of the policies. In accordance with the Balanced approach as described herein, accomplishment of this objective can best be understood, and the method more specifically defined, by reference to the manner in which experience assumptions (as opposed to policy characteristic assumptions) are established.

The concepts of "most likely assumptions" and "provisions for adverse deviation" have been established and are understood in the context of GAAP for traditional life products. In general, the Balanced approach is a method which inserts additional conservatism into the selection of experience assumptions, over and above that included in the "most likely assumptions with adequate provision for adverse deviation". The result of this additional conservatism is a Balanced valuation premium which is greater than the valuation premium which would be obtained by the use of "most likely assumptions with adequate provision for adverse deviation". This additional conservatism and the provisions for adverse deviation are then released into income as the related risks pass. Also, the residual excess of the gross premium over the Balanced valuation premium will be reported in income as premiums are collected. Of course, underlying variations between experience and most likely assumptions also affect income in the period the variation occurs.

Assuming a basic level of "most likely assumptions with adequate provisions for adverse deviation", the additional conservatism introduced to the experience assumptions determines the allocation of income to function or risk, i.e., investment, mortality, expense, withdrawal, and premium collection areas. Thus, the Balanced approach is best defined by delineating the manner in which this additional conservatism in the various experience assumptions is determined.

The relative levels of additional conservatism included in experience assumptions should be established and based on an analysis of the significant functions and services performed and risks assumed by the insurer. In

selecting the specific degree of additional conservatism, matters such as the following should be considered.

The structure of the product and its basic policy design features and characteristics should be examined to identify the service and risk level in mortality, interest, withdrawal, expense, and premium persistency areas. If the pure mortality element is not expected to be significant, relatively little importance would be attributed to this feature of the contract and the degree of additional conservatism included in the mortality assumption would be slight. The level of anticipated margins in policy mortality charges and expected mortality also should be considered. However, intentional early year margins, intended to assist in the immediate recovery of acquisition expenses, would not necessarily lead to a conclusion that little mortality risk was present. Rather, the level of mortality risk inherent in policy charges should be evaluated after elimination of charges intended for another purpose and should reflect both the likelihood that such adjusted margins will be inadequate and the expected level of mortality management (e.g., in terms of experience analysis and modification of future charges) required by the insurer.

The significance of the interest element should be judged by considering matters such as the pattern of expected growth in gross fund values and the expected margins in earned and credited interest rates. For example, high early account values increase the importance of the interest function, as does the expectation that the contract's flexibility would be utilized to make contributions in addition to amounts necessary to keep the policy in force. Thus, if the fund accumulation aspect of the contract was heavily used, greater weight would be given to the interest feature and relatively more additional conservatism would be included in the interest assumption.

Similarly, the insurer's expected ability to maintain an earned rate in excess of the credited rate is a major factor affecting the level of additional conservatism in this assumption. Specifically, as the expected credited rate approaches the net rate which can be earned by following a reasonable and appropriate investment policy (considering the liquidity needs of the product and the desire to generally match asset and liability cash flows), the interest risk increases and significant additional margins in the interest assumption should be introduced. Furthermore, the relationship of the earned rate on which pricing analyses are based and which is needed to achieve the desired profitability and the net rate which can be earned in the marketplace also is an important factor. As above, as the rate required in the pricing process comes closer to the expected net earned rate likely to be available, larger additional conservatism in the interest assumption should be established.

Withdrawal risks also should be considered, although the introduction of "conservatism" into this assumption can be difficult. In this context, additional conservatism means an assumption modification which results in an increase in the total Balanced valuation premium (i.e., all benefit and expense components). If the cost of premature withdrawal is high, then additional conservatism in this assumption should be considered. This condition could exist if cash values accumulate rapidly and if unrecovered acquisition costs are significant, due either to unmatched front-end policy expense charges or back-end surrender charges.

The importance of the receipt of premium is, of course, a key matter to evaluate as the conclusion directly affects the portion of total income attributed to the premium income element. Generally, the weight given to this aspect of the policy would increase as the need to receive future premiums to keep the policy in force or to attain expected profit levels grows. For example, a contract expected to generate permanent insurance features (long-term death benefits and reasonable cash values) may depend more on future premiums (both as to amount and duration of receipt) than would a contract expected to result in term insurance. As a result, relatively more weight might be given to the premium receipt element of the permanent contract.

In addition to the policy's design characteristics, other factors also should be considered in determining the additional conservatism in assumptions, thereby allocating the release of income to primary functions and risks. Many of these factors are matters which impact the design of the policy or its ultimate form in the hands of the insured. As such, these items are closely related to the considerations discussed above with respect to the nature of the contract. Some of these items are:

- The Product Distribution Method--Sales by traditional insurance agents may be expected to emphasize basic insurance needs, resulting in product characteristics comparable to traditional permanent or term contracts. Alternatively, sales by licensed stock brokers might tend to result in products being heavily used for investment purposes. Thus, the distribution method used may affect, and should support, the basic evaluation of the expected form of the contract and the functions performed and risks assumed.

- The Market to Which the Product is Offered--Again, characteristics of the expected market should be considered when evaluating policy design features and the relative level of expected service and risk. Sales to middle income markets for the purposes of providing basic death benefit protection or estate liquidity may result in a product with substantial mortality, investment, and premium components. If the policy design also is balanced and not unduly aggressive in the pricing of interest or mortality elements, additional conservatism in assumptions could be such that income will be released fairly uniformly among the mortality, interest, and premium receipt functions.

  If a high income, sophisticated market is being sought and sales are based more on the product's flexibility and investment features, a different conclusion may be appropriate. In such circumstances, the selection of assumptions might be expected to result in most income being released in proportion to the interest function, with little income being attributed to mortality or premium receipt functions.

- Predictability of Experience and Policy Characteristics--The ability to reliably estimate future experience and policy characteristics is affected significantly by policy provisions, marketing methods, and the target market. As such, the degree to which future experience and policy characteristics (e.g., premium receipts and death benefit levels) can be anticipated also should be carefully considered. If mortality or interest margins are uncertain (either due to aggressive product design

and pricing or to unpredictable mortality levels and investment opportunities), such risks would be high and a large amount of additional conservatism should be included in these assumptions. If the level of future premiums cannot be reliably estimated, but if some cash flow is essential to future profitability, then release of income attributable to premium receipt should be restricted to that minimum premium flow which can be reasonably expected. This would normally result in a relatively low portion of income, if any, being released as premiums are received, reflecting the uncertainty and risk associated with assumptions concerning future premium income.

- The Reasonableness of the Resulting Expected Earnings Pattern -- While accounting methods and actuarial assumptions should not be selected so as to produce a predetermined earnings result, the expected pattern of emerging earnings should conform to a reasonable evaluation of aggregate performance and risk under the contract. Items to consider in determining that the expected earnings are reasonable include the pattern of earnings, the expected relationship of earnings to premium income and revenue margins, the expected pattern of the return on equity, and other corporate measures and standards of performance.

As indicated, these and other factors should be considered as they directly affect the importance and risk related to the basic elements of mortality, investment, withdrawal, and premium receipt. All factors should be considered together as their interdependence and interaction is important in reaching a reasonable overall conclusion. While specific formulas and techniques for determining the additional conservatism included in assumptions and the resulting allocation of income to function cannot be provided due to the wide variation of contract designs, marketing methods, marketplaces, and product management approaches, the following guidelines can be established. Except in unusual circumstances, the resulting Balanced reserve assumptions (including the most likely experience plus normal provisions for adverse deviation plus the additional conservatism) and the implied allocation of income released to function should be within the range defined by the following:

- In some circumstances, the investment, mortality, withdrawal, and other functions and risks may be so significant and the receipt of premium so uncertain or unnecessary to the performance of the contract that all or virtually all income should be attributed to the investment, mortality, withdrawal, and other services and functions. In such cases, either the Full Margin or the Full Release From Risk technique can be used. In the latter case, assumptions should be established by including sufficient additional conservatism in interest, mortality, withdrawal, and possibly other assumptions so as to produce a Balanced valuation premium equal to, or substantially equal to the expected policy gross premium.

- In other circumstatnces, the premium receipt function may be an important service or risk under the contract. In this case, asumptions should be established so that income is released in proporation to the functions and services represented by the premium, mortality, investment, withdrawal, and possibly other elements of the contract.

The Committee believes that circumstances in which the premium receipt function by itself reasonably represents the combination of services, risks and functions, will not be encountered except in unusual situations. Thus, assumptions should rarely, if ever, not include conservatism in excess of the normal provisions for adverse deviation.

Dynamic Adjustments

The lack of fixed policy parameters and interrelationships makes it essential that valuation procedures be sensitive to emerging aggregate premium and benefit experience. All accounting approaches are, at least in part, dependent on the continuing general reasonableness of the policy parameter assumptions. All prospective techniques, including the Traditional, Full Release From Risk, and the Balanced methods, require that key assumptions be made with respect to initial and subsequent premiums, death benefit levels, mortality charges, and interest credits. Even the Full Margin method is based on such assumptions as they directly affect the estimated future incidence and amount of revenue margins. In the event that original assumptions are not materially realized, the use of valuation factors based on inaccurate policy characteristics could easily cause reported income to be severely distorted. Therefore, it is important that benefit and expense reserve valuation techniques automatically adjust to actual developments.

In the benefit reserve area, this most often manifests itself through the application of factors to actual gross fund values. It is intended that by relating reserves to actual gross fund values, changes in premiums, death benefits, and interest credits can be reflected in the valuation process. Practice has shown that this is a reasonable approach in many situations, particularly where relatively modest variations from assumptions can periodically recalculated, following the procedures outlined in Interpretation I-I: Accounting for Nonguaranteed Premium Products.

Comparable procedures can be used in the expense area if factors are based on gross fund values. Alternatively, otherwise static acquisition cost amortization schedules can be adjusted by the ratio of actual and expected in-force or cumulative premium income.

The design and use of any procedure intended to recognize emerging policy experience should be thoroughly tested to assure that it produces reasonable results in situations of modestly varying policy assumptions. This could be done by using the proposed procedures in tests which assume that experience is different from that used in the calculation of the valuation factors or ratios. Such analyses would tend to indicate the range of experience over which the proposed technique would produce results generally consistent with the earnings pattern expected to emerge.

MAJOR SUPPLEMENTARY ISSUES

In addition to the basic accounting question regarding alternative accounting practices for Universal Life contracts sold with reasonably traditional relationships between premiums and face amounts, several other issues arise from the flexible nature of the contracts. This section is intended to briefly discuss these more significant issues and addresses the following matters:

- The manner in which income is reported on contracts with lump-sum premiums.

- Accounting for the old and new contracts in an internal replacement transaction.

Accounting For Contracts With Lump-Sum Premiums

Prior to the development of Universal Life, insurance products generally required the policyholder to pay fixed premiums on fixed schedules in order to maintain the policy in force. This is not true with respect to flexible premium Universal Life policies, which permit policyholders to pay premiums of varying amounts at varying times. Accounting for traditional products did not need to address the impact of varying premiums, but this feature of Universal Life contracts is a significant element which must be carefully considered.

In this context, lump sums are defined to be amounts received or expected to be received, at issue or subsequent thereto, which are in excess of those premium payments which the insurer has a reasonable expectation of receiving on a continuing and long-term basis. Precise and specific definitions of lump sums are not possible as such amounts may not be able to be properly evaluated until subsequent premium paying experience develops. Thus, professional judgment in determining the likely status of amounts received or expected to be received is critical. Matters to consider in determining whether amounts received may or may not constitute lump sums include:

- The degree of correspondence between the amounts actually received and the initial and subsequent planned premiums as indicated in the application for insurance.

- Contracts known to have been issued as a replacement to existing coverage (whether previously issued by the same or different carriers) will be more likely to have initial lump sums and, except in the presence of evidence to the contrary, should normally be assumed to result in initial lump-sum premiums.

- The experience of the insurer should be examined, particularly with respect to the emerging relationships of first year and renewal planned and actual premium payments.

While initial lump sums may be more likely to occur, it should be understood that flexible premium Universal Life contracts permit additional premiums to be paid at issue or at any time thereafter. Therefore, continuing analyses of premium payments is necessary for the identification of lump sums subsequent to issue. When such amounts are identified, accounting methods and procedures should be carefully examined to verify that the accounting principles recommended below have been adhered to and that earnings have not been distorted by the receipt of previously unanticipated lump sums.

In the absence of the special handling of lump sums, reported earnings would be impacted differently under the Traditional, Full Margin, Full Release From Risk, and Balanced approaches. Under the Traditional approach, an accurate assumption with respect to the amount and incidence of lump sums is required. When properly made, such an assumption will allow the release of

the normal percentage of premium profit margin on receipt of the lump sum. Thus, whether at issue or subsequently, lump sums will result in the immediate release of additional earnings.

Under the Full Margin and Full Release From Risk approaches, the accurate estimation of lump sums will not result in any immediate effect on earnings. Under the Full Margin approach income will not be affected at the instant of receipt as the difference between costs and policy loads would be deferred. However, accurate estimation of such amounts is necessary to develop appropriate future revenue margins and corresponding deferred acquisition cost amortization schedules. Thus, while current earnings are less sensitive to unanticipated lump sums, future earnings patterns can be materially affected if such amounts are not reasonably estimated.

Under the Balanced approach, the impact of lump sums would fall between that described above with respect to the Traditional and Full Release From Risk approaches. To the extent that earnings have been allocated to the premium receipt function, the Balanced percentage of premium profit margin would be released on the receipt of lump sums. Once received, the earnings attributable to mortality, interest, withdrawal, and other functions would be affected as invested funds and net amount of risk relationships would be impacted.

The Committee believes that percentage of premium earnings should not be released on the receipt of lump-sum premiums. In the extreme case of a single premium Universal Life contract, where it is not expected that any additional premiums will be received, no earnings should be released on receipt of the initial premium. In this instance, the Committee believes that an evaluation of the functions, services, and risks performed under the contract will result in the allocation of future income to mortality and investment elements and that the Full Margin or Full Release From Risk approach should be utilized.

In other cases where lump sums have been identified and where other premiums are expected to be received, the Committee believes that treatment of the lump-sum amount should be such that percentage of premium earnings are not released on its receipt. Specifically, under the Balanced approach, valuation premiums should be determined such that the total valuation premium is comprised of 100% of the expected lump-sum amounts and the resulting normal Balanced-approach percentage of other premium receipts.

Accounting For Internal Replacement Transactions

While Universal Life is not intended solely as a replacement vehicle, companies that introduce it may view their own and other companies' policies as a major source of new business. As a result, internal and external replacement programs have become common. While externally replaced business poses no new problems for the issuing company, an internal program of replacement does raise new concerns and questions.

Most internal replacement programs will substantially change the expected GAAP profits of existing business because of the different inherent profit levels of the new Universal Life business and the other business currently in

force. It also may significantly affect the expected profitability of the Universal Life business. Whether the replacement program is more or less profitable than other new Universal Life business will depend on the form it takes, the company's practice with respect to compensation and first-year expense charges, the difference between earned and credited interest rates, and the differences in mortality and persistency experience. Because internal replacement programs may have significant profit implications, the circumstances surrounding such a program should be carefully examined, and assumptions and recoverability tests should reflect the new situation.

In addition, without special accounting procedures, deferred acquisition cost balances associated with replaced policies will be written off, and the difference between cash values transfered to the new Universal Life policy and benefit reserves released as a result of such a transfer will be recognized in the period's income. At the termination of the existing policy and the issuance of the new contract, both will be reflected in current income. A question arises as to whether the nature of the transaction and the relationship between the existing policies and the new Universal Life contracts warrants special accounting recognition. Some of the questions which need to be addressed with respect to an internal replacement program and the deferral of costs associated with such a program include:

- How should the costs of replacement be defined?
- Should these replacement costs be considered for deferral?
- If deferred, how should they be amortized?
- What recoverability tests should be performed to ensure that these costs are recoverable?

Replacement Costs

Replacement costs may be defined as being equal to the sum of the unamortized deferred acquisition cost balance associated with the business being replaced and the difference between the cash value transferred to the new policy and the benefit reserves released. Some suggest that replacement costs should be defined as only the unamortized acquisition costs related to the replaced policies. It appears, however, that this definition is incomplete. The gain or loss from the difference between cash values transferred and the benefit reserves released is clearly a result of the replacement transaction and is no less attributable to that activity than are the unrecovered acquisition costs.

An alternative definition of replacement costs might be the sum of the unamortized deferred acquisition costs of the replaced policy and the difference between the reserve released on the replaced policy and the reserve established on the new Universal Life policy. While this may reflect the net result of the transaction, it also would seem to require special treatment of the policy loads assessed against the cash value transferred to the new Universal Life policy. Under normal accounting procedures, these loads would be matched against the costs associated with acquiring the new policy and serve to reduce gross acquisition costs to those net costs which should be deferred. The use of the reserve difference as a measure of the

replacement cost, however, implicitly assigns the front end loads to the replacement transaction and would lead to the deferral of the gross acquisition costs of the Universal Life contract. The Committee believes that it is more appropriate to associate these loads with the accounting for the new policy rather than to net them against the loss associated with the old policy. Therefore, while individual company situations could vary, the total cost of an internal replacement transaction should normally consist of both the unamortized deferred acquisition cost balances related to the replaced policies and the net gain or loss attributable to the difference between the cash value and the GAAP benefit reserves of the replaced business.

Deferral of Replacement Costs

A number of factors support the deferral of costs associated with internal replacement transactions. While this section addresses the deferral of replacement costs from various perspectives, all of the reasons supporting the deferral and the nondistortion of earnings patterns have one concept in common. Directly or indirectly, they all rely on the importance of the continuing relationship with the original policyholder. This fundamental concept regarding the continuity of the relationship with a policyholder appears appropriate because a replacement Universal Life policy is intended to enhance the position of the policyholder and provide ongoing insurance protection. As a result, the transaction appears to represent only a change in the form of protection. From the company's perspective, the replacement transaction represents an additional investment in the policyholder and an effort to maintain a future income stream and prevent the outflow of cash due to surrender of the contract.

First, the ultimate profitability of a replacement product is materially influenced by the degree of balance achieved between the savings from lower commissions and other acquisition costs on the replacement policy and the unrecovered costs associated with the prior product. As a result, the pricing and compensation structures of replacment products may recognize the existence of previously incurred and unrecovered costs. Thus, companies may not pay full first-year sales commissions on replacement business and may use the resulting profit margins to recover the unamortized costs of previous sales efforts. Consequently, the deferral of these unrecovered costs appears to appropriately reflect the assumptions used to price the replacement business.

Second, the failure to defer replacement costs could result in a distortion of the pattern of earnings as current and future earnings vary from anticipated levels. That is, current year losses, followed by greater than normal earnings in subsequent years, appears inconsistent with the economics of the transaction and the continuing nature of an insurance company's operations. Also, such a distortion could be viewed as violating a loss recognition concept discussed in the Audit Guide, which states that "no charge should be made to record an indicated loss currently which will result in creating an apparent profit in the future" (p. 87). While not anticipating a replacement situation, the Audit Guide indicates that losses on continuing blocks of business should not be recognized in current periods if the effects are to create or increase future earnings.

Finally, an argument can be made that replacement costs qualify for deferral under the Audit Guide. These costs are as directly related to the production of the replacement Universal Life policy as normal first-year commissions are related to the production of nonreplacement issues. Because it is possible to associate these costs directly with the issuance of the replacement Universal Life policy, it would appear they meet the criteria included in the Audit Guide for the deferral of expenses--that such costs are directly related to and vary with the production of new business.

Based on the foregoing, the Committee believes that the proper time frame to measure the economic consequences of the replacement transaction is the entire insured period and that the replacement transaction is not of a nature which should cause a distortion in the pattern of reported earnings. Thus, the deferral of the costs associated with an internal replacement generally should be considered appropriate.

Amortization of Deferred Replacement Costs

Once deferred, it becomes necessary to establish the method and period over which such costs will be amortized. The decision concerning the business against which these costs should be amortized should generally be determined independently from the questions concerning the extent to which these costs are recoverable. Both the Audit Guide and general practice permit a range of definitions of the lines or groups of business which should be used to amortize acquisition costs and test for recoverability. For example, the amortization of acquisition expenses can be performed by specifically relating acquisition expenses with narrowly defined blocks of business. This is typically the case when expense reserve factors are used and amortization schedules are, in effect, created for each plan and age of insurance. Alternatively, companies that use work sheet amortization schedules will typically associate aggregate acquisition expenses with expected future composite revenues from broadly defined lines. In neither case does the basis of the amortization schedule prescribe the block of business to be used in recoverability testing. Recoverability limits may be studied by plan, by groups of plans, or by broad lines of business regardless of the refinements that exist in calculating amortization schedules. The situtation is the same for deferred replacement costs. Separate determinations must be made as to the business on which to base amortization schedules and the business which should be used in recoverability analyses.

While various relationships between the replacement costs and the classes of new business may be defined for amortization purposes, one relationship appears the strongest. That is, in most instances, replacement costs can be specifically identified with a previously existing policy and a newly written Universal Life policy. The Committee believes that, except as discussed below, deferred replacement costs should be amortized against the revenue streams derived from the replacement business itself.

As the policy parameters and expected future experience of replacement business will most likely be different from Universal Life business obtained from other sources, it is important that the amortization schedules reflect the policy parameters and expected future experience of the replacement business. Recognition of these characteristics would then accomplish a reasonable matching of such costs to the composite revenues derived from

replacement business. Nonetheless, in some cases, broader definitions of blocks or lines of business may be used to determine the pattern of amortization. However, the use of broader classes of business, such as all Universal Life issues of the current year, is acceptable only if based on the aggregate and averaging concepts generally inherent in work sheet amortization schedules, and if the peculiarities of the replacement business' policy parameters and expected experience are appropriately recognized in the composite schedules.

As indicated, assumptions appropriate for replacement business will normally be different from those appropriate for other new business. The expected premium income pattern may differ substantially from that expected from other new business. Similarly, compensation, other acquisition expenses, and the assessment of first-year expense charges may vary from the level of these items in other new business. The mortality and withdrawal experience of internal replacement issues would be expected to differ from normal Universal Life business. Also, in determining reserves and the amortization for replacement business, it is important to recognize the effects on investment yields caused by the rollover of existing assets. These and other factors require that special consideration be given in establishing assumptions and models used to amortize the costs associated with internal replacement business.

Recoverability

While it is clear that the unique nature of replacement business should be recognized in establishing policy reserves and amortization schedules, it does not appear necessary to require that deferred replacement costs be recoverable from such a narrowly defined block of business. The Audit Guide permits broad definitions of lines of business for recoverability and loss recognition purposes and the same concepts would appear to apply to deferred replacement costs. In this case, each of the following classes of business can be identified for consideration as the block from which deferred replacement costs should be recovered:

- Replacement Universal Life issues of the current year
- All Universal Life issues of the current year
- All ordinary line issues of the current year

Selecting the replacement Universal Life business of the current year as the class of business from which to recover deferred replacement costs is based on the most restrictive definition of a line of business. In many circumstances, it may be the most appropriate. For example, a company with an active internal replacement program may select this alternative as the method which most reasonably recognizes the unique characteristics of the replacement business. The matching of deferred replacement costs with replacement business would recognize important considerations such as the special relationship between the yields on invested assets supporting the replacement business and the current or future interest rates expected to be credited to policyholders. It also would recognize the different mortality and withdrawal experience expected from replacement business and the differing acquisition and commission costs associated with internal replacement

business. If the replacement business cannot recover total replacement costs (after the elimination of all margins for adverse deviation), unrecoverable costs should be written off.

In some circumstances, a company may choose all Universal Life issues of the current year as the source of profit margins from which to recover the deferred replacement costs. This may be justified by references to past definitions of lines of business, which may not have recognized different plans or market sources. Companies choosing this option may believe that the separation of replacement and nonreplacement business would be an unwarranted segmentation of the business of a particular product line. This position also might be supported by describing the replacement costs as expenses that were expected to be incurred as a result of the decision to enter the Universal Life marketplace. In this case, it would not seem unreasonable to associate total acquisition costs with the complete Universal Life line. The effect of such a decision would be to require that all the Universal Life issues of the current year be used to recover the deferred replacement costs, as well as the normal acquisition costs. However, special assumptions reflecting the portion of the total Universal Life line which is replacement business would still be required in recoverability tests.

Implicit in these recoverability alternatives is the notion that the Universal Life business is sufficiently different from traditional ordinary products and operations that it should not be combined with traditional products for purposes of recoverability analyses. Once separated from traditional ordinary products, the Universal Life operation may, of course, be broken into further segments to recognize inherent marketing and experience differences of various Universal Life products.

Another alternative which m ght be considered for use in recoverability tests would not make the distinction between Universal Life and traditional ordinary business. Viewing Universal Life as one more step in the evolution of insurance products, a company may want to include its costs and operations in the current ordinary line GAAP era for purposes of recoverability analyses. In that event, replacement costs would simply be expenses incurred in the writing of new business, and, as such, included in the deferral decisions and recoverability tests of the total line. While this argument may have some merit, the Committee believes that Universal Life business is sufficiently different in marketing and compensation method, expected premium and withdrawal experience, inherent policyholder flexibility, and the level of risks assumed, that it should not be included with the traditional ordinary line of business for purposes of recoverability analyses. Thus, this definition of the business to include in recoverability tests should not be utilized except in unusual circumstances.

The recoverability tests described above suggest that all costs should be deferred if recoverable from related new business and costs not recoverable should be written off. An alternative which has been considered by some is that costs should be deferred only to the extent that the remaining profit margins on the replacement business will be comparable to nonreplacement issues. Costs in excess of these amounts would be written off. Based on the following, the Committee believes that this methodology should not be utilized.

First, the Audit Guide's description of recoverability and loss recognition tests do not seem to provide for the partial application of these concepts. As described, and as generally applied in current practice, costs would be deferred as long as any margin remains, however slight. Costs would be written off only if all profit margins, including provisions for adverse deviation, were absorbed. In addition, practical difficulties seem likely both in determining "normal" profit margins and in applying the method when profit margins on replacement business prior to considering replacement costs are less than those "normal" margins. In the latter instance, all replacement costs will be recognized in the current period and may significantly affect earnings. As a result, this method of deferring replacement costs is considered appropriate.

STATEMENT 1984-33

October 1, 1984

Commissioner of Internal Revenue
Attention: CC:LR:T
Internal Revenue Service
Room 4429
Washington, D.C. 20224

Re: Solicitation for assistance in drafting regulatory projects

Dear Sir:

Introduction

On August 22, 1984, a notice appeared in the Federal Register (49 FR 33396) which invited comment on a list of specific regulatory initiatives which are to be undertaken by the Internal Revenue Service (IRS) as a result of the recent enactment of the Tax Reform Act of 1984. In addition to the specific items listed, comment was also sought on any other regulatory matters which will be addressed as a result of the adoption of the legislation.

Background

The American Academy of Actuaries ("Academy") is a professional association of over 7,600 actuaries involved in all areas of specialization within the actuarial profession. Included within our membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA), as well as comparable percentages of actuaries providing actuarial services for other employee benefit plans such as life, health, and disability programs.

The Academy finds it difficult to comment on tax regulations in general, since we generally do not address major public policy decisions which are not actuarial in nature. The Academy views its role in the government relations arena as providing information and actuarial analysis to public policy decision-makers, so that policy decisions can be made with informed judgment.

Nevertheless and despite the fact that actuarial considerations are unlikely to ever be the driving force behind major decisions on tax policy, actuarial input can be quite useful in shaping and molding tax policy to deal appropriately with the extremely complex, yet vitally important, employee benefits area. For example, the determination of required contribution levels to plans to provide benefits and the setting of appropriate reserve levels to meet future obligations are actuarial in nature.

Our comments herein are addressed to one specific regulatory proposal listed in the Federal Register notice (Section 79 dealing with group term life insurance) and to two additional items which may lead to regulatory amplification: (1) the authority of IRS to define a "qualified" actuary for certain health and welfare plans, and (2) the authority of the IRS to establish

mandatory actuarial assumptions for use with such plans. We also offer comments on the study which the Treasury Department has been instructed to undertake with regard to the need for funding and participation standards for health and welfare plans.

Group Term Life Insurance Plans

Under prior law, the cost of group term life insurance in excess of $50,000 purchased by an employer for an employee was included in the employee's taxable income, as determined with reference to a uniform premium table developed by the IRS. Post-retirement group term life insurance coverage was excluded from the income of retirees in any amount. Under the Tax Reform Act of 1984, the $50,000 limitation on the amount of group term insurance that may be provided tax-free to employees was extended to apply to retirees as well as active employees. The nondiscrimination rules which had previously applied only to active employees was extended to cover retirees. Finally, the actual cost of such insurance benefits (as opposed to the cost prescribed by IRS tables) is included in gross income of both employees and retirees if the plan is determined to be in violation of the nondiscrimination rules.

The Academy takes no position on the propriety of these statutory changes. However, certain actuarial considerations are appropriate when developing the regulations under Section 79 for group term life insurance. The Academy was very active in commenting to the IRS in 1983 when changes to the uniform premium table under Section 79 were being considered (see our statements of September 2, 1983 and October 20, 1983). Copies of these two statements are attached for your convenience and we ask that they be considered in any review of Section 79 by the IRS.

We were pleased that the rates in the final uniform premium table released by the IRS in the Federal Register on December 6, 1983 (48 FR 54594-54595) were reduced somewhat to be more nearly reflective of rates in the marketplace than those originally proposed. However, we again wish to stress the importance of the IRS using appropriate actuarial principles and practices in developing these rates. Also, we would propose that the IRS adopt a program of periodically updating the table on a regular cycle. This would assure that obsolescence in the table is kept to a minimum.

Actuarial Qualifications

The Tax Reform Act of 1984 provides that in connection with funded welfare benefit plans (including voluntary employees' beneficiary associations (VEBAs) under section 501(c)(9) of IRC) reserves in excess of "safe harbor" limits will be permitted if certified by a "qualified actuary" (to be determined under Treasury regulations). We believe that this phrase is in need of definition.

In the pension area this need was clearly recognized in ERISA and in that instance Congress chose to create the Joint Board for the Enrollment of Actuaries to examine and license individuals as "enrolled actuaries." At the present time, there is no similar statutory or regulatory framework for establishing actuarial qualifications for purposes of funded welfare benefit plans. We believe that the actuarial profession is best suited to establish those qualification standards.

Academy membership includes actuaries in all areas of practice and serves as the hallmark of a qualified actuary in the United States. However, we recognize that not all actuaries are necessarily qualified for all assignments. Accordingly, our Guides to Professional Conduct contain extensive guidance to ensure that: "The member will bear in mind that the actuary acts as an expert when giving actuarial advice and will give such advice only when qualified to do so."

In setting forth qualification standards, we believe that the profession itself is better suited to establish actuarial standards than the federal establishment in many areas. For example, we note that the General Accounting Office recommended that the Joint Board for the Enrollment of Actuaries seek the imput and assistance of the actuarial profession in drafting appropriate standards for the determination of data sufficiency with regards to multiemployer plans. This is a fine example of government/private sector cooperation, and is one which we believe is in the public interest.

The Academy has a Committee on Qualifications to address issues such as these. We strongly urge direct participation of the actuarial profession in defining the qualifications of an actuary to engage in any particular assignment. The Academy has a strong commitment to self-regulation and is prepared to work closely with the IRS if such regulations are to be developed.

Actuarial Assumptions

The setting of actuarial assumptions is a key ingredient in any actuarial assignment. The provisions relating to funded welfare benefit plans in the Tax Reform Act of 1984 require that assumptions be reasonable in the aggregate. This is quite appropriate and follows the precedent set by ERISA in the pension area.

However, the Conference Report goes further and indicates that "in addition to requiring that actuarial assumptions are to be reasonable in the aggregate, Treasury regulations may prescribe specific interest rate and mortality assumptions to be used in all actuarial calculations." Such a simplistic approach would ignore the fact that experience is different from plan to plan for a variety of reasons (age/sex composition of group, nature of work, geographical area, etc.). Attempting to mandate any set of uniform assumptions will inevitably result in inappropriate assumptions being used for large numbers of plans. Setting appropriate actuarial assumptions requires the application of actuarial judgment to fit the facts and circumstances at hand.

We are concerned at the prospect that the IRS might attempt to prescribe specific actuarial assumptions for funded welfare benefit plans. We believe the approach used in ERISA for setting actuarial assumptions for pension valuations is much more appropriate.

The Treasury Study

We would like to take this opportunity to discuss briefly several other issues which merit the attention of the IRS as it proceeds with the study of health and welfare plans which it is required to submit to Congress by February, 1985. We are eager and willing to assist the IRS in this study, and look forward to close consultation as the study progresses.

STATEMENT 1984-33

1. General Comments on Employee Benefit Plans

Employee benefit plans provide an array of insurance and retirement benefits which greatly increase the present and future economic security of millions of Americans. Salary dollars cannot replicate an annuity at retirement that cannot be outlived, life insurance for the family of a deceased worker, the cost of hospitalization in the event of major illness, or income to a disabled worker. Employee benefit plans deliver dollars at the time they are needed most. Moreover, in general, these benefits can be more economically provided on a group basis to an employee workforce than on an individual basis, due to the significant savings in administrative costs and to the stability that comes with a pooling of risks across a broad cross section of employees.

There is no question that the growth of employee benefit plans in the past few decades has been greatly stimulated by tax policy toward those plans. This tax policy has been the result of deliberate Congressional intent which has been demonstrably successful in fostering the development of employee benefit plans. It would be naive and erroneous to assume that employers would continue to provide the same level of benefits in the event that the favorable tax treatment of certain types of employee benefit plans were significantly curtailed or even eliminated. The pressure from employees with the basic attitude "If I have to pay taxes on it anyway, give it to me in cash" would simply be too great. The end result would be a decline in the level of protection provided by the private sector, inevitably leading to greater demand and strain on governmental programs. Given the financial difficulties facing programs such as Medicare and Social Security, a decline in private sector programs would hardly seem to be in the public interest.

2. Need for Stability

There is a need for more stability in the tax treatment of employee benefit plans. We have experienced two major tax bills affecting employee benefit plans in 1982 and 1984 and it appears that they will be subject to further Congressional scrutiny in 1985. It is difficult for plan sponsors to make rational decisions about their employee benefit plans in such a rapidly changing environment. We urge that the Treasury study to be conducted stress the need to establish a more stable environment for employee benefit plans.

3. Financial Condition

The maintenance of a well-run and properly financed health and welfare plan involves the determination of both an appropriate contribution level to provide the expected benefits and appropriate reserve levels to cover the accrual of benefit obligations. Both of these are actuarial processes.

Tax policy should recognize the need for these determinations to be made according to sound actuarial principles and practices. Such recognition does exist in the pension area under ERISA. However, that recognition is not as clear in connection with health and welfare plans. Nevertheless, appropriate funding of these plans is as important as in the pension area.

The Academy stands ready to work with the IRS to define sound actuarial principles and practices where required. A major priority for the Academy at the present time is the establishment of a structure within our profession to articulate actuarial standards of practice. This structure would be appropriate to deal with issues such as actuarial principles and practices in connection with health and welfare plans. Included in actuarial principles and practices are such matters as disclosure requirements and the content of an actuarial report.

4. The Actuary/Auditor Relationship

The relationship between actuaries and accountants under ERISA has given rise to an unresolved problem in the auditing area. Section 103 of ERISA specifies in considerable detail a division of responsibility in the reports of actuaries and accountants, in which there is virtually no overlap. Further, it indicates that each professional "may rely" on the work of the other. In our opinion, a reasonable interpretation of the Congressional intent of these words is that each "would rely" on the work of the other under normal circumstances. Close scrutiny of the work of the other should not be the norm, but should arise only in unusual circumstances.

In practice it does not work this way. The literature of the American Institute of Certified Public Accountants (AICPA) is written in such a way that routine audits of the enrolled actuary's work product is the norm. It is unclear to us that anyone benefits from this exercise, least of all plan participants. We recommend that any regulations or proposed legislation governing the establishment of standards for health and welfare plans take into account the requirement for close cooperation and cross reliance by actuaries and auditors on each other's work product.

5. Need For Efficient Reporting Requirements

The costs associated with regulatory compliance under ERISA in the pension area proved to be large and were especially burdensome to small plan sponsors. To the extent that the paperwork burden on small and large plans alike can be eased, the beneficiaries will gain. With this in mind, we urge that the regulatory environment relating to health and welfare plans not impose unnecessarily complex or lengthy reporting requirements and that it be kept as simple as possible.

Conclusions

We appreciate the opportunity of making these comments, and look forward to assisting IRS as it pursues its lengthy and difficult regulatory agenda in the coming months. The Academy is ready and eager to provide actuarial assistance in these endeavors.

Respectfully submitted,

Stephen G. Kellison
Executive Director

STATEMENT 1984-34

October 2, 1984

Mr. John Montgomery, Chairman
NAIC Standing Technical Task Force
c/o California Department of Insurance
600 South Commonwealth Avenue
Los Angeles, California 90005

Dear John:

At a recent meeting of the American Academy of Actuaries Committee on Life Insurance, we discussed the action taken earlier at the Standing Technical Advisory Committee's meeting, on the proposed changes to the standard valuation law advocated by Paul Sarnoff. The members of the committee were concerned to hear that, in spite of the recommendation of the Standing Technical Advisory Committee, STATF directed that work commence on a modification of the standard valuation law. We were particularly concerned that it appeared an objective had been set to present a modification for consideration by the NAIC in December.

We were unable to identify any compelling reasons for such rapid action. The issue has been under consideration for some time, and nothing has changed which would compel immediate action.

On the other hand, a poorly-designed regulation could adversely and unnecessarily affect the surplus of many life insurance companies. There is also a danger that such changes might create opportunities for life insurance companies to unreasonably increase their reserves, if they wish, in order to achieve federal income tax benefits. Allowing such tax manipulation to take place could seriously undermine the credibility of the NAIC valuation process in the eyes of the tax authorities.

The 1984 Tax Act gives considerable authority over reserves to the NAIC. This delegation of authority is something that most actuaries support. But, with the authority comes the responsibility for judicious management of the valuation standards.

The Academy's Life Insurance Committee supports the actuarial recommendations of the Standing Technical Advisory Committee. While it may be that changes in the valuation law with respect to policies with cash values in excess of reserves may be appropriate, we urge you to make such changes only after careful consideration. In particular, such changes should have much more careful evaluation than is possible between now and December.

Alan Lauer is a member of this committee and participated in the discussion of the issue. Because of his regulatory responsibilities, he felt it would be inappropriate for him to participate in the Committee's conclusion.

Sincerely,

Richard S. Robertson (ces)

Richard S. Robertson, Chairman
Committee on Life Insurance

STATEMENT 1984-35

October 19, 1984

Ms. Betsy Cropsey
Project Manager, Other Postemployment Benefits
Financial Accounting Standards Board
High Ridge Park
P.O. Box 3821
Stamford, Connecticut 06905

Dear Betsy:

When we visited with the Board and staff on September 25, I promised to see what information we could gather from various actuarial consulting firms to assist you in your research project.

After inquiring within TPF&C, I found that we have recently made a study of postemployment welfare benefits using our Employee Benefits Information Center (EBIC) data base. The study consists of a series of questions and answers regarding the benefit provisions of 250 companies in the EBIC data base. The companies that make up the study group can be categorized as 59% industrial, 39% non-industrial, and 2% non-profit organizations.

This material is enclosed for your use in the FASB study. It is divided into three categories: Retiree Medical Plans, Retiree Dental Plans, and Retiree Life Insurance Plans. For each specific question, the percentage of companies offering the benefit or provision is indicated. Some of the totals are not 100% because of the way the rounding was done for the study, but all companies are included in the questions. If you have trouble interpreting it, Susan MacInnes in my office (404-261-7820) can help you.

I hope you will find the results of this study useful. We may also be able to get you more details of the postemployment welfare benefits should you need them. In addition, I have asked several other consulting firms for comparable information which may assist your study. We will be back in touch.

If you have any questions, or the Academy can assist you further, please don't hesitate to call me.

Sincerely,

A. Norman Crowder, III
President

STATEMENT 1984-35

Retiree Medical Plans

All companies in the EBIC Data Base offer medical coverage for active employees.

I. Medical Coverage for Retirees

94% - Medical coverage provided for life
5% - Medical coverage only from early retirement to age 65
1% - No retiree medical coverage
100%

II. Service Requirements for Retiree Medical Coverage

A. At Early Retirement

10% - No requirements
10% - 5 years of service or less
50% - 10 years of service
12% - More than 10 years of service
18% - Varies by age at retirement
1% - No retiree medical coverage
101%

B. At Normal Retirement

40% - No requirement
43% - 5 years of service or less
10% - 10 years of service
0% - More than 10 years of service
6% - No retiree medical coverage
99%

STATEMENT 1984-35

III. Employee Contributions for Retiree Medical Coverage

A. Before Age 65

Monthly Contribution	Employee Only	Employee + Spouse
None	45%	32%
Less than $10	14%	9%
$10 to $19.99	15%	10%
$20 to $29.99	4%	10%
$30 to $39.99	1%	6%
$40 to $59.99	3%	7%
$60 to $79.99	4%	1%
$80 to $99.99	0%	1%
$100 or more	0%	8%
Varies by service	5%	5%
Varies by employee option	6%	6%
Other	3%	4%
No retiree medical coverage	1%	1%
	101%	100%

B. After Age 65

Monthly Contribution	Employee Only	Employee + Spouse
None	54%	47%
Less than $10	18%	9%
$10 to $19.99	8%	13%
$20 to $29.99	4%	5%
$30 to $$39.99	0%	4%
$40 to $59.99	2%	4%
$60 to $79.99	1%	1%
$80 to $99.99	0%	1%
$100 or more	0%	2%
Varies by service	3%	3%
Varies by employee option	4%	4%
Other	1%	1%
No retiree medical coverage	6%	6%
	101%	100%

IV. Type of Coverage Before Age 65

84%	- Same as for active employees
7%	- Different from active employees
1%	- Varies by service
6%	- Varies by employee option
1%	- No medical coverage
99%	

V. Type of Coverage After Age 65

60% - Same as active
- 48% - Integrated with Medicare
- 3% - Adjusted* for Medicare
- 9% - COB with Medicare

34% - Different from active
- 12% - Medicare Fill-In only
- 18% - Comprehensive or Base + Major Medical Plan
  - 12% - Integrated with Medicare
  - 4% - Adjusted* for Medicare
  - 2% - COB with Medicare
- 1% - Hospital Indemnity plan
- 1% - Varies by service
- 2% - Other (employee option, etc.)

6% - No medical coverage

100%

* Covered expense reduced by Medicare Benefit before Plan coinsurance is applied

IV. Design of Retiree Medical Plans After Age 65

A. Medicare Fill-In Plans Only

1. Deductibles (Per Person)

52% - No deductible*
31% - $25 to $50 per year
14% - $100 to $150 per year
3% - More than $150 per year

100%

* Some companies have a special deductible for prescription drug coverage

2. Lifetime Maximums (Per Person)

17% - Less than $25,000
10% - $25,000 to $50,000
3% - $50,000 to $100,000
10% - $100,000 to $200,000
10% - $200,000 to $300,000
3% - $300,000 to $400,000
0% - $400,000 to $500,000
7% - $500,000 or more
7% - Other
31% - Unlimited

98%

3. Expenses Covered

Type of Expense	Yes	Medicare Deductible Only	No	Total
Medicare Part "A" expenses	97%	3%	0%	100%
Medicare Part "B" expenses	90%	3%	7%	100%
Prescription Drugs	66%	N/A	34%	100%

B. Retiree Comprehensive Plans and Basic (or Fill-In) + Major Medical Plans

1. Type of Plan

64% - Comprehensive
33% - Basic (or Fill-In) + Major Medical
1% - Hospital Indemnity
2% - Other (employee option, etc.)
100%

2. Deductibles (Per Person)

2% - None
18% - $75 or less
57% - $100 to $150
13% - $200 or more
11% - Other (employee option, etc.)
101%

3. Lifetime Maximums (Per Person)

Maximum Amount	Applies to All Expenses		Applies to MM Only		N/A
Active max, continued	23%		14%		
Less than $100,000		1%		2%	
$100,000 to $200,000		1%		1%	
$200,000 to $300,000		5%		6%	
$300,000 to $400,000		1%		1%	
$400,000 to $500,000		0%		0%	
$500,000 or more		14%		4%	
Separate retiree max*	18%		9%		
Less than $50,000		3%		3%	
$50,000 to $100,000		4%		1%	
$100,000 to $200,000		6%		2%	
$200,000 to $300,000		2%		2%	
$300,000 to $400,000		0%		0%	
$400,000 to $500,000		0%		0%	
$500,000 or more		1%		0%	
Unlimited					32%
Other (employee option, etc.)					3%
	41%		23%		35%

4. Annual Stop Loss Provision

24% - No provision
76% - Have provision
17% - Less than $750 per person
4% - $750 to $1,000 per person
29% - $1,000 to $1,250 per person
2% - $1,250 to $1,500 per person
5% - $1,500 to $1,750 per person
0% - $1,750 to $2,000 per person
4% - $2,000 to $2,500 per person
3% - $2,500 or more per person
2% - Based pay
2% - Applied per family only
6% - Other (employee option, etc.)
100%

5. Coverage for Specific Types of Expenses

a. Hospital Room and Board

		Deductible Applied		
Coinsurance	Co-Payments or Separate Deductible	Yes	No	Other
100%	2%	5%	50%	
90% to 95%	0%	4%	0%	
85%	0%	5%	0%	
80%	2%	21%	2%	
70% to 75%	0%	1%	0%	
Other (employee option, etc.)	0%	2%	2%	5%
	4%	38%	54%	5%

b. Convalescent Care

		Deductible Applied		
Coinsurance	Co-Payments or Separate Deductible	Yes	No	Other
100%	1%	4%	30%	
90% to 95%		3%	0%	
85%		3%	0%	
80%		28%	0%	
70% to 75%		1%	0%	
Other (employee option, etc.)		0%	1%	4%
Not Covered				21%
	1%	41%	33%	25%

c. Surgeon

	Deductible Applied		
Coinsurance	Yes	No	Other
Scheduled	0%	9%	
100%	5%	26%	
90% to 95%	3%	3%	
85%	5%	1%	
80%	34%	7%	
Other (employee option, etc.)			4%
Not Covered			2%
	48%	46%	6%

d. Physician Office Visits

	Deductible Applied		
Coinsurance	Yes	No	Other
100%	1%	4%	
90% to 95%	3%	0%	
85%	6%	0%	
80%	77%	3%	
Other (employee option, etc.)			2%
Not Covered			1%
	89%	7%	4%

e. Prescription Drugs

	Deductible Applied			
Coinsurance	Co-Payments	Yes	No	Other
100%	7%	1%	2%	
90% to 95%		3%	0%	
85%		5%	0%	
80%		73%	1%	1%
70% to 75%		1%	0%	0%
Other (employee option, etc.)				3%
Not Covered				1%
	7%	83%	3%	6%

f. Private Duty Nursing

	Deductible Applied		
Coinsurance	Yes	No	Other
100%	1%	1%	
90% to 95%	3%	0%	
85%	6%	0%	
80%	80%	2%	
70% to 75%	1%	0%	
Other (employee option, etc.)			2%
Not Covered			1%
	92%	3%	4%

STATEMENT 1984-35

Retiree Dental Plans

90% of the companies in the EBIC data base offer dental plans for their active employees.

I. Dental Coverage for Retirees

23% - Dental coverage provided for life
13% - Dental coverage provided only from early retirement to age 65
54% - Dental coverage ceases
10% - No dental for active employees
100%

The following information is based on the companies that offer active employee dental plans.

II. Service Requirements for Retiree Dental Coverage

A. At Early Retirement

4% - No requirements
3% - 5 years of service or less
20% - 10 years of service
5% - More than 10 years of service
8% - Varies by age at retirement
60% - Coverage ceases
100%

B. At Normal Retirement

12% - No requirements
8% - 5 years of service or less
4% - 10 years of service
0% - More than 10 years of service
75% - Coverage ceases
99%

III. Employee Contributions for Retiree Dental Coverage

A. Before Age 65

Contributions	Employee Only	Employee +Spouse
Included in Medical contributions	10%	12%
Required	6%	9%
Not Required	23%	18%
Varies by service	1%	1%
Coverage ceases	60%	60%
	100%	99%

B. After Age 65

Contributions	Employee Only	Employee + Spouse
Included in Medical contributions	5%	6%
Required	4%	5%
Not Required	16%	14%
Coverage ceases	75%	75%
	100%	100%

IV. Type of Coverage for Retirees

With very few exceptions retiree dental plans are identical to active employee plans. The following information is based on those companies that offer lifetime dental coverage.

1. Type of Reimbursement

86% - Reasonable and customary
9% - Scheduled maximums
4%-Reasonable and customary for some expenses, scheduled for other expenses
2% - Employee option
101%

2. Deductibles (Per Person)

19% - No deductible
16% - $25 per year
28% - $35 to $50 per year
4% - $75 or more per year
25% - Combined medical/dental deductible
9% - Other
101%

3. Reimbursement for Major Services (Bridges/Dentures)

12% - Scheduled maximums
86% - Reasonable and customary
46% - 50%
30% - More than 50%
11% - Other
2% - Employee option
100%

4. Annual Per Person Maximum

2% - Less than $750
7% - $750 to $1,000
56% - $1,000
19% - More than $1,000
11% - Unlimited
6% - Other (employee option, etc.)
101%

STATEMENT 1984-35

Retiree Life Insurance Plans

All companies in the EBIC Data Base offer group life insurance for active employees.

I. Life Insurance for Retirees - Basic Level

76% - Some amount of group life continued for life
24% - No lifetime retiree group life
100%

II. Service Requirements for Retiree Basic Group Life

A. At Early Retirement

9% - No requirement
8% - 5 years of service or less
38% - 6 to 10 years of service
9% - More than 10 years of service
12% - Varies by age at retirement
24% - No retiree group life
100%

B. At Normal Retirement

28% - No requirement
36% - 5 years of service or less
9% - 6 to 10 years of service
3% - More than 10 years of service
24% - No retiree group life
100%

III. Employee Contributions for Retiree Group Life

A. Before Age 65

4% - Required
68% - Not required
5% - Other (employee option, etc.)
24% - No retiree group life
101%

B. After Age 65

3% - Required
70% - Not required
3% - Other (employee option, etc.)
24% - No retiree group life
100%

STATEMENT 1984-35

IV. Level of Retiree Life Insurance Coverage after All Reductions Have Been Made

	Dollar Maximum Group Life Insurance				
Type of Benefit	$10,000 or Less	$11,000 to $50,000	More than $50,000	Other/ N/A	Total
Multiple of Pay					
Less than .5	2%	4%	6%		13%
.5 to .9	1%	4%	8%		13%
1 or more	2%	2%	4%		8%
Flat Dollar	22%	0%	0%		22%
Other(employee option, etc.)	3%	1%	2%	12%	20%
No Retiree Group Life				24%	24%
Total	32%	11%	21%	36%	100%

STATEMENT 1984-36

November 12, 1984

Mr. Steven Finan
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room S-4521
Washington, D.C. 20210

Dear Steve:

As a result of our recent phone conversation on actuarial evaluations of postretirement health and welfare benefits, I am including a brief summary describing the evaluation process as applied to health benefits. The purpose of the summary is to describe the process, including a few of the similarities to pension valuations as well as a number of differences. For a postretirement valuation, the differences are substantial, and require the attention of one who is experienced in both the actuarial and health and welfare areas. Additionally, I have attached a copy of the American Academy of Actuaries Statement to the House Subcommittee on Labor-Management Relations in September of this year. We had discussed that document in our conversation as well.

I currently serve on the Academy's Committee on Health and chair the Subcommittee on Health and Welfare Plans. It is our Subcommittee's purpose and intention to provide any assistance necessary in order to provide better information to decision-makers in the health and welfare area. In particular, should you (or other Department of Labor representatives) wish further actuarial input to current or future studies, we would be pleased to assist.

Should questions arise regarding this material, please call me at (312) 726-0677. I look forward to working with you in the future.

Sincerely,

Tom Nelson

Thomas G. Nelson
Chairman
Subcomittee on Health and Welfare Plans

STATEMENT 1984-36

SUMMARY DESCRIPTION OF POST-RETIREMENT HEALTH AND WELFARE VALUATION

I. BACKGROUND

Life and medical benefits provided after retirement to former employees are generally recognized as potentially material costs, depending upon such variables as plan design and workforce demographics. Available evidence indicates that the vast majority of postretirement health and welfare plans are funded and accounted for on a pay-as-you-go basis. Additionally, it has been the exception, rather than the rule, for employers to establish liabilities for such obligations.

The financial evaluation of such benefits closely parallels that of pensions, primarily because of the extended timeframes involved and the probabilistic nature of projecting future events and their associated costs. Examples of the types of contingencies which are incorporated in the design of the valuation model include death, withdrawl from work, retirement (early or normal), retiree acceptance of the plan due to its contribution requirements, etc.

The types of information typically generated by the financial projections include:

- Present values of expected future benefits
- Expected future cash flows
- Potential leveled expense accruals

The present value estimations that result from such valuations can be shocking, frequently equalling or exceeding the unfunded pension obligation of a given employer. The cash flow figures for employers can unmask the expected track of future costs for these plans. The accrual level information can assist in visualizing the leveled expense amounts per year if the obligation were to be expensed or funded over the working lifetimes of employees.

Valuation - The steps in an actuarial evaluation of postretirement health and welfare benefits can be visualized as: collecting data, setting assumptions, adapting a computerized model and projecting financial results.

Collecting data - Pension-type census information for both actives and current retirees is necessary for the projection. Important census breakdowns include such items as plan, age, sex, dependent coverage, disability status, etc. Recent plan experience is also generally necessary, as are current plan descriptions. Known future plan changes (if any) must also be studied.

Setting assumptions - A number of areas exist in which consistency with pension valuation assumptions often are presumed. These might include rates of mortality, retirement, disabled mortality, turnover, salary increases, investments, etc. A medical plan, however, will generally require additional assumptions about the future regarding claim costs by plan, acceptance rates of coverage, medical inflation, plan utilization increases, Medicare's influence on claim payments, increased costs due to aging, cost effects due to expected plan changes, credibility of past experience, effects of dependent coverage,

etc. These latter assumptions are fundamental to the valuation, and demand the attention of an individual experienced in the costs and provisions of health plans.

Adapting the model - The valuation is a projection of the level of future expected payments, based upon knowledge of the recent past, the present and the future. Various assumptions about the future are necessary in such projections since actual results depend upon a number of unknown variables. As previously mentioned, particular assumptions regarding the future, such as benefit offerings, incidence of claims, price levels, salary levels, investment/discount rates, et al must be made because they are not known. The pension-type model generally employed is based upon an extensive list of such assumptions and contingencies. Often, best estimates are made for each significant variable, with knowledge that any of the assumptions can be altered in order to test the effects (e.g., - best case or worst case scenarios) on projection results.

Even in large groups, some fluctuations, from time period to time period can be expected. Thus, while the projections for future years will generally flow relatively smoothly from year to year, a precise matching of eventual "actual" to currently "expected" results will not be possible. The model must recognize that average claim costs will typically climb due to such assumptions as age, inflation, and utilization. Medicare generally will effect a discrete change downward in expected future costs, with uncertain effects as years pass. Disability can effect higher costs as well. Recognition of sex differences will shift the expected size and incidence of costs. The model must be structured to handle the actuary's assumptions regarding these factors.

Specific individual insureds cannot be projected due to unpredictability; however, when large numbers of individuals are combined in reasonably homogenous groups, various discrete probability distributions are used to help provide relative accuracy in understanding future costs. In visualizing the process, however, it is often easier to think in terms of average claimants, average ages, average costs, etc. rather than probability distributions.

Essentially, the computerized model handles each insured person, providing average benefits to each from eligibility date onward. Average benefits change with age, utilization, inflation, and Medicare eligibility. For smaller plans, should plan costs be less than 100% credible, an expected level of benefits must be blended with the past experience for the group in order to arrive at expected future claim costs.

Projecting financial results - From the previous steps one is able through the model to assess the magnitude of the promises to retirees in terms of the total obligation, the expected ongoing cash requirements for claim payments, and relatively level expensing/funding patterns which more closely match the incurral of the liability with the working lifetimes of the employees.

Any of a number of actuarial cost methods might be used to project liabilities and accruals. Two of the more popular methods, "projected unit credit" and "entry age normal" are briefly described in the following paragraphs.

The projected unit credit method would be considered a "benefit" approach in accounting terminology. Its accruals are typically more conservative (higher) than pay-as-you-go funding costs, and involve examination of a "past service cost" as well as an expense for current service (identified typically as the "normal cost"). Theoretically, the normal cost (NC) for an individual under the unit credit approach would be the present value of benefits earned during the year, discounting for interest, mortality, etc. For an individual, the unit credit NC would be expected to increase until retirement due to the shortening discount period each year, as well as due to inflationary tendencies in the case of medical coverage. An employer's normal cost would be the sum of individual totals, meaning that the employer normal cost may increase over time, depending upon worker terminations and new hires. The past service cost (PSC) under the unit credit approach is the present value of benefits assignable to service in the past. In an inflationary environment, with a fairly stable population, the PSC would be expected to increase with time. Often the PSC is paid off (in either funding or bookkeeping terms) with a fixed number of level payments which, together with interest, accumulate to the initial past service cost.

The entry age normal approach would be considered a "cost" approach in accounting terms. Like projected unit credit, its accruals are normally more conservative than pay-as-you-go costs, and involve past service, in addition to normal costs for current and future benefit earnings. The entry age normal cost is a level amount which funds the present value of future benefits (if actuarial assumptions are realized) over the period from entry to retirement. Normal costs for individuals remain level; an employer NC may remain approximately level, depending upon the realization of actuarial assumptions. The PSC under entry age normal amounts to the present value of benefits minus the present value of future normal costs. The payment schedule for the initial PSC is often a fixed amount over an established period, perhaps discounting for interest.

Recognition of accruals under either of the former methods will generally involve costs increases beyond those of the cash methods now generally in use by employers. Balance sheets will also reflect the effects of any decisions to recognize the promises of these benefit plans as liabilities.

STATEMENT 1984-37

November 14, 1984

Ms. Betsy Cropsey
Project Manager, Other Postemployment Benefits
Financial Accounting Standards Board
High Ridge Park
P.O. Box 3821
Stamford, Connecticut 06905

Dear Betsy:

As a result of our recent phone conversation on actuarial evaluations of postretirement health and welfare benefits, I am including a brief summary describing the evaluation process as applied to health benefits. The purpose of the summary is to describe the process, including a few of the similarities to pension valuations as well as a number of the differences. For a postretirement valuation, the differences are substantial, and require the attention of one who is experienced in both the actuarial and health and welfare areas. Additionally, I have attached copies of the most recent American Academy of Actuaries Statements on the topic. We had previously discussed those documents as well.

Should questions arise regarding this material, please feel free to contact me. Also, when your schedule for the measurement and recognition project is established, please let me know if there is anything our Subcommittee can do to assist the Board. I look forward to working with you in the future.

Sincerely,

Tom Nelson

Thomas G. Nelson
Chairman
Subcommittee on Health and Welfare Plans

STATEMENT 1984-38

This package of materials was presented at a meeting of the NAIC Standing Technical Actuarial (EX5) Task Force on the subject of "valuation actuary" on December 8, 1984.

The package includes the following:

1. A report on the actuary's role in statutory reporting.

2. A report on the Committee on Life Insurance Financial Reporting Principles.

3. The final report of the Joint Committee on the Role of the Valuation Actuary in the United States.

In addition to these written handouts a number of oral presentations were made, some including audio-visual aids which are not included in this package. Subject addressed in addition to those listed above:

1. Qualification standards for serving as a valuation actuary.

2. Actuarial standards of practice.

3. Discipline.

The following individuals made presentations on this subject at the meeting:

Walter S. Rugland, a member of the Joint Committee on the Role of the Valuation Actuary in the United States.

Virgil D. Wagner, Chairman of the Committee on Life Insurance Financial Reporting Principles.

Allan D. Affleck, Chairman of the Insurance Subcommittee on Actuary/Auditor Relationships.

Gary D. Simms, General Counsel.

STATEMENT 1984-38

ACTUARY'S ROLE IN STATUTORY REPORTING

- Board of Directors designate a "valuation actuary"
- Valuation actuary's opinion printed in blank
- Include valuation actuary's opinion in published statements
- Current status, discussions with industry groups
- Relationship to expanded opinion

CURRENT DRAFT OF POSSIBLE LANGUAGE

Appointment of Valuation Actuary

"For each company required to submit an annual statement pursuant to the Standard Valuation Law, the board of directors thereof shall by resolution appoint a valuation actuary of the company, who shall submit to the commissioner such reports as the commissioner shall require. A certified copy of the resolution appointing the valuation actuary, and of every subsequent resolution relating to the apointment of a valuation actuary, shall be filed with the commissioner within 15 days of its effective date."

Valuation Actuary's Opinion on Statement Blank

"There is to be included on Page 1 of the annual statement the statement of the valuation actuary setting forth his or her opinion relating to the policy reserves and other actuarial items. "Valuation Actuary" as used here means a member of the American Academy of Actuaries, or a person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the insurance regulatory official of the domiciliary state."

Valuation Actuary's Opinion in Published Statements

"All companies which are required to submit a statement of a valuation actuary to the insurance commissioner of this state shall also include that statement of the valuation actuary in all statutory financial statements published by the company for presentation to the policyholders, shareholders or the public showing the financial position of the company at the end of the calendar year. In any case in which a summary of the statutory financial position of the company at the end of the calendar year is distributed to policyholders, shareholders or the public, that summary must include a notice identifying the valuation actuary, and indicating that a statement of actuarial opinion by the valuation actuary has been prepared and signed, as required by state law."

STATEMENT 1984-38

December 7, 1984

REPORT OF THE AMERICAN ACADEMY OF ACTUARIES COMMITTEE ON LIFE INSURANCE FINANCIAL REPORTING PRINCIPLES ON THE STATUTORY ACTUARIAL OPINION

A question has continued to exist since 1975, when the current Actuary's Opinion first became a part of the statutory annual statement, as to whether an actuary's opinion that reserves make "good and sufficient" provision for future obligations can be expressed without some consideration of the assets in support of those reserves. Some actuaries believe the anticipated cash flows from the assets must be considered, while others have held that the opinion relates only to the computed amount of reserves as a singular measure of the future obligations under the insurance policies. The appropriateness of the current opinion has been increasingly challenged with the advent of widely fluctuating interest rates and the associated introduction of interest-sensitive products.

The American Academy of Actuaries Committee on Life Insurance Financial Reporting Principles (the Committee) has prepared a draft modification of the actuarial opinion and Recommendation 7 which would clarify the matching of insurance and investment cash flows is a part of the Actuary's scope of responsibility. The Comittee has carefully monitored work of the Society of Actuaries and the NAIC in order to have appropriate standards of practice ready on a timely basis. The Committee has attempted to use techniques consistent with those being considered by comittees of the Society of Actuaries and as included in the Joint Society/Academy Committee Report on the Role of the Valuation Actuary in the U.S.

The primary change in the working draft from the current opinion is that, in addition to an opinion on the amount of reserves, an opinion is expressed that anitcipated cash flows from the assets plus anticipated consideration to be received from inforce policies make a "good and sufficient" provision for the contractual obligations and related expenses of the company under its policies. The actuary would arrive at his opinion by testing the insurance and investment cash flows using a variety of interest rate paths. The actuary would use investment information provided by the company and required to be on file at the company.

In conceptual terms the actuary tests that the investment cash flows resulting from assets which have book values equal to the statutory reserves, plus anticipated considerations, are adequate to meet contractual obligations and related expenses using assumptions with sufficient margins to cover future reasonable deviations from best estimate expected assumptions. If not, additional reserves would be required. At the same time the actuary would disclose in the actuarial report to company management an amount, if any, of additional internally designated surplus required to meet the same test, but in this case using assumptions with sufficient margins to cover a wider range of plausible deviations from best estimate expected assumptions.

The Committee will continue to work on this project with the goal of resolving some remaining open issues and exposing a draft work product to the Academy membership for comment, hopefully, early in 1985. It is believed that valuable input will be obtained from Academy members through the exposure and comment process.

STATEMENT 1984-38

FINAL REPORT OF THE JOINT COMMITTEE ON THE ROLE OF THE VALUATION ACTUARY IN THE UNITED STATES

The Joint Committee on the Role of the Valuation Actuary in the United States was established by action of the Academy and Society boards in December 1983. The Joint Committee's charge, detailed in Appendix A, was to make recommendations to the Academy and Society boards concerning:

1) The appropriate role for the Valuation Actuary in the United States.

2) What is necessary to effect and support this role, including the relative responsibilities of the Academy and Society.

The Joint Committee has addressed only the statutory valuations of life insurance companies. Such valuations must encompass life and health insurance, annuities and all other products sold by life insurance companies. We have not addressed valuations made for other purposes, such as general purpose financial reporting or acquisitions.

Membership

The Joint Committee consists of John Fibiger, Walt Rugland and Virgil Wagner, representing the Academy; and Don Cody, Burt Jay and Gary Corbett (Chairman), representing the Society.

Major Recommendation

The Joint Committee has developed two major recommendations, the first describing the role of the Valuation Actuary; the second, the general principles underlying the valuation of life insurane companies for solvency/solidity purposes.

1) The Valuation Actuary

The Committee recommends that each state enact a statute requiring the directors of a life insurance company licensed in the state to appoint by resolution an actuary to be the Valuation Actuary of the Company and to file a certified copy of that resolution and of every subsequent resolution relating to the appointment, dismissal or change of a Valuation Actuary with the appropriate state regulatory authority on a timely basis.

Valuation actuaries who are members of the American Academy of Actuaries would be subject to qualification standards established by the Academy, and accountability would be ensured through the Guides to Professional Conduct and accompanying disciplinary measures. The qualification standards would address the problem of assuring that the Valuation Actuary remain knowledgeable concerning current valuation principles and standards of practice.

The Academy will work with the state regulators to establish analogous standards and measures for valuation actuaries who are not Academy members.

2) Principles Underlying the Valuation of Life Insurance Companies for Solvency/Solidity Purposes

The Committee believes that ultimately the Valuation Actuary should be responsible for the selection of assumptions and the establishment of reserves appropriate under the circumstances. Guidelines for selecting the assumptions and making the calculations would be provided in the form of principles contained in actuarial literature and standards of practice promulgated by the actuarial profession. The availability of such principles and standards, along with the qualification standards for the Valuation Actuary and his/her relationship to management and regulators, as described in the first recommendation, would provide regulators with the confidence level needed.

Until such time as comprehensive valuation principles and standards have been developed, we believe that specific legal solvency requirements must continue to be defined. The basis of these requirements is the statutory annual statement in which reserves are determined in accordance with the Standard Valuation Law, other statutes and regulations, and statutory accounting principles. These requirements are accepted as being necessary to provide the regulators and the courts with an identifiable basis for enforcing appropriate remedies in the case of a company failing to meet such requirements.

In addition to the legal solvency requirement, a Statement of Actuarial Opinion would be required from a qualified designated Valuation Actuary that:

(1) the reserves established are such that the related anticipated policy and investment cash flows will make a good and sufficient provision for all future obligations on a basis sufficient to cover future reasonable deviations from expected assumptions; and
(2) that such reserves and additional internally designated surplus are such that the related anticipated policy and investment cash flows will make a good and sufficient provision for all future obligations on a basis sufficient to cover future plausible deviations from expected assumptions.

Satisfying Part (1) of the Opinion may require reserves to be established which exceed the legal solvency standard. Any portion of surplus necessary to satisfy Part (2) of the Opinion must be recognized by management (i.e. internally designated). This amount, together with the basis of its determination, would be available for review by regulators, but would not be required to be published in financial statements. Significant changes in operations or in valuation assumptions during the year must be assessed as to the materiality of their impact on designated surplus.

Documentation of the basis for the Opinion would be provided in the Valuation Actuary's report to management and to the Board of Directors.

In time, when confidence in the protection afforded by the actuarial opinion becomes firmly established, the solvency standards promulgated by statute or regulation should cover only principles, possibly including a minimum standard methodology. It is expected that the actuarial profession would work closely with the regulators to develop these statutory valuation principles. The selection of assumptions appropriate to the company and environment and consistent with the statutory principles would be left to the professional judgment of the Valuation Actuary. These assumptions and the associated methods would be fully described in the Valuation Actuary's report which should be submitted to regulators on a confidential basis.

Comments on the Recommendations

1) The Valuation Actuary

The relationship of the Valuation Actuary to management, owners and regulators received much discussion. Possible relationships ranged from the status quo, where the actuary responsible for valuation is part of the management structure, to a requirement for complete independence of the Valuation Actuary from the company and its owners. This relationship, which is similar to that in Canada, should provide the regulators with sufficient assurance as to the knowledgeable objectivity of the Valuation Actuary.

2) Underlying Valuation Principles

We believe that valuation standards, appropriate for all products under all circumstances, can not be prescribed by statute or regulation. If this were once possible, with traditional products and more stable economic environments, it is certainly not possible today. Judgement by an actuary knowledgeable concerning the specific product, the situation of the company and possible economic environments is necessary in order to calculate reserves appropriate for any given purpose. Such calculations should be based on sound actuarial principles. We agree that, to date, the actuarial profession has neither identified nor promulgated such principles and thus we can not expect regulators to accept a new valuation system when one of its major building blocks is not in place. But until we require actuaries to go beyond the statutory formulas in valuing life insurance companies, it is unlikely that the necessary energies will be devoted to the task of developing valuation principles.

To solve this "chicken and egg" problem, we are recommending the superimposing of the requirement for a Valuation Actuary's Statement of Actuarial Opinion on statutory solvency requirements. This additional requirement will necessitate the development of valuation principles. It is our expectation that within a few years sufficient principles, and associated standards of practice, will be developed and promulgated that it will be generally agreed that reserves based on such principles and standards should replace outmoded and inflexible statutory requirements.

However, with or without statutory valuation standards, a Statement of Actuarial Opinion by a Valuation Actuary, even assuming appropriate competence and independence, will not necessarily prevent a company from becoming insolvent as a result of current unsound business practices. Audits and reviews, both internal and external, will be necessary to assure the

accuracy of asset and liability information. The Academy committee charged with establishing standards of practice for the Valuation Actuary must address the question of the appropriate scope of the Actuarial Opinion. For example, to what extent does it cover the accuracy of in-force records or the quality of the investment portfolio?

A more detailed description of the principles we propose should underly the valuation of life insurance companies for solvency/solidity purposes can be found in Principles of Valuation Reserves, Assets Needed, Solvency and Solidity. This memo, reproduced in part as Appendix B, was written by Don Cody for the Joint Committee.

ıe Effecting and Supporting of the Major Recommendations

The second charge to the Joint Committee requested that we determine what nust be done to effect and support the recommended role in the following ·eas:

a) Law and regulations
b) Research
c) Education and training
Principles/standards of practice

hird charge we were to address how the profession should organize to ılish the tasks identified in the second charge. In this section of the ve have combined our response to these two charges.

Changes in law and regulations.

We appreciate that our recommendation would call for extensive revision to the law and regulations of all the states respecting the valuations of life insurance companies. Such revisions can occur only with the support of the NAIC and of the life insurance industry. We would look to the Academy to propose the necessary changes to establish the position of Valuation Actuary and the requirement for a Statement of Actuarial Opinion. Close co-ordination with the NAIC technical groups and the appropriate industry committees would be required.

Research

Research necessary to support the Valuation Actuary should be the responsibility of the Society. We recommend that such research be coordinated by the Committee on Life Insurance Company Valuation Principles.

c) Education and Training

The Society must address education and training needs for both students and practicing actuaries. The E and E Committees must provide appropriate education in the principles and standards governing the valuation of life insurance companies for all prospective FSAs who will be called upon to provide actuarial opinions on such valuations.

A greater need, at least for some years, will be to educate valuation actuaries, not exposed to the new valuation system in their formal education, in the principles and standards of the new system. The responsibility for such education should lie with the Society's Services to Members Policy Committee, working closely with the Committee on Life Insurance Company Valuation Principles and with the appropriate Academy committees.

d) The society is responsible for developing principles of actuarial science, as opposed to standards of actuarial practice. In the valuation area, this will be the responsibility of the Committee on Life Insurance Company Valuation Principles. The Joint Committee's recommendations, when adopted by the Academy and Society boards, will form the framework for the work of this committee. The resulting principles should be applicable to both Canada and the U.S. but the standards necessary to implement the principles might well vary.

The Academy is the U.S. organization responsible for codifying standards of actuarial practice through the promulgation of Recommendations and Interpretations. The Academy's Committee on Life Insurance Financial Reporting Principles is the body currently responsible for codification in the area of life insurance company valuation. It, or its successor committees, will continue in this role within the proposed structure headed by the Actuarial Standards Board.

Beyond the work and committee structures described above, we recommend the establishment of a steering committee to:

(1) communciate and coordinate with non-actuarial audiences, such as insurance regulators, the insurance industry and the accounting profession;

and (2) coordinate the work of committees within the actuarial profession addressing the problems relating to the responsibilities of the Valuation Actuary in the United States.

Until such a steering committee is established, the present Joint Committee will function in this role.

Other Activities of the Joint Committee

In Appendix C, are listed all activities undertaken or initiated by the Joint Committee that are not described elsewhere in the report.

We respectfully request approval of this report and that the Academy and Society take immediate steps to implement our recommendations.

American Academy of Actuaries
John Fibiger
Walter S. Rugland
Virgil Wagner

Society of Actuaries
Donald Cody
Burton Jay
Gary Corbett ,Chairman

APPENDIX A

1. Determine the appropriate role for the valuation actuary in the United States, including:

   a. Scope - e.g., assets as well as liabilites
   b. Nature of statement to be signed by the valuation actuary
   c. Judgment v. statutes and regulations
   d. Qualifications required to be a valuation actuary.

2. Determine what must be done to effect and support this role, including:

   a. Changes in laws and regulations
   b. Research
   c. Education and training
   d. Principles/standards of practice

3. Determine how the above is to be accomplished, including:

   a. Relations and coordination with other bodies (e.g., NAIC, ACLI, CAS, CIA, AICPA)
   b. Split of assignments between Academy and Society
   c. Committees/task forces required within each organization

APPENDIX B

Principles of Valuation Reserves, Assets Needed, Solvency and Solidity

(Prepared for the AAA-SOA Joint Committee on Role of Valuation Actuary in the U.S.)

We have discussed the potential scope of responsibility of the valuation actuary in the broadest context (a) for the Opinion as to the good sufficiency of statutory reserves to assure solvency and (b) for a possible Report to Management as to (i) the availability of assets needed (surplus needed) for capacity utilized by in-force and (ii) for vitality surplus for change and growth, to assure solidity. While there is much traditional literature and much additional modern literature produced recently by the SOA Committee on Valuation, its four Task Forces and AAA Committees, no concise recitation of principles exists.

This presentation applies primarily to statutory financials, but relationships to GAAP financials and to pricing are touched on. While traditional concepts of reserves and surplus are not essentially inconsistent with modern concepts as presented here, it is desirable to put them aside because they have been so oversimplified in practice that they can produce incorrect determinations in some situations, e.g. interest sensitive products.

Background material is abstracted in my January 20, 1984 "Literature Available for Continuing Education of a Valuation Actuary", produced for this Joint Committee. This presentation represents my own perceptions of the

research findings of the SOA Committee on Valuation and Related Problems and its four Task Forces.

1. Principles of Valuation Reserves and Contingency Surplus

In a statutory or GAAP balance sheet, aggregate assets held are apportioned among valuation reserves (and other liabilities), contingency surplus needed for capacity utilized by in-force, and viality surplus for growth and change. The modern approach defines valuation reserves as assets needed to assure good and sufficient provision for contract obligations at a specified sufficient provision for contract obligations at a much lower level of probability of ruin e.g., 1%, 0.1%, are the sum of the valuation reserves and the contingency surplus needed for capacity utilized by in-force. The research of the SOA Committee on Valuation and Related Problems and its four determinations within this conceptual framework. For reasons of practicability, the procedures involve translating levels of probability into universes of scenarios and basing reserves and contingency surplus needed on a "worst" scenario in the universe.

Levels of probability of ruin illustrated above need further research. The level of probability of ruin chosen for reserves is very important to the balance sheet. For instance, a higher level, like 10%, would make nominal insolvency much less likely but would put a greater burden on surplus adequacy and Early Warning tests to assure solidity.

1.1 Valuation Reserves

Considering the relatively high level of probability of ruin (5% or ?%), the extent of variation in actuarial parameters from expected to be contemplated in valuation reserves can be characterized as follows:

- C-3 Risk (Interest Rate Environment) is paramount in interest sensitive products and other high reserve products with voluntary book value withdrawal privileges. It can be especially high where asset cash flow and liability cash flow are seriously mismatched.

- C-2 Risk (Claims, Expenses) can be large in disability and medical coverages, but smaller "normal" variations will occur in contracts involving mortality, provided appropriate reinsurance is used.

- C-1 Risk (Defaults and Common Stocks). Barring concentrated or speculative investments, reasonable capital losses can be anticipated as a charge against investment income.

1.2 Contingency Surplus Needed for Capacity Utilized by In-Force

These constitute additional amounts of assets held to assure good and sufficient provision for contract obligations at a much lower level of probability of ruin (1%, 0.1%, 0.01%, 0.001%) depending on the choice of management as recommended by the valuation actuary and acceptable to regulators. The additional risks contemplated here are of a catastrophic nature, not likely to occur within expected lifetime of a particular class of contracts:

C-1 Risk: The Great Depression (deflationary); a very serious high variable interest rate environment with inflation, followed by an extended stagflation; a serious earthquake.

C-2 Risk: Disability claims correlated with C-1 risk; epidemic; large variation in total death claims in a small company; a quantum jump in medical care claims; very poor underwriting of medical care or disability coverage in association or sponsored group; expenses in C-1 Risk inflation.

C-3 Risk: Very large and sustained upside or downside interest movement; C-1 or C-2 Risk realized in a dangerous C-3 Risk environment.

It is important to note that assets needed to cover this contingency surplus for capacity utilized are not available to provide vitality surplus for growth and change essential to a viable healthy company. This causes a constraint on the level of probability chosen (ability to grow and change versus assurance of protection against adversity).

1.3 Release from Risk

Statutory valuation reserves (and GAAP valuation reserves) are released from risk mechanisms in that they control the release of margins and the emergence of profit. The greater the loadings in actuarial factors, the slower is this release. If contingency surplus for capacity utilized is added to the reserves, the slower is the release of margins from the total of reserves and surplus.

1.4 Solvency

Nominal insolvency occurs when the sum of statutory reserves, other liabilities, and minimum statutory capital exceeds statutory book value assets. Rehabilitation status (actual insolvency) can occur only under court order petitioned by the State Insurance Department. Involved in the consideration by the court would be a careful scrutiny of all asset and liability items. Also, rehabilitation action would be preceded by negotiation with other companies as to possible purchase or merger.

It is seen, therefore, that statutory reserves established by the valuation actuary as good and sufficient provision for contract obligations are only an early ingredient of the rehabilitation process. Nevertheless, since the valuation actuary may find that he must establish reserves higher in aggregate than SVL minimum responsibility and authority to establish such higher reserves.

1.5 Solidity

This implies contingency surplus needed for capacity utilized for in-force at a designated low probability level of ruin is avialable. More strongly, it implies the availability of additional vitality surplus for growth and change. Solidity is a perogative of management, becoming of interest to regulators when early warning flags are flying. Thus, solidity is a matter to be addressed in the Valuation Actuary's Report to Managment and in Insurance Departments' triennial examinations.

Decreasing solidity always precedes nominal insolvency except where unforseen catastrophes occurs.

APPENDIX C

1) We prepared an article, which appeared in The Actuary, describing the charge and work of the Joint Committee.

2) We have distributed, under the auspices of the Society's Services to Members Policy Committee, Literature Available for Continuing Education of the Valuation Actuary. This is a seven-page memo, written by Don Cody, which summarizes the literature developed by the Society's Committee on Valuation and Related Problems and materials available from other sources.

3) We have arranged with the Financial Reporting Section of the Society to sponsor a One Day Open Forum for Valuation Actuaries in Chicago on October 3.

4) We recommend to the Society's Program Committee and to the Financial Reporting Section that the Section be responsible for the entire program at the May 1985 Society meeting in St. Louis. One track of this program will be devoted to valuation.

5) We recommended to the Society's Executive Committee the establishment of a Task Force on Actuarial Principles. This recommendation was accepted. The basic charge to this Task Force is to recommend the Society's role in determining actuarial principles and how this role is to be performed.

6) We recommended to the Society's Board of Govenors the appointment of a Committee on Life Insurance Company Valuation Principles. This recommendation was accepted.

7) We have reviewed the activities underway within the Academy relating to standards of practice, qualification standards, and relations with accountants. We have determined that these activities are consistent with our recommendations.

STATEMENT 1984-39

STATEMENT OF STEPHEN G. KELLISON
EXECUTIVE DIRECTOR OF THE AMERICAN ACADEMY OF ACTUARIES
TO THE NAIC TECHNICAL SERVICES (EX5) SUBCOMMITTEE
DECEMBER 12, 1984

Introduction

The purpose of this statement is to speak in favor of the establishment of a more organized coordination between the NAIC and the actuarial profession. The American Academy of Actuaries is the public interface organization for the actuarial profession in the U.S. and includes actuaries in all areas of specialization within its membership.

The balance of this statement discusses ways of achieving stronger liaison.

Rationale

Insurance regulators face greater pressures today than ever before. Problems and issues are more complex and difficult to resolve, yet resources to address them are more limited. Statements of actuarial opinion and other actuarial input into regulatory matters offer one avenue to assist insurance regulators in stretching their scarce resources further, while at the same time improving the quality of regulation.

Structure

The NAIC has already taken the first positive step in this direction with the creation of the Technical Services (EX5) Subcommittee and the placement of the Life and Health Actuarial Task Force under it. The challenge at the present time is twofold: (1) how should this structure operate for maximum effectiveness, and (2) what additional steps are needed?

Role of (EX5)

As we understand it, the role of the new (EX5) Subcommittee in connection with actuarial matters is the following:

1. To ensure that needed actuarial input is being provided to NAIC officers, committees, subcommittees, and task forces.

2. To provide a central focal point to coordinate actuarial activities.

3. To create a reporting mechanism for actuarial groups within the NAIC.

4. To establish priorities of various actuarial projects.

Examples of Actuarial Projects

The following is a short list (certainly not complete) of examples of the types of general actuarial issues in which the (EX5) Subcommittee could have oversight.

1. Enhancing the value of statements of actuarial opinion from valuation actuaries as regulatory tools for insurance regulators.

2. Developing actuarial standards to analyze the matching of assets and liabilities.

3. Providing needed analysis and research to deal with risk classification issues, such as unisex and blindness.

4. Specifying disclosure standards for actuarial assumptions and methodologies used in pricing and in reserving.

5. Strengthening the actuarial basis for the operation of guaranty funds.

6. Identifying actuarial issues relating to the transfer of risk in reinsurance agreements.

Proposals

The following are additional steps which should be taken to further strengthen the relationship between the NAIC and the actuarial profession.

1. We were pleased to learn that the proposal to add an actuary to the staff of the Support Services Office in Kansas City has been approved. Such a person could be of great value to the operation of the (EX5) Subcommittee and the entire NAIC. We hope the position will be quickly filled.

2. A Casualty Actuarial Task Force should be appointed. This task force would parallel the Life and Health Actuarial Task Force already in existence and would also report to the (EX5) Subcommitte. It would deal with a variety of matters such as the actuarial principles and practices used in loss reserving and pricing.

3. The American Academy of Actuaries offers to appoint a high level liaison committee to periodically meet with the (EX5) Subcommittee and the officers of the NAIC. This liaison committee would be chaired by an officer of the Academy and would have as members actuaries on the Board of Directors and actuaries active in committees dealing with insurance regulatory issues. The purposes of the liaison committee would be:

   - To act as a central clearinghouse of information within the actuarial profession on activities relating to the NIAC in order to prevent gaps and overlaps.

   - To assist the NAIC in identifying actuarial projects to be worked on and to mobilize resources within the actuarial profession to address these projects.

   - To help in establishing priorities.

   - To provide other advice and counsel, as appropriate, to the (EX5) Subcommittee, Actuarial Task Forces, and the NAIC leadership.

Summary

In closing, we believe that the actuarial profession has a strong commitment to do our part in fostering high quality insurance regulation. Stronger liaison between the NAIC and the actuarial profession would be beneficial in achieving this objective. We hope the ideas presented in this statement are useful in this regard.