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1981



ANNUAL MEETING—OCTOBER 21, 1981
STATEMENTS RELEASED IN 1981

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NOTICE

The Academy is not responsible for statements made or opinions expressed
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JOURNAL

ANNUAL MEETING

October 21, 1981

Atlanta, Georgia

MR. WALTER L. GRACE (President): This Annual Meeting completes the 16th year of the Academy's existence. We have a full program for you this morning, just as the Academy's 16th year was chock full of important activities. Our program this morning gives you a quick look at some of those important activities. We will first have a short business session, then a Panel of Presidents, and then, we'll have four panel discussions - one on health insurance, one on risk classification, one on the Academy's long-range planning process, and one on social insurance and pension matters.

At this time I want to thank Robin Leckie and the Society of Actuaries for giving us such a big chunk out of the Society's program time. The Academy rotates its Annual Meeting among the founding organizations. We do this as one way of communicating with our members. It's especially significant when we have our Annual Meeting in conjunction with the Society's because over 70% of the Academy's members are also Society members. Robin, we do appreciate the time you have given us out of your program and I thank you again.

We will now have a report from the Nominating Committee which will be given by President Elect, Bill Halvorson.

**BUSINESS SESSION
NOMINATION AND ELECTION OF DIRECTORS**

WILLIAM A. HALVORSON: I'm reporting for Mr. Dale Gustafson, the Chairman of the Nominating Committee, who was unable to be here today.

At its meeting on October 9, 1981, the Board of Directors of the American Academy of Actuaries elected the following officers for a term of one year to commence at the close of the Annual Meeting:

President-Elect	F. Adger Williams
Treasurer	W. James MacGinnitie
Secretary	Carl R. Ohman

And the following officers for two year terms:

Vice President	David R. Carpenter
Vice President	William A. Ferguson

The following continue as members of the Executive Committee:

President	William A. Halvorson
Vice President	A. Norman Crowder
Vice President	Bartley L. Munson
Past President	Walter L. Grace

Also at its October 9, 1981 meeting, the Board elected William Spencer a Director, to fill the unexpired term of William Hand, who has resigned.

The Nominating Committee here presents the following six names to be placed in nomination for Director at this meeting:

Ronald E. Ferguson
John H. Harding
Willard A. Hartman
Burton D. Jay
Marc M. Twinney
Michael A. Walters

(It was moved, seconded and carried that nominations be closed. It was moved, seconded and carried that the nominees be elected.)

MR. GRACE: Thank you, Bill. We will now hear the Secretary's Report from our new Secretary, Carl Ohman.

**BUSINESS SESSION
REPORT OF THE SECRETARY
CARL R. OHMAN**

MR. CARL R. OHMAN: I'm presenting this report on behalf of the outgoing Secretary, Charles B. H. Watson, who's unable to be here this morning.

During the past year, meetings of the Board of Directors of the American Academy of Actuaries have been held on five occasions: October 31, 1980; January 20, 1981; February 27, 1981; June 3, 1981; and October 9, 1981.

The meeting held in February of this year was a special Board meeting, in that it consisted entirely of an in-depth review and discussion of the report of the Academy Long-Range Planning Committee. The other meetings were more customary, in that they dealt with business which was more immediately at hand.

Actions taken at the first four Board meetings have previously been reported through the medium of the Academy Newsletter. This report describes the non-routine items of business which were dealt with at the Academy Board meeting held on October 9.

1. Pursuant to the Bylaws as amended last year, the Board elected the Academy officers for the year 1981/82. The results of this election have been reported to you at this business session.
2. The Board elected, as a new member of the Board, Mr. William Spencer. Mr. Spencer was selected to complete the term of Mr. William Hand, who found it necessary to resign from the Board for personal reasons. Mr. Spencer's term ends in 1983.
3. The Board agreed that the membership dues for calendar year 1982 will continue at the same level as for calendar year 1981. The dues amount is \$125 for all members, payable as of January 1.
4. The Board authorized the appointment of a Budget and Finance Committee. The Committee is to consist of the Treasurer, who will serve as Chairman, the President-Elect, the Secretary, and three elected Board members to be selected by the President. This Committee will have as its specific duties preparation of the annual budget and related financial projections, recommendation of the dues structure, and development and maintenance of an investment policy for Academy funds. In addition, the elected Board members would constitute an Audit subcommittee, which would recommend appointment of the Auditor and be responsible for reviewing the Auditor's report. Coincident with the appointment of this Committee, the Investment Committee was discharged.
5. The Board authorized the adoption of Opinion A-3, pertaining to the content of actuarial reports. This Opinion had previously been

exposed to the members and the version adopted by the Board reflected comments received. In addition, the Board authorized the Committee on Guides to Professional Conduct to send out an exposure draft of Opinion A-7 to the Academy members. This constitutes a general opinion with respect to Actuarial Principles and Practices, and is intended ultimately to replace Opinions A-4 and A-6.

6. The Board approved the adoption of Qualification Standards with respect to life insurance actuaries and property and casualty actuaries. These Standards had previously been submitted to the Academy membership for comments and the Standards adopted reflected comments received. The Board also authorized the referral of these Qualification Standards to the Committee on Guides to Professional Conduct in order that the position of these standards with respect to enforcement within the Academy could be determined.
7. The Board authorized the President of the Academy to appoint a Committee with the purpose of implementing the report of the Joint Committee on Pension Terminology. It is intended that this Committee will have liaison representatives appointed by the American Society of Pension Actuaries, the Canadian Institute of Actuaries, the Conference of Actuaries in Public Practice, and the Society of Actuaries.
8. The Board adopted a statement with respect to the Procedures to be employed in issuing exposure drafts of Guides, Opinions, Recommendations and Interpretations. These Procedures will be published in the 1982 Year Book.
9. The Board agreed that the Pension Accounting Subcommittee should be constituted as a full Committee of the Academy, and the President was authorized to appoint the members of that Committee.
10. After hearing a very encouraging report with respect to the Loss Reserve Seminar held in September, the Board authorized the holding of a similar seminar in 1982.
11. The Board was informed that the Executive Committee had approved the publication of the Academy Newsletter on a monthly, rather than bi-monthly, basis.
12. The Board received a report with respect to the adoption of a Statement of Purposes in the Academy, a report from the Task Force on Communications with Members, a report from the Task Force on Academy Statements, and a report from the Joint Committee on Public Relations. Comments on all of these were requested from Board members and action was deferred until a subsequent meeting.

It is also of a significance to note that, since October 1, 1980, 594 new applications for membership in the Academy have been received. In the same period, 655 applications have been approved, 2 were not proceeded with, and 103 are still in process.

MR. GRACE: Thank you, Carl. We will now hear from our new Treasurer, Jim MacGinnitie, who served as Assistant Treasurer this year.

**BUSINESS SESSION
REPORT OF THE TREASURER
W. JAMES MAC GINNITIE**

MR. W. JAMES MACGINNITIE: I would like to report to you briefly on the Treasurer's 1981 functions.

Membership in the Academy has increased from 6,208 members on October 31, 1980 to 6,544 members as of September 30, 1981. It is anticipated that membership will continue to increase at a moderate rate with membership approaching 7,000 by the end of 1982. Continued growth is indicative of the integral role the Academy plays in the actuarial profession.

By year end 1981, income is anticipated to exceed projected expenses by approximately \$150,000, leaving us with cash assets of approximately \$300,000. Our 1981 expenses are currently projected to be approximately \$700,000. Membership growth, administrative economies, and investment income from improved cash management should yield an excess of income over expenses in 1982 of approximately \$60,000, which would then bring our December 31, 1982, fund balance close to \$360,000. This amounts to a reserve equal to approximately five months' expenditures, or \$55 per member.

The Board has approved continuation of the present dues structure, without increase, for 1982.

Academy expenses are anticipated to grow in proportion to the increase in activity on behalf of members. Publication and distribution of Opinions, Recommendations, and Interpretations, and other material, as well as testimony on professional matters have utilized an increasingly substantial portion of Academy resources and are projected to do so in 1982.

Detailed financial reports of the Academy are reviewed regularly by the Board and a certified audit is conducted annually at the close of the fiscal year.

MR. GRACE: Thank you, Jim. We will now hear from our hard working Executive Director, Steve Kellison.

BUSINESS SESSION
REPORT OF THE EXECUTIVE DIRECTOR
STEPHEN G. KELLISON

Thank you, Walt. This report is designed to provide a brief summary of developments in the Academy offices and of other Academy activities not covered elsewhere in this program since the 1980 annual meeting. 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. The growth of Academy activities is largely the result of the rapid transformation of the actuarial profession over the 16 years of the Academy's existence from a private inward-looking group to a true outward-looking public profession, with public responsibilities and accountability.

The past year has been one of considerable growth in the Washington office of the Academy. We currently have a staff of 11 employees in the Washington office. In addition, the Chicago office of the Society of Actuaries provides a number of administrative functions related to the computer-based membership roster of the Academy.

At this time, I would like to publicly recognize those Academy employees who are in attendance at this meeting. Our newest employee is Erich Parker, who is the new Director of Public Information and who has been on the payroll since only October 9. Later in this program, Bill Halvorson will make a special presentation on the new public relations program for the actuarial profession. After hearing Bill's presentation you will know that Erich will be busy. We also are pleased that Cyndy Sharp, our Director of Administration, and Bill Hager, our General Counsel, are here today. Cyndy supervises the increasing array of administrative functions of the Academy, while Bill not only handles all of our legal needs but has also taken on increased responsibility for the government relations program of the Academy. Finally, I would like to recognize our Membership Manager in the Chicago office, Madeline Madden. Many of you have been graced with Madeline's dedicated service at the registration desk during this meeting.

All of these people and those who remain behind in Washington taking care of business work very hard on your behalf. I hope that you will take time to meet them and express your appreciation to them during this meeting.

During the past year, the Academy has made a major improvement in our admissions system. Until recently, the average length of time necessary to process the typical application was four to six months, which resulted in a number of complaints. We have made a number of changes to streamline our procedures, and I am very pleased to announce that within the past few months we have been able to reduce the average processing time to less than two months.

As most of you are aware, the professional role of the actuary is one of the Academy's major areas of interest. This manifests itself through such initiatives as our new pronouncement on qualifications standards, which was mentioned in the Secretary's report and will be distributed in the near future, our Guides and Opinions as to Professional Conduct, and our standards of practice, known as Recommendations and Interpretations. The increasing volume of this activity is necessary for the actuarial profession to maintain and increase our public credibility with a variety of external audiences. However, we have become increasingly aware of two problems which we need to address. The first is the need to better communicate to you, the membership; why these standards are necessary, how you can better familiarize yourself with them, what the distinctions are among the various types of standards, and what disciplinary force they have. The second is the need to get you, the membership, more directly involved in the development of these standards through improved procedures for handling exposure drafts.

Both of these needs are addressed in a document entitled, "Procedures for the Development of Standards of Professional Conduct and Practice," which was approved by the Board of Directors and which will be distributed to you in the near future. When you receive this document I commend it to your careful attention. Not only does it address the two needs just cited, but it has other purposes as well. Among these are an administrative procedure for the efficient handling of exposure drafts and a sound legal foundation that these standards meet "due process" requirements and provisions of administrative law. Although recent exposure drafts have generated significant comment, we wish to encourage an even higher level of membership comment in future exposure drafts which you receive. This is a direct way for you to get involved in a most important professional activity and all Academy committees working on these standards are committed to carefully consider all comments received.

Another important area of Academy activity is the preparation of statements, testimony, and other communications on public issues involving actuarial considerations. A number of Academy committees are quite active in this endeavor which cuts across all areas of specialization within the profession. In order to provide you with an insight into the scope of this activity, I have tabulated the public statements issued by Academy committees since the last annual meeting. There have been 33 such statements. They fall rather naturally into four general categories:

- 9 were to the U.S. Congress
- 6 were to federal regulatory agencies
- 12 were to the accounting profession (AICPA and FASB)
- 6 were to the NAIC

Although any of these initiatives are worthy of mention, I would like to call particular attention to the work of the Academy Committee on Risk Classification on H.R. 100, which is an omnibus bill that, among other things, would require unisex pricing in all lines of insurance, both prospectively and retrospectively. You will be hearing a lot more about the study of the fiscal impact of this bill, which the Academy committee did for Congress, at one of the concurrent sessions later this morning. In my personal opinion, the work that was done on this issue is the most

extensive and most effective work ever done by the Academy on a piece of Congressional legislation.

In order to provide more effective staff support to Academy committees working on these issues, the Washington office staff has developed, and is continuing to refine, a monitoring system to track these various legislative, regulatory, accounting, and NAIC issues. Unfortunately, little of this effort is visible to the membership at large. We are exploring various options that would provide the membership with more extensive and earlier information about developing issues than the brief "Checklist of Academy Statements" which appears in each Newsletter issue after-the-fact. Although we have not yet developed any specific program ready for implementation, we are cognizant of the value it would have and are trying to develop a workable solution. In any event, we do encourage all actuaries to get more interested and involved in these important issues impinging on the professional practice of the actuary.

Although the Academy has made considerable strides in dealing with the types of issues just cited above, we need to do a better job of dealing with issues affecting actuarial practice at the state and local level. We believe that the key to greater success at the state and local level is the more active and structured involvement of actuaries at the state and local level. In this regard I call your attention to the front page of the September issue of the Newsletter containing an article along these lines from Fred Kilbourne, Chairman of the Committee on Accreditation. We plan a major initiative in this direction during the next two years. It will be integrated with the new public relations program which Bill Halvorson will discuss in just a few minutes.

Meetings and publications are other areas of increased Academy interest. As mentioned in the Secretary's report, the Academy co-sponsored a highly successful seminar on casualty loss reserves with the Casualty Actuarial Society in September and it is planned to hold such a seminar again in 1982. Although this seminar had the normal purpose of any professional meeting--namely, continuing education--we felt that it was also a very important initiative to strengthen the posture of the actuarial profession with both the NAIC and with the accounting profession in connection with actuarial statements of opinion on annual statement blanks.

In the area of publications, as indicated in the Secretary's report, we have just increased the frequency of publication of our Newsletter from bimonthly to monthly. This should permit the Academy to provide you with more timely material of professional interest. In fact, you will note that our October issue, which has not yet been mailed, is located on the tables outside this room at the coffee break. This is a special annual meeting issue which I think you will find to be of interest, so please feel free to take a copy as you leave this session.

These are important days for the actuarial profession. I would surmise that all of you were struck, as I was, by President Reagan's use of the word "actuarial" in his nationally televised speech on September 24, 1981. I believe that this is the first such reference to actuaries in a major speech by any President of the United States in history. Visibility such as this gives us a great opportunity as a profession to establish a

much stronger identity and presence as a profession in the months and years ahead. I hope you feel as I do that with renewed effort we can achieve the kind of recognition as a profession that we think we deserve. The opportunity is there, but so is the challenge. Are we equal to the challenge? Time will tell.

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.

MR. GRACE: Thank you, Steve. One of the advantages of the Bylaws change in which the Officers of the Academy are elected at the Board meeting preceding the Annual Meeting, rather than following the Annual Meeting, is that we can ask our in-coming President-Elect to say a few words of greeting. Here is Adger Williams, our new President-Elect.

BUSINESS SESSION
REMARKS OF THE PRESIDENT-ELECT
P. ADGER WILLIAMS

Thank you, Walt. It's hard to believe that the American Academy of Actuaries is 16 years old.

Like most offsprings in their teens, the Academy is often viewed with dismay by its parents, the founding actuarial organization, as it seeks to establish its own identity.

The Academy was conceived and born with an understanding of the need for formal recognition of the actuarial profession.

That need has not changed. But a clarification of the role of the American Academy is desirable as we come of age and emerge as a public profession. The recently released Statement of Purpose says that we must identify for the public who actuaries are, what actuaries do, and how actuaries govern themselves. This is not a change in purpose; rather, it reemphasizes the fact that we are one profession, with the need to be recognized as such.

Actuaries work with many types of insurance, and in many different actuarial disciplines; but we are one profession.

We are represented by a variety of societies, associations, conferences, institutes and academies, but we are still one profession.

There are some things the actuarial organizations do best together and other things they do best apart. We should not hesitate to emphasize those areas where separateness is most fulfilling to us as actuaries. But we should also work together to bring about mutually beneficial programs, which present one face to the public, always remembering that we are one profession and must appear as such to the public.

Since we are one profession, I look forward to serving all of you in the actuarial profession during my coming years in office.

MR. GRACE: Thank you, Adger. Bill Halvorson has served as one of the Academy's representatives on the Joint Committee on Public Relations and will give us a report on this topic.

BUSINESS SESSION
SPECIAL REPORT-PUBLIC RELATIONS
WILLIAM A. HALVORSON

During 1981, Paul Janus, the Academy's Public Relations Committee chairman, and I have had the privilege of working with a Joint Committee on Public Relations, chaired by Ben Whiteley, who was also the Society of Actuaries Public Relations Committee chairman, in the development of a public relations program for the profession in the United States.

The Joint Committee was authorized by that informal organization with the acronym C.O.P., the Council of Presidents, and contained representatives from the Society of Actuaries, The Casualty Actuarial Society, The Conference of Actuaries in Public Practice, the Canadian Institute of Actuaries and the Academy.

A report of this Joint Committee on PR was delivered to the C.O.P. on September 16, 1981, and is now being distributed to the Board Members of these respective organizations.

President Grace has asked me to provide an overview of the Joint Committee's Report in eight minutes; and I hope to do so. In the interest of time, I had some slides prepared yesterday so that I would not have to read all of the items of potential interest to you.

The Joint Committee's first act was to ask the C.O.P for some professional help. In addition to Linda Delgadillo's advice and counsel, the Joint Committee retained Mr. Maurice Bishea. Maurice is a partner in the public relations firm of Bishea and Meili, located in Milwaukee.

Our professionals advised us that we should first find out where we stood, in relationship to our various publics; that is, to see ourselves as others see us - good advice for anyone in private or public life.

Limited surveys of our various publics were designed, and executed. The response rate was high, giving our Joint Committee some confidence that the range of views about us was valid for our planning purposes.

Some highlights of these surveys can be summarized as follows:

As actuaries, we seldom see ourselves as others see us. Survey results:

1. Publics such as employee benefit plan sponsors, insurance executives and regulators are very aware of actuaries. These are people who come into continuing contact with actuaries and are, to one extent or another, aware of their relationships with actuaries and actuarial work.
2. Publics such as newspaper publishers and legislators are not generally aware of actuaries or of the work of the actuary.

3. All of the publics expressed an interest in wanting actuaries to be professional in terms of qualifications and participation in continuing education.
4. Our publics want us to be objective.
5. There was some expression of skepticism as to how professional or ethical we are. This was particularly noticeable in the responses of regulators and legislators.
6. Our publics do not fully recognize that actuaries have a dual responsibility to plan participants and to employee benefit plan sponsors.

As you can see, we have some pluses and some minuses, and although we may be somewhat disappointed that we are not well understood, and that our performance is not always exemplary, we were not overly surprised. We now know we have a major job to do.

We were also advised that if we were to be successful, we needed to define our Public Relations Goals. General goals as well as specific goals were deemed to be more useful than just general goals. For working purposes, and subject to additional debates and discussions by members and Boards, the Committee recommended the following goals:

Goals of a Public Relations Program

1. To increase visibility for the actuarial profession.
2. To gain public recognition that the actuary is the primary source of an objective appraisal of the ability of any insurer, self-insurer or employee benefit plan to meet the promises it has made to its policyholders or plan participants.
3. To gain public acknowledgement that:
 - A. The actuary's function in society is to assure insurance company policyholders, employee benefit plan participants and public regulators that insurers and risk bearing plans promising future financial security are being operated in a sound and equitable manner; and
 - B. The actuary's responsibility to insurers, risk managers and employee benefit plan sponsors is to inform them on the probable costs, risks and rewards involved in making promises to existing and future policyholders and plan participants.
4. To create an expectation on the part of public regulators, legislators and the media that actuaries can provide valuable and objective insight on public issues involving the bearing of risk such as insurance or self-funding, social insurance or security programs, and employee-employer benefit programs, and by so doing improve the public's decision making process in these complex areas of concern.

5. To convince the public that actuaries, trained as they are in mathematics, probabilities, statistics, demography, economics, business, accounting, finance and law as applied to insurance and employee benefit plans, are unique and necessary professionals ... whose judgment and skills can be applied to many complex social and business problems involving future (uncertain) events and commitments.
6. To enhance public acceptance that the profession is aware of its responsibility to the public, is sensitive to public concerns, and is committed, through a code of professional conduct and recognized professional standards, to be rigidly self-regulated.
7. To create an awareness and appreciation within the actuarial profession of the value of reaching out and communicating in a positive way with our profession's publics.

Perhaps today, I should pause on this last goal, #7. The Committee has recognized that perhaps this should be our first project - that unless our own members understand our need to reach out to our publics and establish effective two-way communications, our programs will not work.

What, specifically, did the Joint Committee recommend that the Academy do?

Public Relations Program

- . Hire a director of public information
- . Establish an active media outreach program
 - . News releases
 - . Backgrounders
 - . Feature articles
 - . News tips
 - . Interviews
- . Develop a communications network
- . Initiate outreach programs to:
 - . NAIC
 - . Legislators
 - . Media
 - . Other Professional Groups
 - . Members
- . Maintain fact gathering
 - . Surveys
 - . Clipping service
 - . Monitoring by Joint Committee

It was first recommended that the Academy be given primary responsibility to conduct the public interface aspects of the profession's public relations programs.

In that respect, they also recommended that the Academy hire a full time Director of Public Information. I'm pleased to say that the Academy Board acted on this recommendation at their June meeting, and after a search for the right person, the Academy now has on board Mr. Erich Parker, who has both the credentials, and the experience and energy, to help perform the functions of this job for the profession in the U.S.

Time does not permit me to dwell on each of the programs listed, but I would like to alert each of you to the recommendations to develop a Communications and Government Relations Network in the U.S.

Communications & Government Relations Network

*Selected Academy members in all major cities and states

*Duties to include:

- Monitor media coverage of actuarial topics to alert Washington, D.C. office
- Contacts with local media, regulators, legislators, etc. to provide data and information where needed
- Source of information for members of actuarial profession
- Local promotion of actuarial profession

*Selected members to be trained in PR by Director of Public Information

*Organized under eight to ten regional directors

The Academy Board, on October 9, authorized the President of the Academy to begin work on defining the duties of this network, and to work with the Academy's Accreditation Committee and the Public Relations Committee in launching this momentous undertaking early in 1982.

It is the intention of the C.O.P. to continue the Joint Committee on Public Relations, and to ask them to monitor developments on behalf of the profession, as well as to recommend new programs, when needed, or to refine existing plans.

Needless to say, I believe we are embarking on a most important five to ten year effort - which will be as comprehensive as any we have endeavored. The profession has great opportunities and great responsibilities; and each of you can be a part of this effort to gain better acceptance of the profession by our publics.

MR. GRACE: Thank you, Bill. Well, my year as President is at its end. Now it is my very pleasant duty to turn the reigns over to my successor. We know you are ready, Bill, so now is the time. We wish you well. Come up here, and with a handshake, let me turn over the Presidency of the Academy to you.

BUSINESS SESSION
PANEL OF PRESIDENTS
"THE PRESIDENTS HAVE THEIR LAST WORD"

*Moderator: WALTER L. GRACE. Panelists: WILLIAM A. FERGUSON, ROBIN B. LECKIE,
JEROME A. SCHEIBL*

MR. WALTER L. GRACE: Today's Annual Meeting concludes the sixteenth year of the Academy's existence. It has been a year of increased activity, many activities successful and some less than successful, but notable among the activities was an emphasis on interorganizational cooperation. Accordingly, it seemed appropriate for me to invite to appear on a panel with me today the three Presidents of the Academy's founding organizations. They have graciously accepted and so the four of us will share our thoughts with you for about 50 minutes this morning.

With me today are Bill Ferguson, who served as President of the Conference of Actuaries in Public Practice this year, Robin Leckie, President of the Society of Actuaries, and Jerry Scheibl, President of the Casualty Actuarial Society.

I should explain that the four of us are in various stages of becoming Past Presidents. Bill attained that exalted position about two weeks ago. Robin got there yesterday and I have just handed over the gavel to Bill Halvorson. And Jerry will become a Past President next month.

But today we have our last word together. We will talk back and forth about some of the major issues facing our profession, where things went well this year, where not as well, and what we see for the future.

Let me note that sitting out in that audience are a lot of future presidents of our organizations. We do not know who you are but we know you are out there. Time will catch up with you and then you will be in our shoes. Perhaps you would like to know what it is like being President. Bill, tell us what it is like being President of the Conference of Actuaries in Public Practice.

MR. WILLIAM A. FERGUSON: It has been a great experience! It has been time consuming! It has been humbling!

I am always amazed at the number of people who are willing to work - and work long and hard - for the profession. It has been fun being a coordinator of some of these efforts and occasionally a catalyst.

Being President of the Conference is much less time consuming than being President of the Society of Actuaries or The Academy, but it still involves about 15 meeting days in the year - Board, Executive Committee, Council of Presidents, Special Committees and Academy Board meetings (which the Conference expects the President and President-Elect to attend). In total, it probably takes about 25% of one's time. It helps to be part of a firm which is a strong supporter of the actuarial profession which, of course, is my personal position. I particularly admire those fellows from small firms who take on time consuming roles in the profession.

The experience was humbling in the sense that there are so many issues and problems being actively pursued that I found it quite impossible to keep abreast of all that was going on.

Overall, it was a gratifying experience! And I recommend it to you.

MR. JEROME A. SCHEIBL: To begin with, I never dreamed that I would be called upon to serve as president. When I was asked to go through the chairs, I was awed not so much of the job - as I was of the giants in our profession who had served in this office.

I accepted the honor hoping for a quiet year without some unusual demands on the profession and without having to cope with some mutinous element within our Society. My second concern was my Presidential Address which had to be given three years after my election as vice president. Now I am down to one month and I still have some work to do on it.

As my time came to assume office, I was concerned that my year would be bland if it was to be one of routine caretaking and ceremony. I found out quickly that there was little reason for such concern. The issues demanding attention were very real and could not be avoided. While there was little danger of a mutiny, I quickly discovered that there are different schools of thought in our Society - both on a professional and personal level.

I also learned that there is an unglamorous side to this job. Without a professional staff, the president must attend to a lot of minor matters just to be sure that those things that must be done get done. Our committees generally do a bang-up job, but the president must assure that their efforts are adequately coordinated.

The highlight of my term has been the opportunities I have had to visit with our students at meetings of our regional affiliates and with prospective students on and off college campuses. I had forgotten the enthusiasm of youth and I was amazed at how college curricula have changed in the last 20 or 30 years. My only regret is that I could not start over and register as a freshman again.

I have really enjoyed my year. I have learned a lot and I hope that I have left a positive mark on our Society and the profession as a whole.

I look forward to again giving my employer 100 percent of my time and attention. It will be like getting a fresh start in midcareer and I think both my employer and I have benefited from my experience in the president's chair.

I still have two years remaining on the Board of Directors and five years on the Nominating Committee. At the end of that time, I will undoubtedly have more profound observations on what it was like being president.

MR. ROBIN B. LECKIE: At the time of election, one anticipates a combination of:

- (i) Opportunity
- (ii) Challenge
- (iii) Apprehension
- (iv) Frustration

My experience during this past year has been weighted more to the first two. The year has been enjoyable, a very real and satisfying personal experience, and with fewer administrative burdens or frustrating situations than I might reasonably have expected. This is more a fortuitous result than good management on my part.

We are part of a dynamic, important profession, moving through a time of volatile, social and economic change. It is very satisfying to have the opportunity to participate in the resolution of the issues before our profession and in promoting the further development of our profession. It is particularly gratifying to see the number of new members entering our profession with enthusiasm and hope and to some degree, with a trust that those of us who have led the profession this past year knew what we were doing.

While I have enjoyed my year, I am pleased that I can now see the responsibility rest with my successor, Bob Hoskins. One year is enough!

MR. WALTER L. GRACE: For me, being President of the Academy has been the highlight of my career as an actuary. I have met a lot of people, made a lot of friends and, for me, being President has been pure fun.

I have spent a lot more time on the job than at first I thought I would. Very time consuming is maintaining first hand knowledge of the issues that continually confront the Academy - issues that span the whole wide range of disciplines that comprise our profession.

The governance part of the job is of course time consuming. Plans have to be made for Executive Committee and Board meetings, agendas drawn up, and after the meeting the follow up actions must be directed.

Some time of the Academy President is concerned with interorganizational relationships. Some of these problems are resolved at the Council of Presidents level. Others required individual discussion with the President of the other organization.

One of the most important helps to an Academy President is extensive prior experience in the Academy Committee structure. Making a contribution to a committee effort is the first in a number of stepping stones. One soon realizes the personal rewards that come with serving your profession in a committee assignment. Soon effectiveness grows, and then some are tapped to be committee chairmen. Later, comes a time on the Board of Directors. Then, an officer appointment and you are on your way to a crack at the top job.

It is a tremendously rewarding experience. I recommend it. And it is not impossible to get there. We pick a new one every year.

Let me now ask my second question. What are the major issues facing our profession? Robin?

MR. LECKIE: There is no shortage of need for actuarial research. For example, well designed up-to-date experience studies for mortality, morbidity, withdrawal, salary scales, etc. We need the mathematical and statistical and actuarial tools and methods to produce the studies and to interpret or analyze data. At the same time, there is no shortage of those competent to produce the studies and develop the tools; witness the contributions to our meetings, the papers written and published, the large number of volunteers to staff our committees.

And yet actuarial research is a major issue facing our profession. The problem is identifying the research needed and matching it with those competent to produce the research. There is a need to extract experience contributions from our companies or from governments and to produce from them reports which can be used by the profession. There is the need to obtain funding for major projects. Sometimes the need is no more than to properly articulate our problems in a form which can be taken up by the researcher. A good example has been the implications of high and volatile interest rate on what we do and our inability to develop the implications and the responses. (I mention this as currently some light is emerging from the tunnel).

Actuarial research is an issue. But it is an issue the profession is addressing and will resolve. For example, AERF was formed a few years ago to define and arrange for funding of major actuarial projects. They have had a number of successes, including the Universal Coverage Project. The Society of Actuaries has recently formed a Research Policy Committee, chaired by one of its Vice Presidents, to oversee the various research and experience study committees, to set research priorities for the Society, to prepare an annual research plan, and to facilitate effective Board action for research projects. The Society has also recently hired a full time Director of Research, Jim Cowen. The Committee on Research now regularly holds an annual research forum and publishes new developments in ARCH. Finally, seminars, symposiums, our regular meetings and now special interest sections will all go a long way to pin-pointing our research requirements and providing the forum for developing solutions.

MR. FERGUSON: One of the major issues is the future course of professionalism.

What is professionalism? The dictionary says that a "profession" is an occupation requiring an education and that "professionalism" is the standards, practice and methods of a professional as opposed to an amateur.

As I see it, professionalism in the actuarial profession includes:

- Standards of Conduct. These include the Guides to Professional Conduct and the elaborations of them, whatever named, which, in general, address the question of how to act and behave.
- Standards of Practice. The Standards of Practice are generally called Recommendations and the explanation of the recommendations are called interpretations -- but not always. Standards of Practice in general relate to how to properly perform an actuarial task.
- Qualification Standards. Certain generalized qualification is presumed from the completion of examinations given by the exam giving organizations, but the concept of qualification standards includes the establishment of additional standards based on examinations and other factors which, if satisfied, create a presumed competence for an individual to do a particular task. Whether or not a person is on a particular list of qualified individuals affects the burden of proof should the competence of the individual ever be challenged. If the individual is on a list, the burden of proof is on the challenger and vice versa.
- Disciplinary Procedures. Each organization has its disciplinary procedures and, in general, there is cooperation among the organizations in the fact-finding stage. Disciplinary action can be private or public and can take the form of a warning, admonition, reprimand, suspension or expulsion.

In addition to the actuarial organizations, the Joint Board for the Enrollment of Actuaries also has its Regulations governing the performance of actuarial services under ERISA and its disciplinary procedures. Since the Joint Board controls the pension actuary's license to practice, it is understandable that pension actuaries are concerned most with Joint Board standards and procedures.

All of the existing organizations have Guides to Professional Conduct and explanatory opinions. The Academy has more explicit Standards of Practice than the other organizations but each has some standards -- sometimes interwoven with the Guides to Professional Conduct.

Several years ago, it was apparently agreed among the then leaders of the actuarial organizations that it would be highly desirable to have identical or nearly identical Guides to Professional Conduct and Practice. A joint committee was created by the Society of Actuaries, the Casualty Actuarial Society, the Academy and the Conference and this committee had the objective of developing statements which could be adopted by the Boards of the various organizations. This approach broke down somewhere around Opinion 3 and it now appears that the organizations will go their own way on Guides and Standards. Will this lead to different standards of conduct and practice for members of the profession depending upon the organizations to which they belong? I think not! I find persuasive the argument that the courts will ultimately set the standards of conduct and practice on a case-by-case basis, looking to the professional codes and standards of the actuarial professions, to actuarial literature, and to common actuarial practice. A corollary to this position is that resignation from an organization to avoid its standards is likely to be ineffective.

It certainly isn't necessary for all of the actuarial organizations to have identical Guides and Standards but to have conflicting standards could create most difficult situations.

I am hopeful that the Boards of the organizations will address the problems of professionalism, both from the viewpoint of their organization and its members and from the viewpoint of the profession as a whole. Failure to do so is likely to lead to standards being imposed by government and by the courts and will hinder our overall objective of being recognized as a true profession by other professions and by our various publics.

MR. GRACE: I think a major problem facing our profession is to improve the way we communicate in two specific areas.

1. The way we communicate to our publics.
2. The way we communicate to our members.

Communication to our publics of course is embodied in the new public relations program outlined by Bill Halvorson this morning. I support this effort completely and I think it is vital that it be successful. I suspect that most actuaries feel as I do that our profession's past efforts in the area of public relations have been miserable failures and it is time we go ahead with an organized plan to provide an effective public relations program for the profession. The plan outlined by Bill Halvorson this morning was put together with the help of a public relations professional. We have needed this kind of help.

I should point out that it will take some time to put this new program into effect and that progress will be slow. But once we get started, the results will be positive and cumulative in effect. Success is a must for the future well being of our profession.

The second communications problem applies more especially to the Academy - we need to improve the way we communicate with our members. Membership communication has been the subject of a special Academy task force for the past year, and a very extensive report was just recently made to the Academy Board.

Fundamental in the findings of this report was the opinion that too many Academy members just do not understand what the Academy is all about. If this is true, and regretfully I believe it is, then we must mount a coordinate campaign to improve our membership communications.

Many helpful suggestions were made in the report to the Board. As the Academy leadership deals with these suggestions, I think many will be implemented. I cannot go into details here because many of the ideas need administrative and financial evaluation but I am convinced we should and will take significant steps to improve the way we communicate with our members.

MR. SCHELBL: The general issues discussed by Robin, Walt and Bill are prominent among the concerns facing the Casualty Actuarial Society; however, most of our issues as I see them are more unique to the CAS.

First of all, we are growing fast; perhaps faster than we can readily accommodate and still provide necessary services to our members with our present organization structure. Despite our 67-year existence, over half of our Fellows have been Fellows for less than five years.

Our organizational structure has been adequate for a 500-member society, but now that we are about to double that amount and then some, we must assess the adequacy of this structure. An ad hoc committee is studying this problem and will make recommendations to our Board of Directors next year.

Traditional loss reserving practices are being challenged. Scapegoats are being sought to blame for high casualty insurance rates that have been generated by our society's attitudes toward monetary entitlement as the solution to righting all wrongs. These scapegoats are the actuaries who deliver the bad news. Our profession is being challenged and at times even scoffed at. It is hard for the public to understand that rates are so strongly dependent on losses that may not have as yet been paid, or for that matter may not have as yet been reported at the time new rates are promulgated. We have a long way to go in educating the public to appreciate the propriety of actuarial concepts.

The issue of casualty loss reserve certification has been with us for the last few years. It probably would not have been much of an issue at all if there had been an ample supply of casualty actuaries to begin with. Realistically, we have conceded that we cannot insist that all qualified loss reserve specialists now be members of our profession, although the time may come well in the future when that may be the solution. In the meantime, we have an issue that must be continually addressed to preserve the need for professional qualifications of those who are trained, tested and experienced in this field, whether members of our Society or not.

The past decade or so has seen changes in the casualty insurance field that have not been noticed by many except those closely related to the pricing of our products. Reliance on rating bureaus as centralized ratemaking authorities has been decreasing in our business. With this, we have seen a greater need for our Society's members to practice on the company or consultant level. Movements are now under way to change laws in some states to remove some of the legal permission for ratemaking in concert for workers compensation - the line in which casualty ratemaking has been the most sophisticated.

Whether this is a good move or not is not for us to argue here. The important thing to note is that such changes represent a discontinuity in our customary way of doing business, in the customary way actuaries provide their services, in the customary way actuaries relate to each other and, most importantly, in the customary data bases and data analyses with which we have become familiar. These changes are issues that challenge our profession.

MR. GRACE: Where have things gone well?

MR. LECKIE: During the 1970's a great deal of time and effort went into proposals for reorganization of the actuarial profession in North America. The process was undoubtedly necessary, but unfortunately was frustrating and met with a notable lack of success. For the last few years, our efforts have been directed more to the strengthening of our individual organizations, while at the same time, cooperating with other organizations and coordinating efforts wherever possible. Two highly visible interorganizational successes have been AERF and the Council of Presidents. We also have our joint committees, all of which have achieved considerable success this past year. For example, the Joint Committee on Pension Terminology has brought in revised terminology accepted by all actuarial organizations. The Joint Committee on Public Relations has produced a coordinated public relations plan. The Joint Committee on Operational Economics is coordinating a number of inter-organizational functions.

Panels such as this one and the similar panels we had at Anaheim and Ottawa, together with joint sessions at local actuarial clubs have also enhanced a spirit of cooperation.

The Academy's planning process has started us all looking carefully at our organizational missions. This has also been carried on with a spirit of cooperation and understanding and should help to indicate our future direction.

MR. FERGUSON: One example where things have gone well is the annual meeting for Enrolled Actuaries. I am particularly interested in this success story because the meeting is jointly sponsored by the Conference and the Academy and because I had a hand in getting these meetings started -- as chairman of an Academy Task Force in 1965. There were nearly 700 (684) people at the first meeting in 1976 and nearly 1000 (977) at the 1981 meeting -- and that represents about one-third of all enrolled actuaries. The meeting programs reflect the interest of EA's as determined by survey and are designed for both the beginner (the program includes three hour learning sessions) and the most experienced actuary (problem solving clinics - "think tank" type sessions). It is the largest and most comprehensive meeting for pension actuaries in the United States.

MR. SCHEIBL: It seems odd, but no one has ever written a textbook on casualty actuarial principles. Our Board has agreed that a textbook of the survey type should be prepared through the sponsorship of our Society and the contracting of a principle author. This might be viewed as an accomplishment at this point. Now all we have to do is to make sure the textbook is written.

Over the last few years, we have made great strides in providing for the continuing education of our members. We have had an annual program in the spring in which we have called for papers on specific subjects. These have been quite useful and have provided us with bound volumes of specialized material. The 1981 call for papers on inflation implications on property casualty insurance was successful and the response to the 1982 call for papers on pricing the large risk has been encouraging.

We are also providing more seminars than we have in the past and they have been well attended. This year's seminars concentrated on risk classification and, in conjunction with the American Academy, a seminar was held on casualty loss reserves. These both were quite successful and plans for continuing these types of programs are under way.

We have also successfully launched a program for providing basic refresher courses at our meetings for members who tend to specialize in other areas. Such a program has been appreciated and well received.

We have recognized the need for members to get together in special interest groups and have therefore adopted a program similar to the Society of Actuaries' program on sections.

Finally, we have recognized that more of our members have and will continue to remember the CAS in their wills. A survey has been made of the projects that may be selected as memorials depending on the size of bequests. We hope to wrap this up at our November Board meeting.

MR. GRACE: From the Academy viewpoint, I have seen in the last year or two a notable improvement in the effectiveness of the Academy's public interface activities.

One of the highlights this year, of course, was our testimony in Washington in the area of risk classification. One of the purposes of the Academy is to make authoritative statements on issues within the special competence of actuaries. Our testimony on H.R.100 was in response to a congressional request to study the impact of the bill on those affected. Clearly, here was a need for the profession to speak with one voice. And we did speak with one voice. Implications from the standpoint of casualty actuaries, life actuaries, health actuaries and pension actuaries were presented in one well documented, hard hitting report to congressional people. This was a major project for our Risk Classification Committee, it had a very definite impact. The public interest has been well served by making this report available.

Other key activities at the federal level included testimony on Social Security and a number of activities in the health insurance area.

The Academy has also had increased contacts at the NAIC level all across the insurance scene - in life insurance, in health insurance and in property and liability insurance.

The Academy has also increased its visibility with the accounting profession, both with continuing contact with the AICPA and with newly established contacts with the Financial Accounting Standards Board. In the latter case the Academy testified at a public hearing on the FASB's discussion memorandum on accounting for pension costs.

All in all it has been a busy year and I think very successful from the standpoint of having the profession provide authoritative input over a broad range of activities within the interests of actuaries.

Let us move to the next question, Jerry. This year, where have things not gone so well?

MR. SCHEIBL: A truly professional society must develop standards for professional conduct and an efficient disciplinary machine. Despite all of the discussion and work that has gone into these areas within the last few years and with all due respect for those that have given freely of their time and energies, we still have a long way to go.

We are still at the point where we are crossing t's and dotting i's in developing guides for professional conduct and, because of this, these guides may not be received by our members as the warnings they are intended to be.

Also, our disciplinary system leaves much to be desired as far as timeliness of proceedings and acting as an effective deterrent to nonprofessional acts. We have no centralized disciplinary body in our multisociety structure and, therefore, we run the risks of inconsistent conclusions and inconsistent disciplinary actions based on the same evidence.

We have done little to improve this situation in the past year.

MR. FERGUSON: I am discomfited by the growing tendency of the actuarial organizations to "go their own way."

For some time, especially since the members of the Society of Actuaries rejected merger with the Fraternal Actuarial Association, it has generally been conceded that reorganization of the actuarial profession is "out" and that cooperation among the actuarial organizations is "in".

Perhaps we lose sight of our needs when we talk of reorganization and the profession. It is not reorganization -- it is organization. Remember we are a profession of only 10,000 members, counting generously, and it is important that we use our resources efficiently -- to minimize redundant activities with other actuarial organizations and to maximize our external efforts with government, the other professions and the public.

I have two suggestions. The first is to encourage individuals who are active in the profession to be active in each of the organizations to which they belong -- whether at the officer, board or committee level. The second suggestion is to expand the role of the Council of Presidents -- perhaps to convert it into "The Actuarial Council in America".

MR. LECKIE: I believe there is an unfortunate element of complacency among many of our members. Dynamic changes are or should be taking place in our profession and some members do not seem to want to be involved. And also because we happen to be analytical, we tend to develop individual rather than collective solutions. Associated with this problem - and certainly a difficulty in the Society of Actuaries - is identifying and coordinating and utilizing all of the skills of our members in the areas on committees where a need exists. We have not been very effective at matching volunteers with committee requirements.

I do not wish to imply that members are not willing to do the work of the profession - quite the contrary, we have had no trouble having members devote much time and effort, often at their own personal expense, for the advancement of our profession. But there is still an element of apathy by many individuals, which is difficult to overcome. Incidentally, I am preaching to the wrong group here, my remarks are intended for those who chose not to come.

MR. GRACE: I am going to elaborate on the concern expressed by Robin Leckie but especially from the standpoint of the Academy. We do not do a good job at all of identifying and selecting new volunteers to bring into the Academy committee structure.

Part of the problem can be solved by better communications to our members, as I mentioned earlier. Many members do not understand Academy activities; if more of them did, some of them might be interested in volunteering to help. But another part of the problem is the lack of an effective mechanism for matching needs with people.

Ours is basically a volunteer effort. We have a small and very effective Washington staff, but basically it's the 400 or so volunteers that makes the Academy tick. I believe the Academy leadership and committee chairmen need to work together on this problem. We need to bring in a continual stream of younger people, with their energy and fresh ideas. We need to have a method of identifying aptitudes and interests of a new volunteer and then placing him in a spot for which he is well fitted.

I do not know what the solution is, but maybe we need a Committee on Staffing; maybe some new initiatives on the part of our Washington staff. Whatever the solution, it is a problem I leave in the capable hands of Bill Halvorson and Adger Williams.

Our next question is where is the profession going from here? Jerry?

MR. SCHEIBL: While we have made great strides in tying together the pieces of the actuarial profession in North America, I think we still have a long way to go.

The Casualty Actuarial Society Board of Directors has a continuing dialogue with its Long Range Planning Committee on what the role of the CAS should be. The American Academy has just completed its draft on defining its purpose. Undoubtedly, the other societies are or will be doing this too at sometime or another in the future.

Each time we carve out a niche independently, we stand to affect the delicate balance of relationships the North American societies have built with each other. This is not necessarily bad, as each society perceives threats and opportunities to its specialty areas from its own viewpoint and must deal with them accordingly.

The threats to the casualty segment of the actuarial profession are very real today. They come from the many new opportunities that are surfacing for consultation and technical assistance in casualty actuarial matters.

Both members and nonmembers of our various actuarial societies are looking to provide this assistance. Some are qualified to do so - some are not. Worse yet are those who think they are qualified but are not. Poor service, poor advice to a client on the part of one who calls himself a qualified casualty actuary - or even hints at such qualifications - reflects on the integrity of the entire profession. It is a matter of assuring that those clients who pay for actuarial advice get their money's worth.

So I think it will not be too long before we again sit down to discuss reorganization of our profession. We have done it twice within the last 10 or 15 years and we are bound to do it again. We probably will not merge, but as happened after the other discussions, we will move closer to unifying the profession and agreeing on the price we have to pay to do so.

MR. LECKIE: Organizationally, we will continue on the track currently taken, that is, planning and strengthening our individual organizations while cooperating in the general interest of the total profession. I believe this is a sound policy for the present, but as I noted in my Society Presidential Address, the long-term course will call for some further rationalization of our profession in North America. I believe we are addressing the issues of today and knocking heads together in the spirit of cooperation, but the system itself is not ideal and will continue to present difficulties in the years ahead.

I am concerned about the lack of a common acceptable standard for identifying an actuary. Our current actuarial qualifications must be very confusing to students and it is hard to blame those who take the easiest qualification route. It must also be confusing to the recipients of actuarial services. The nature of our economy today establishes an increasing need for the discipline of our profession. But the nature of the profession is changing as the relative weights of the risks we encounter change. For example, mortality is a decreasing risk while income expectations are an increasing risk.

The profession is becoming more professional and there is increasing reliance on the judgment of actuaries, particularly noticeable outside the United States, but with increasing emphasis within the United States as well.

There will be no shortage of challenges and opportunities for actuaries in the future.

MR. FERGUSON: Organizationally, I expect there will be several actuarial organizations, each with a slightly different objective and purpose. The first actuarial organization was the Institute of Actuaries in England which was formed in 1848. The Faculty of Actuaries was formed in Scotland in 1856, eight years later. In the United States, the Actuarial Society of America was formed in 1889 and the American Institute of Actuaries in 1909 -- that's 20 years later. In 1949, the two American organizations were merged to form the Society of Actuaries and the Conference of Actuaries was formed in 1950 -- one year later. The American Academy of Actuaries was formed in 1965 and the American Society of Pension Actuaries was formed in 1966, also one year later. At the present time, there is currently under discussion the formation of at least two new actuarial groups -- Actuaries in Regulation and the Society of Government Actuaries. The point in reciting

this history is to emphasize the unlikelihood that a single organization will ever represent the actuarial profession in the United States -- and if reorganization into one organization is ever achieved, it is unlikely to last. If we are to have several actuarial organizations, it is important that they cooperate and support each other as opposed to working competitively -- to minimize redundancies, to maximize our external efforts with government, with the other professions and with the public. I have confidence that this will happen.

The recent past has seen several changes in the profession:

- . Consolidation within the insurance industry has led to fewer actuaries being needed to perform the necessary tasks.
- . Computers now do routinely the tasks which were previously thought to be intricate actuarial calculations.
- . The market for benefit consulting has matured.
- . The number of opportunities for employment in government has increased.
- . The property and casualty field has created opportunities both with the insurance companies and in consulting.

This pattern of change will continue and it is important to the future of the actuarial profession that its members and its leaders expect change and, in fact, aggressively work to make change -- by demonstrating capabilities in fields not traditionally associated with actuarial work. To do this effectively, we need to change our own attitudes about our capabilities so that we will confidently present ourselves to our publics as the profession with the ability to solve problems with long-term influence. I am confident that this also will happen.

MR. GRACE: I believe it is inevitable that our profession will become more of a public profession. The number of our members in independent consulting work continues to grow, and actuaries in private employment have to deal more and more with issues that impact the public. Actuaries do mysterious things in their work, but their end results must be in the best interest of the public. The public has every right to demand this.

We have talked earlier this morning about a new public relations program. Later this morning we will talk about the Academy Long Range Planning report and how it is leading us toward a clearer understanding of the roles of our respective organizations and of the overall needs of our profession.

Where are we going? Let me project, if I may, to the year 2000. That's only 18 years away, but the Academy will then be a healthy 35 years old. What will the profession look like then?

To make this projection, I must make some assumptions:

1. Organizational structure. I assume that by the year 2000, the matter of organizational structure will have been long since

settled. Whether one organization remains or whether we have two, three or four is almost unimportant for my assumption. The important point is that the profession has agreed on what must be done and it is getting these things done as a unified profession with a common purpose and with no duplicative effort.

2. Public relations. As a result of a public relations program started in 1982, and continuing throughout the years, by the year 2000 the general public will have a far clearer image of the actuary.
3. Legal recognition of the Actuary. In the 1980's actuarial opinions may be required by the NAIC for statement of Health Service Corporations and for HMO's. Other government required actuarial opinions, as yet unidentified, may also be added by the year 2000.
4. Standards of Conduct and Practice. Pressure, both internal and external, will continue through the 1980's and 1990's for us to refine our self-regulatory process. I would like to assume we do this in an orderly and deliberative manner, for example, without interference from governmental agencies that might come if we had some kind of professional conduct scandal in the profession.

Those are my assumptions. They are optimistic assumptions, but still quite reasonable. What will our profession look like?

1. Our profession will be quite a bit larger in size than our current 10,000 members. At least double, maybe triple our current size.
2. Some of the increased size will be due to the fact that actuaries have taken on broadened responsibilities. For example, in insurance companies actuaries will be much more involved in investments, the natural result of concern with asset immunization along product lines. There are a number of other areas where actuaries are expanding their scope of activities.
3. Increased public involvement will lead to more actuaries being involved in government.
4. The paid professional staff will be much larger than it is currently. Notable in the increased staff will be a number of actuaries involved in purely professional activities; professional conduct, standards of practice and discipline.
5. Our self-regulatory process will be more fully developed and more useful to our members. Actuaries will continue to perform their duties having the public interest in the forefront.
6. Activities in research and continuing education will provide overall better informed actuaries who have available more sophisticated techniques to solve their problems.

7. Finally, the profession will continue to depend on volunteers. Service to the profession will be even more important than it is today to the individual and to the organization. Input will be received from a larger percentage of our membership than is the case today. We will be stronger because of that.

Well, there is my picture of the future. I think it will happen as long as we continue to work together as a unified profession.

MR. GRACE: Thus ends this panel of the four presidents who have worked together this year. Thank you Bill, Robin and Jerry for your participation today. Thank you for your *strong support of the Academy*. We have covered a lot of ground. We have enjoyed working together.

We know we are leaving a lot of challenges to our successors. It is time for them to bring their new ideas to bear on our profession's problems. They surely have our support and our best wishes for success.

CONCURRENT SESSION HEALTH INSURANCE

Moderator: WILBUR H. ODELL. Panelists: E. PAUL BARNHARDT, STEPHEN D. BRINK,
ROBERT H. DOBSON, HARRY L. SUTTON, JR.

Academy activities on:

1. Valuation standards
2. Rate and loss ratio regulation
3. Health and welfare plans
4. HMOs
5. National health policy issues
6. Actuarial statements of opinion
7. Qualifications of health insurance actuaries

MR. W. H. ODELL: Especially during the last two years we have seen sweeping changes in attitudes to health care delivery systems, the health insurance mechanism, and alternative methods of financing health care. Many of these developments are of vital interest to actuaries. You have read about some of these in the Academy's Newsletter.

Your panel are members of the Committee on Health Insurance. The committee seeks to assure that problems of concern to health insurance actuaries are addressed, assure that health actuaries receive the support they need from the rest of the profession, make the public aware of what health actuaries can do, and make available the expertise of health actuaries to governments and other publics.

Paul Barnhardt, Steve Brink, Harry Sutton and Bob Dobson will present to you information about some of the current issues which are of most concern to health actuaries. They will place special emphasis on how these developments impact on the role of actuaries and the constructive role which actuaries are playing through your Academy in meeting the challenges inherent to the public as well as our profession in these developments. We will particularly look forward to not only your questions, but also comments and suggestions as to what additional action actuaries through your Academy can be taking on these important issues.

Paul Barnhardt will bring you up to date on developments in the area of valuation standards and also in the area of rate and loss ratio regulation. Notice that this second question, dealing with rate and loss ratio regulation, involves not only state jurisdictions, but also the federal jurisdiction as evidenced by the Baucus Amendment which Paul will tell you about.

MR. E. PAUL BARNHARDT: I might just say a few words about the functioning of my particular subcommittee. I am chairman of the subcommittee of the Academy Health Insurance Committee which deals with liaison with the NAIC and with the state insurance departments. We do not get involved ourselves in major study projects or major research work in connection with this liaison with the NAIC. Instead, we serve as a kind of referral and review

subcommittee on behalf of the actuarial profession. One of our important functions may simply be to refer a request of the NAIC to what we regard as the appropriate organization or committee to handle that particular request. We have referred some of the requests of the NAIC to the Society of Actuaries, for example. Some have been referred to the HIAA. So, depending on the nature of what is being asked for by the NAIC, one of our functions is simply to serve as a kind of actuarial clearing house and try to see that it gets to the right people to do the job properly.

That leads me into the first area that I want to talk about briefly, which is the question of A&H valuation standards. In the past, the NAIC has asked really for an updating of almost all statutory valuation standards with regard to individual health insurance and to some extent in the group area -- for example, group LTD disability claim valuation. In response to these requests from the NAIC, two special committees of the Society of Actuaries have been created and the request for the formation of those committees came through our particular subcommittee. Now one of those is a Society Committee that is concerned with the determination of new valuation standards for disability insurance, both active life or policy reserves in the individual health area and claim reserves in both individual and group disability. That committee has been working very hard on this project for a couple of years already. There is a lot to do and the committee is attempting to define what the parameters are that affect disability continuance. They have been doing a lot of work on the considerable amount of data that they have been able to collect. Our function in relation to this, in addition to the referral task, is simply to provide a certain amount of comment and opinion and review for the benefit of the NAIC groups that are interested in these projects. The second one, which again involves a special committee of the Society of Actuaries that was set up in response to the request, is the work being done by the Society's Committee on Accident and Health Valuation Principles. This is a more fundamental type of project where the Society Committee in this case is considering the whole field of accident and health valuation from the standpoint of what new techniques and what new philosophies might be applied. One specific area of accident and health valuation that is of particular interest and concern here is Major and Comprehensive Medical insurance. There never has been a really specific valuation standard in effect on coverage of that kind. One of the things this committee is giving attention to is how does one really go about establishing some kind of standard, regulatory standard, for the valuation of that kind of coverage where the effects of inflation, the variety of benefits in effect vary so enormously from time to time, and in regions of the country, and from one plan to another -- how do you deal with this kind of immense variety in attempting to establish some kind of regulatory guidelines or standards. Now this committee has prepared a draft report on accident and health valuation principles. The Board of Governors of the Society in its meeting just before this Annual Meeting has approved the release of that report on an exposure basis. It is in the form of a draft report and will be released on an exposure basis for comment from the actuarial profession. So that is the stage to which that has evolved.

The one other area of valuation standards that has been dealt with in the last several years has been in the area of the more basic coverages of hospital and surgical insurance. New standards are now in effect and have

been for a couple of years in the area of hospital insurance, surgical insurance, etc.

Another area which our committee is not really working with, but which is also under way, is the development of valuation standards for cancer insurance. There is a special technical advisory committee working in the area, of which Bill Odell here happens to be the chairman, and this special committee is working on the problem of establishing standards of valuation for cancer coverage.

Now to get briefly to the area of rate filing and loss ratio regulation. This is another area that the profession has been very much interested in, and to which our committee has been trying to provide some input and direction. There are now pending before committees of the NAIC revisions to the Accident and Health Rate Filing Guidelines that were first promulgated by the NAIC about two years ago. As companies and regulators have attempted to work with those guidelines, it has become clearer that there are certain shortcomings and certain things that needed further attention and some revision. At the present time, some proposed revisions in these Accident and Health Rate Filing Guidelines are pending with the committees of the NAIC that are concerned with this area. We have been attempting to provide some professional input and review on that problem.

In addition to that, as Bill mentioned, we now have before us, for the first time in regulatory history, federal guidelines that have to do with loss ratios and with rate filing. This comes about because of the passage of the Baucus Amendment. In this case, the federal government, through the Baucus Amendment, is in the process of establishing regulations relating to Medicare Supplement coverage. Coverage that is intended to meet the requirements of the Baucus Amendment involves the filing of actuarial documents with the federal government, justifying anticipated loss ratios which are expected to be 60% in the case of individual Medicare Supplement coverage. Several drafts have been prepared of those federal regulations which the Academy Health Insurance Committee has had the opportunity to review and has had some influence in modifying some of the original drafting of those federal guidelines. So we do have this interesting development before us that for the first time, the federal government is involved in the question of loss ratio guidelines and rate filing with respect to individual health insurance.

The only other point that I want to just briefly mention is that our committee also attempts to handle any other kinds of problems or requests or inquiries that come from the NAIC, or that are suggested to the NAIC from the profession that have to do with the actuarial aspects of state regulation. For example, we try to provide changes in the annual statement blank that involve actuarial matters. We try to provide some input in those areas as they come along from time to time and anything at all where we can serve the actuarial profession or serve the public or serve the total health industry, we try to provide that contact and interface on behalf of the entire actuarial profession.

MR. ODELL: The activities of Paul's group cover a wide waterfront and this is part of our effort to use the expertise of the actuaries to good

advantage in the public's sphere, working with regulators to at least provide some assurance that we will have reasonably well thought-out regulation.

MR. STEPHEN D. BRINK: I would like to give you a brief update on the Academy's activities in regards to health and welfare plans. Maybe update is not quite correct, since in the past the Academy's activities in this area have been quite limited. But that role is changing.

Currently the Academy is developing discussion memorandums on actuarial principles and practices for use with employee benefit plans. Two separate memorandums are in process, one dealing with pre-retirement benefits and the other on post-retirement health benefits. Post-retirement health benefits are treated separately because these plans involve issues of advance funding, somewhat like pension plans.

It may be helpful to review the reasons behind the development of these discussion memorandums. First, let us focus on pre-retirement health benefit plans.

Over the last decade, there has been a rapid expansion in the use of alternate financing and risk sharing arrangements for health and welfare plans. Ten years ago, the vast majority of these plans were insured. However, today approximately 25% of all health benefits are provided through self-funded plans. This shift to non-traditional arrangements has produced a fundamental change in the financing and risk sharing of health and welfare plans and is likely to continue.

Because of the rapid expansion of non-traditional arrangements, we believe many plan sponsors are not properly recognizing their liabilities and costs. Where liabilities and costs are recognized, diverse practices exist, not always consistent with sound actuarial principles.

The accounting profession provides some guidance on generally accepted accounting principles for health and welfare funds, not sponsors, through their 1972 industry audit guide, Audits of Employee Health and Welfare Funds. Early in 1980 the American Institute of Certified Public Accountants (AICPA) sent out an exposure draft of a reviewed audit guide for audits of employee benefit plans. The Academy was asked to submit comments, which it did. To some extent these comments were reflected in the AICPA's exposure draft. After that time, the Academy indicated that parts of the audit guide needed substantial reorganization and greater depth in certain subjects.

After numerous attempts, the Academy was not able to arrange a meeting with the members of the AICPA Committee. We later learned that no further work on the proposed audit guide would be done, but that a position paper would be prepared on the subject. Subsequently, on March 18, 1981, the AICPA presented an issues paper on health and welfare plans to the Financial Accounting Standards Board (FASB) for consideration. We are not aware of any subsequent activity regarding this issues paper.

Another reason for the development of the discussion memorandum, is that actuarial literature is relatively sparse regarding actuarial principles

and practices for health and welfare plans. The Academy's Financial Reporting Recommendations and Interpretations generally involve life and casualty insurance company practices, while Pension Plan Recommendations and Interpretations are obviously limited to pension plans.

Finally, the costs of health and welfare benefit programs have increased significantly in recent years due to inflation and changes in general economic conditions. Dollars spent on health and welfare employee benefit programs now exceed amounts spent on pension plans according to the 1979 Employee Benefit Survey prepared by the U.S. Chamber of Commerce. Moreover, these costs are rising faster than pension costs and the overall cost of living. You can almost bet that these rising costs will receive greater attention in future years.

The concerns surrounding post-retirement health benefits are generally the same as for pre-retirement benefits. That is, there has been an increase in self-funded plans, plan sponsors not properly recognizing their costs, few accounting guides, sparse actuarial literature, and rising costs. However, post-retirement health plans raise the question as to whether the costs of these plans should be recognized over the working lifetimes of the employees. There appears to be some reluctance on the part of sponsors, and their accountants, to recognize the long range implications of continuing health benefits to retired persons.

From an actuarial standpoint it seems reasonable that where a plan sponsor undertakes and communicates a long term commitment to provide post-retirement health benefits, he creates an obligation. Even though the nature of that obligation varies, it seems that some obligations are permanent enough to warrant advance cost recognition.

On February 19, 1981, the FASB issued a discussion memorandum on employers' accounting for pensions and other post-employment benefits. The Academy made a formal response through the Pension Accounting Subcommittee. Public hearings were held in July, and I understand that an updated discussion memorandum should be issued in early '82, followed by more public hearings and a final statement in 1983. Meanwhile, the Academy has continued its work developing a discussion memorandum, along with a number of examples of likely costs based on a range of reasonable assumptions.

Each of these discussion drafts attempts to outline these problems, as viewed by the actuarial profession -- the nature of the plan sponsor's obligation, how costs and liabilities should be recognized, and procedures used in estimating costs and liabilities.

The purpose in preparing discussion memorandums, of course, is to provide the first step in the development of a published opinion. Another primary objective is to have a reference document by which to communicate with the accounting profession and other interested publics. We want to be in a position to accurately state our views and encourage the accounting profession to properly recognize the costs of health plans.

As you can tell, the objective of the Academy is to stay ahead of these issues and to shape policy rather than reacting to it. We would all appreciate your input.

MR. HARRY L. SUTTON, JR.: It is a pleasure to be with you all here today. Bill Odell has asked me to discuss two questions. The first relates to the Academy's activity related to HMOs and the second relates to our involvement in current trends in national health care policy.

First, a few words about the HMO. As many of you are aware, we are in a period of dramatic change in the HMO area. Federal impetus, which began in 1970, was buttressed by the HMO Act of 1973, and has resulted in grants of about \$100 million since then, with federal loans in the area of \$300 to \$400 million by the time all commitments are made. We will be winding down sharply during the next several years. Unless something changes, the grant program will cease by the end of 1982. Federal activity will consist of monitoring compliance with federal standards, continuing committed loan disbursements, quality review, personnel/management training and possibly reviewing HMO programs for additional loan funds. Participation in the HMO movement by insurance companies and Blue Cross/Blue Shield plans has been varied and it is not clear whether significant increased commitments will develop in the near future.

As far as the independent HMOs are concerned, they are certainly impacted by the same disastrous inflationary trends that have hit insurance companies and Blue Cross/Blue Shield plans, unfortunately often without the financial resources to withstand them. As with any new industry, management capability and development of talented personnel sometimes have been lacking. During the past year, several important elements relative to the Academy have involved the HMO movement. I will not discuss the certification of HMO statements by actuaries nor, except in passing, the qualification of health insurance actuaries as it may relate to HMO personnel. These subjects will be covered by Bob Dobson.

Over the last two years there have been approximately ten bankruptcies in the HMO field, a few of which have left large outstanding debts, with hospitals and physicians billing individual employees, or seeking reimbursement by employers. While state insurance departments, or other jurisdictional authorities, may have assumed that federal regulation would provide adequate direction and protection, they have been disappointed. Consequently an HMO Task Force of the NAIC, with an industry committee set up by the HMO trade associations and others have been meeting to set up mandatory capital and surplus requirements and reserve requirements to try to minimize any potential losses to enrolling members of HMOs. Academy members have been participating in monitoring these results. It is expected that a final model bill will be approved by the Commissioners late this year and that the NAIC Committee will cease existence. The recommendations try to be as favorable as possible, to promote competition in health care delivery, while providing some minimum protection to subscribers if the plan should terminate operations. The direction is to promote hold-harmless provider contracts with the HMO, in order to minimize surplus or capital requirements. Because of past bankruptcies, several states have enacted statutes that are substantially more onerous than any proposed NAIC bill. The unfortunate effect of these, while protecting the public, is to set capital requirements high enough that only a large corporation could afford to enter the business at a given location. The likely entrants will be possible branches of existing HMOs with capital, insurance carriers or Blue Cross/Blue Shield plans, occasional large employers or consortiums who are willing to invest capital in setting

up a specific prepaid health plan for an area. Probably capital requirements are minimum for existing large multiple specialty groups; doubtless a number of these may set up an umbrella whereby they will go into business in their local area.

For those of you who follow the HMO business, you may be aware that the HMO Amendments of 1981 permit so-called "actuarial rating." This means that instead of the traditional community rating system (all rates should be identical for all employers, or that premium revenue per person enrolled should be constant) prospective rates might be set on a basis similar to insurance carrier manual rates. The federal government calls it the "Actuarial Relief Act of 1981." The Academy has indicated to the Department of Health & Human Services that actuarial expertise seems to be an absolute necessity to vary rates by cells, where differences of utilization or cost can be demonstrated by some type of data. In connection with this, we have suggested upgrading training programs for HMO personnel in the financial and actuarial area, encouraging actuarial background among HMO personnel and suggesting that they may wish to consider the course of study and interim examinations being prepared by the Academy for Service Plan personnel. Also, we have recommended that educational programs being developed by the trade associations and the federal government should include adequate attention to actuarial aspects. We have pointed out that the proposed new Health Section of the Society of Actuaries, with a possible health care examination track, should be followed closely for the training of HMO personnel.

We think that various areas of the federal government have recognized the need for actuarial expertise in the HMO rate development and budgets, approval of rate structures, reserves and other aspects of prepaid health care programs. Also, FASB is stirring up the subject of accounting rules for HMO -- but moving very slowly. The Academy is monitoring this development.

The second subject Bill has asked me to talk about relates to national health policy issues. Even with the last Democratic administration, and particularly with the new administration, it seems as if any real impetus for a national health insurance program (particularly of the Kennedy type) is a dead issue for some years. In the short run, various additional efforts at regulatory control of cost in the health care field also appear dead --- although the current inflationary trend in hospital and other costs may cause a second look at this by the administration. The current approach being considered by the Reagan administration to control health care costs is encouragement of "real competition" in the health care field. Essentially this means promoting benefit plans with cost-sharing or multiple options; promoting or mandating choices to the employee among competing health plans; encouraging preferred provider plans with publication of consumer price information in a meaningful way; encouraging rebate plans which would encourage decreased utilization of medical services through financial incentives. I am sure that you who have reviewed these bills, as well as the Academy Committee, have sensed a great over-simplification of the issues with inadequate attention to the possibilities for selection and confusion in the health insurance marketplace, if the bills were to become law. In addition to the regular employer market, the federal government is very interested in having insurance carriers aggressively seek out Medicare or Medicaid eligibles to

replace the existing federally financed program. This might be on a multiple-choice basis.

The Academy's Health Committee reviewed the text of a number of well known bills and prepared a brief testimony which was presented by Bill Odell, John Cookson and me before a House Committee holding hearings recently. We tried to present the testimony on the basis of technical expertise to avoid political issues. We offered to provide actuarial assistance to Congress or others in reviewing proposals. We kept our presentation brief and covered five points:

1. We agreed that promotion of health benefit plans with cost sharing and deductibles would result in some lower utilization of services and decreased cost. Decreased utilization should have some pressure on inflation.
2. We pointed out the severe problems of equity in setting a dollar cap on employer contributions to health benefit plans. We discussed only the complexity and not desirability.
3. We discussed the potential anti-selection aspects of requiring multiple health benefit options, in particular, low options with rebates.
4. We discussed the difficulty in evaluation of risk and possible cost-shifting to older or sicker employees in the event of requiring multiple plan options.
5. We commented on the difficulty of setting rates for multiple plans for the same employer, the additional administrative cost, and the likely increased premium margins that would be required by competing carriers.

We mentioned the Academy's interest in the financial reporting requirements of self-insured trusts.

The administration's competition bills have not yet been published or discussed, but it is clear that further attention will be given to competition, multiple choices or any other method possible to reduce federal costs in the health care area. The Academy's Committee on Health will undoubtedly have much to review during the next several years, as this area develops further. If there are any questions, I would be happy to discuss them as the presentations are completed.

MR. ROBERT H. DOBSON: My subjects are actuarial statements of opinion and qualifications of health insurance actuaries. It may not be immediately obvious how these two are related but they are both subjects that I have been involved in to varying degrees over the last several years. It dates back to a committee that I chaired which was established some two years ago at the annual Society meeting in Miami. This committee was a Technical Advisory Committee and was an industry committee rather than an actuarial committee, though most of the members were actuaries.

The hierarchy of the different committees involved in both of these subjects gets pretty confusing, so my first slide is intended to clarify some of this confusion.

Slide No. 1: NAIC C-4 - Alias Technical Subcommittee
 - Alias ?
 Technical Advisory Committee

AAA Health Committee
 NAIC Liaison Subcommittee
 Qualifications Subcommittee

AAA Health Qualifications Committee

The NAIC C-4 Committee, which has been mentioned earlier, I show here as "alias" Technical Subcommittee, because at the time they formed the Technical Advisory Committee that I chaired they were called the Technical Subcommittee. Then the name was changed to the NAIC C-4, then it was eliminated completely, and now it is being reformed. We do not know what the name of it will be. That is the question mark here. I attended part of their meeting Sunday, but they went into executive session to discuss future plans and structure. I understand they are calling themselves the Actuarial Task Force to the B Health Committee.

Anyway, I chaired a Technical Advisory Committee which reported to this committee of many names - the subject of which was reserve requirements for hospital and medical service corporations. It was defined such that it included health maintenance organizations in addition to Blue Cross and Blue Shield Plans and similar organizations.

We completed our report in January, 1981. The report was intended to be a guide to regulators and while the main thrust was surplus requirements for these types of organizations, we emphasized, and this is a quote from the cover letter to the report, that "regulators are currently facing very serious and difficult questions in the regulation of hospital and medical service corporations. While the questions concerning Blue Cross and Blue Shield Plans may appear to be different from those concerning health maintenance organizations, we urge consistent regulation of the two types of corporations which are actually quite similar. Our conclusions and recommendations refer only to the generic term hospital and medical service corporations but they apply to Blue Cross and Blue Shield Plans and health maintenance organizations."

At the time, the regulation of Blue Cross and Blue Shield Plans was primarily aimed at preventing them from accumulating too much surplus while the regulation of HMOs, because of the insolvencies that Harry has referred to earlier, was aimed at preventing insolvency and requiring some minimum surplus level. Since then some Blue Cross and Blue Shield Plans have been experiencing financial trouble, largely, I might add, from regulation designed to keep them from accumulating sufficient surplus.

The recommendations of this Technical Advisory Committee largely center on the fact that the appropriate surplus for any corporation must be based on the particular risk characteristics of that corporation. Primarily, however, we emphasize that additional actuarial involvement would be where we would look if we had the same problems that the regulators do. Because of this our first recommendation called for a statement of opinion from a qualified actuary in connection with the statutory financial statements. This is the recommendation shown on the slide here.

Slide No. 2:

TAC Recommendation #1

A Statement of Opinion from a qualified actuary should be required in connection with the statutory financial statements filed by corporations. This statement should relate to the Liability for Unpaid Claims, Provision for Experience Rating Refunds, and any other actuarial items appropriate for the financial statement.

Our second recommendation called for a rate filing including an actuarial certification when the corporation's contingency reserves fall outside of an acceptable range defined for the particular corporation.

Slide No. 3:

TAC Recommendation #2

Rate Filing including an Actuarial Certification, as well as budget and other financial projections, should be required when a corporation's contingency reserves fall outside of an acceptable range defined for the particular corporation.

This means, for example, that if for a particular corporation, the Plan had agreed with the State regulator that an appropriate surplus range was from, say, 10 to 20% of premium, rate filings would be required if surplus got above 20% or below 10%.

It was basically from the recommendations of this Technical Advisory Committee that the Academy's health committee got involved in drafting what would be required statements of actuarial opinion for financial statements for the NAIC group currently called -- well, we do not know. Paul Barnhardt's subcommittee is charged with NAIC liaison and he spearheaded the actual preparation of these statements of opinion. There are actually separate special blanks for Blue Cross Plans and for HMOs, though the regulation and requirements on blank filings vary significantly from state to state. Some of the organizations file the casualty blanks. Some file the regular life and health blank. Of course, both of these blanks require actuarial statements of opinion currently, so we are improving consistency with the similar requirement for the Blue Cross blank and the HMO blank. Paul's draft was adopted by the NAIC group Sunday as an exposure draft. The next slide shows the items that will be included as a minimum in the Blue Cross statement of actuarial opinion.

Slide No. 4:

Blues Statement of Actuarial Opinion

The list should include but not necessarily be limited to:

- (i) Claims Unpaid (Page 3, Item 1)
- (ii) Provision for Deferred Maternity Benefits
(Page 3, Item 2)
- (iii) Provision for Experience Rating Refunds (Page 3, Items 9A)
- (iv) Other Liabilities (Page 3, Item 10)
(Opinion, Under This Item, with Respect to Actuarial Liabilities, if any)
- (v) Premium items, such as Receivables, Due and Unpaid, Unearned, and Paid in Advance as they may relate to actuarial items.

The HMO list is similar but doesn't have the page references because they do have a different blank.

Slide No. 5: HMO Statement of Actuarial Opinion

The list should include but not necessarily be limited to:

- (i) Claims Unpaid (Reported and Unreported)
- (ii) Provision for Deferred Maternity Benefits, if any
- (iii) Other Actuarial Liabilities
- (iv) Due items, such as Receivables, Due and Unpaid, Unearned, and Paid in Advance as they may relate to actuarial items

Finally, the definition of an actuary that would be included in the instruction to the annual statement requiring these actuarial statements of opinion would be as follows:

Slide No. 6:

"Qualified Health Service Corporation Actuary", as used herein, means a member in good standing of the American Academy of Actuaries or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation.

And it is that last phrase that leads into my second subject which is the Qualification Committee.

Now refer back to the first slide. I started out talking about the Technical Advisory Committee that reported to the NAIC C-4 group. I mentioned that there was an NAIC liaison subcommittee of the Academy health committee. There is also a Qualifications Subcommittee to the Academy Health Committee. I chair the Qualifications Subcommittee. It gets further confusing because when the work of that subcommittee began, the Academy Board decided that it would be more appropriate to make it a full committee. The final item listed on this slide is the AAA Health Qualifications Committee. The membership is the same as the Qualifications Subcommittee and the charge is the same, but it was given full committee status under the membership vice president, Adger Williams.

The charge to the Qualifications Committee is two-fold.

Slide No. 7: Qualifications Committee Charge

- (1) To develop and, subject to Board approval, implement a voluntary program for recognition of health actuaries who work for Health Service Corporations, but who are not members of the Academy.
- (2) To recommend to the Board a longer term education and examination program for health actuaries.

First, as you see, the charge is to develop and, subject to Board approval, implement a voluntary program for recognition of health actuaries who work for health service corporations but who are not members of the Academy. That is the immediate task and that is what most of our energies have been devoted to so far. The second, and longer term charge, is to recommend to

the Board a longer term education and examination program for health actuaries. We will be getting more into that once we finish with the first charge.

The next slide shows the membership of this committee, and the affiliation of each of the members.

Slide No. 8: Academy Health Qualifications Committee

Bob Dobson	SOA	BC/BS of Alabama
Bill Hezzelwood	SOA	Pacific Mutual
Jim Hutchison	SOA	BCA/BSA
Pat O'Reilly	SOA	BC/BS of Illinois
Jim Purdy	SOA	Travelers
Bob Schuler	CAS	BC of Western PA
Emil Strug	CAS	BC/BS of Mass
Vern Switzer	CAS	State Farm

5 Blues, 3 Commercials
5 SOA, 3 CAS

You will see that we have five members who are with Blue Cross and Blue Shield Plans and three who are with commercial carriers. We similarly have five Society of Actuaries members and three Casualty Actuarial Society members. Those five and three are not the same, though, as you can see. I think we have good mix. The committee has done a lot of work and I have been particularly pleased with the interest of the people from commercial carriers since it really directly affects more Blue Cross and Blue Shield employees and HMO employees.

Our definition of "health service corporation" is shown on the next slide.

Slide No. 9:

For these purposes, "Health Service Corporation" includes any organization providing hospital, medical, or dental benefits on a service basis, and, therefore, specifically includes Blue Cross and Blue Shield Plans, Delta Dental Plans, Health Maintenance Organizations, and similar institutions.

You can see that it includes Blue Cross and Blue Shield plans, Delta dental plans, HMOs, and any similar institution.

What we are doing is developing an examination to be jointly administered by the Society of Actuaries, hopefully the Casualty Actuarial Society, though that has not been set yet, and the Academy, to be given next May and for some limited time period thereafter in connection with the Society exams.

To take this exam, a person needs the following experience: the equivalent of at least seven years of full-time responsible actuarial work including the equivalent of at least three years of full-time responsible actuarial work for health service corporations. Now this does not mean that the person has to have been an employee of the health service corporation, but

they have to have been doing actuarial work for them. So this could include consultants. In addition, a recommendation by two Academy members is necessary.

It is important to state that this does not lead to Academy membership. It leads to recognition by the Academy that the person is a qualified health service corporation actuary. It is not a certification, but a recognition. This has legal implications. Further, it is not meant to denote something better than being an Academy member.

The final slide here shows the "examinations subjects" that will be included.

Slide No. 10: Examination Subjects

1. Principles of Insurance Underwriting, and Professionalism	20 Points
2. Ratemaking	20 Points
3. Financial Statements	30 Points
4. Mathematics of Finance and Insurance	10 Points
5. Social Insurance	10 Points

Is is a fairly extensive reading list that will be mailed out in a notification package within the next month. It is not assumed that any of the individuals that might take the exam could do so successfully without a great deal of preparation.

I know that I have tried to cover a lot of ground in a short time, so I will certainly welcome any questions or comments on either of these subjects.

MR. MARK GANZER: I was disappointed in the Baucus Amendments to Social Security. I have been working on pricing the product. In case anybody is curious, the annual claim cost, based on my calculation, will range between \$30 and \$100 per person per year, highly influenced by geography (California, New York and Florida being high claim cost states) and it has been my determination that for practical intents and purposes, claim cost can be considered level. We are talking about the details of distribution. People who stay alive for a long time are in better health than one might expect. It is not irrational to have a level kind of claim cost. There are some huge variations by state. A \$200 deductible forever on Part B benefits? A \$5,000 maximum forever? We have been talking about inflation today. It is inconceivable to me that those deductible and maximum amounts will remain valid for very long. I think a much better design would have been to index the Part B deductible, perhaps by some appropriate element of the CPI. I do not know why there is a maximum. And so I was really disturbed. Okay, now about the 60% loss ratio. Try to price that and develop adequate compensation allowances and make a profit on the minimum standards product. You can not get your agents to sell it. Mass Marketing people can not really sell it. So, we can not sell this product. So what do you do? You add on some benefits. What kind of benefits do you add on? First dollar coverage -- the most expensive, absolutely the most expensive kind of benefits. Has the public been served by this? I suggest perhaps not.

And as far as the loss ratio requirement -- 60% -- I think that is a ridiculous requirement. I do not know what the right number should be, but what is so bad about 30% or 40% loss ratio, considering the nature of the coverage and this is catastrophic coverage.

MR. ODELL: Mark, would it be fair to summarize your question as saying that you are concerned about #1, the loss ratio requirement and #2, the prescribed benefit design of the Medicare Supplement Policy which has been regulated by Baucus.

MR. GANZER: Yes, of what I have said so far.

MR. ODELL: Let me make a statement as to what the Academy did and did not address and call on a couple of our people here to make some comments. We did not address the level of the prescribed loss ratio, because that was a political decision. We did address the subject of how the loss ratio was calculated. We did not address the design of the benefits, because that was almost a matter of regulatory definition as to what policies would be considered this type. So we did not per se address the questions you raised. We would be interested in your comments as to whether or not we should have. We were trying to provide expert input into Health Care Financing Administration (HCFA) to get a reasonable or at least an internally consistent result, whether or not we agree to the political conclusions. And after this, perhaps we can bring you up to date on some things that have happened just in the last few weeks. The loss ratio question is subject to a number of problems and interpretations. I will say this, the regulations were sent by HCFA to their internal actuaries and to this committee. While one might not consider them perfect, they were far better than they would have been without the Academy's work. I would like for Paul and Bob to comment on the loss ratio aspect -- not only in terms of Baucus, but their feelings about it, because what we may do in terms of professionals interrelating with HCFA may not reflect what we all feel individually about a 60% loss ratio, which may be very close to what you think, by the way.

MR. BARNHARDT: Just to comment on this loss ratio thing, there certainly is not anything magic about 60% and I think one of the problems about this whole area of loss ratio regulation is that it has really been largely arbitrary and political from the outset, and not just Baucus. But of all the different NAIC and state department loss ratio guidelines, I am not aware of any one of them that was ever evolved on the basis of any realistic expense and compensation studies. They have been almost exclusively arbitrary and political and that is really about the best you can say about them. It is unfortunate that much of this has gotten ahead of the actuarial profession and one can always look back on it and wonder if there would not have been some way that we might have stayed off or avoided some of this, but that has been the pattern on this loss ratio thing from the beginning, that it has been a rather arbitrary and political kind of process and the Baucus Amendment certainly is not the worst of them. Iowa just recently promulgated for discussion purposes a loss ratio regulation that talks about 70% for all forms of health insurance, as I understand it, including Disability Income. So this loss ratio thing is something that has gotten out of control and has become, unfortunately, a political kind of football with everybody getting in the act trying to push it up to a higher level than the last guy, and it is something that the

industry and the actuarial profession has to be concerned about, because it is not being done with any intelligence and is completely unsupported by expense or compensation type of research. About all I can say is that I agree with your concerns and looking back on it, I do not know what we might have done -- some of this has crept along very quickly and took others by surprise.

MR. ODELL: Bob, do you have anything to add to that?

MR. DOBSON: You might be interested, Mark, in what has gone forward in just the last month or so. Under the Baucus Amendment, HCFA or the Secretary of Health is required to make a study of the effectiveness of state regulation vis-a-vis the Medicare Supplement Policies and also to determine whether or not with respect to policies other than Medicare Supplement, sold to Medicare beneficiaries, we need federal regulation like we already have under the Baucus Amendment for Medicare Supplements. HCFA is designing that study presently and requests for proposals have gone out. Your Committee on Health Insurance has visited twice with the people in HCFA. Bill Hager has visited with people in HCFA. We have written to them twice, urging that in the design of the study they get actuaries involved, because they are probably going to pick up loss ratio data from annual statements and then analyze and try to interpret from that the effectiveness of state regulation, and I think we all in this room are reasonably aware of the dangers in this. The Academy's position is that whether or not you make the study may be determined by law and regulation, but let us try to get actuarial expertise into the design of the study.

MR. GANZER: More comments on loss ratio regulation. I recognize there have been guidelines going back at least to the 1950 s. The initial form of the Michigan loss ratio requirement was kind of abhorrent, and they cut back a little bit and recognized some actuarial principles. I think the entire life insurance industry fell asleep on this, too. What would happen if life insurance were regulated at 60% loss ratio or 70% loss ratio? I admit that the term products will probably produce that anyway. Take your profit makers, your traditional non-par products or your par products (I do not know what it looks like in a mutual company) -- what is the implication there? Well, your profits go away or you cut back on your compensation, or you design high premium, high cash value, high dividend policies. And so, I find ourselves coming back to a place where we were back in the '20 s and '30 s when life was a little bit simpler, and I really think that there are some issues that we, as professionals, have to take a little bit more global outlook at to determine how we might be effective.

MR. ODELL: Would anyone on the panel like to comment on that?

MR. DOBSON: You mentioned earlier that we, as a committee, had agreed that it was not appropriate to comment on the level of the loss ratio or really whether the regulation of the loss ratio was appropriate at all. I think it is important to separate insurance industry concerns from actuarial concerns. I would like to see if we could poll the people here and see how many think we should have addressed the loss ratio issue. Should the Academy, as a professional body, have commented on whether or not it was appropriate to have loss ratio regulation at all? How many say, "Yes?" (almost unanimous). I am surprised. Now, should the Academy as a professional body have commented on the level of the loss ratio? (majority "yes", a few "no")

MR. STARR E. BABBITT: I am with the Tennessee Department of Insurance. On both those questions, I had my hand halfway up. Obviously, there is something about a loss ratio that is easily understandable by the layman, or relatively easy, anyhow. Now, a 20% loss ratio I think is a little bit obscene, but on the other hand, I agree with Mark, there is nothing magic about 60%. But if you get into a legislative hearing with loss ratios like 20% or 10%, you are in trouble, because the legislators think that there is something magic about a loss ratio. I have known cases where a 22% loss ratio had a combined loss and expense ratio of 137%. The company, when they found that out, stopped issuing that policy. They thought they were making money out of it. But, you have to come up with something that somebody other than an actuary can understand. That is why my hand was halfway up on both of those questions.

MR. ODELL: Incidentally, if anyone is interested in a specific example where low loss ratios are the rule rather than the exception, consider Title insurance where I think the loss ratio is around 10%, or boiler machinery which is relatively low.

MR. JEFFREY D. MILLER: I share the concern about loss ratio regulation in life insurance as well, but it occurs to me that when you are developing a life insurance policy, you have two choices, you can develop a select policy where you have a substantial underwriting involvement and the claims are expected to be fairly low and you can have a general non-underwritten or guaranteed-issue type policy where there is no underwriting and claims are high. And it is quite possible that a person could spend less money for the select policy and get the same coverage that they get for the guaranteed-issue policy where the loss ratio is higher. I was wondering if any of the Academy activities with respect to loss ratio recognition has discussed the underwriting expenses and maybe used the combined loss and underwriting expense ratio in this rate regulation?

MR. ODELL: That is a good question. Perhaps someone on the panel remembers such a discussion by the Academy addressed to a government body as an Academy statement? I do not recall any such.

MR. DOBSON: I do not really believe so, Bill. I think the point you are bringing up here is another aspect of this whole question of expense. You know underwriting is an area of expense. The question of expense, type of marketing, the type of claims administration, all these things are relevant considerations and that is really the kind of consideration that sort of gets lost track of in this loss ratio approach. There is a failure by and large to take any direct account of the legitimate expenses of underwriting, marketing, and administering business, and that is one of the shortcomings of the over-simplified loss ratio approach. I think the point you are making is relevant and I do not know what we can do to get that element of the equation back into focus again -- it has been pretty much lost sight of all the way along. I did have one other comment I wanted to make on this and this is one that is critical of the industry. You know, for 20 years, going back to 1953, there was this 50% sort of guideline loss ratio in effect in the NAIC and recognized by a lot of states. I think the industry is to be faulted for really never having taken that seriously. You know, for 20 years everybody just made fun of that and an awful lot of companies never did really take that seriously or tried to file rates that

took it seriously, or tried to live up to the implications of that. I really think some of the problems we are having today are really the fault of the insurance business for going for so many years without really taking some of these things seriously and I think we are now reaping the harvest of many years of indifference and even insincerity, in terms of what has been filed with state insurance departments. So I really think that we in the profession and those of us who are involved in the health insurance industry should really blame ourselves somewhat for some of the things that happen.

MR. ODELL: I think those comments are very well taken. I might add one other observation of a technical nature. Somewhere in the legislation somebody put in interest. If you have a long-term contract and some of these policies are guaranteed renewable, and someone first says calculate your loss ratio and you have to get at least 55%, and then someone comes out with legislation that says you need 60% and put in interest, you have dramatic effect. The "with interest calculation" that gives you a 60% ratio is really equivalent, perhaps, to "without interest calculations" of 65% or 70%, so your loss ratio has not gone from 50% to 60%, but has probably gone from 50% to 70%. This is a point that has been often missed.

MR. J. ALAN LAUER: I would like to take exception to the comment that Bill Odell just made referring to low loss ratios for title insurance and steam boiler. I suspect that Bill knows why the loss ratios are so low, because a heavy part of the premium is spent for loss prevention activities and that loss prevention activities in one sense could logically be included in the numerator of the loss ratio. I am a rather recent expert on health insurance, having only been involved for about 4 months, but my general impression, which I am sure is that of the public or at least most other actuaries here, is that one of the major items in the complement of the loss ratio for health insurance is marketing expense. And I would say that many members of the Academy, let us say particularly those who work for Blue Cross organizations, maybe a lot of them have worked for state insurance departments, would feel that 50% is way too low a permissible loss ratio. Since the interest of the various members of the Academy do differ quite substantially, I feel that it was quite appropriate for your committee, if I understand correctly your explanation, that you explained the nature of the elements of the loss ratio, perhaps why 100% loss ratio is not appropriate, but leave it to the interested insurance companies or organizations such as the HIAA or other trade organizations to lobby for what they think is a reasonable loss ratio and why they think that a substantial marketing expense should be provided for or allowed. If I might just make one other brief point, one of the earlier speakers was talking about the Medicare Supplement policies and the 60% loss ratio that is mandated. There I have been dealing very heavily with Blue Cross rate filings recently. In the course of that, I have had a fair amount of contact with senior citizens who are quite vocal and politically somewhat potent and I think that there is a fair amount of feeling among the public, especially the public over 65, that that is not the segment of the public that should be taken by large marketing costs and that there may be a difference between selling insurance to younger people who may be in a better position to defend themselves, or to recover if they have been taken, and doing the same thing with elderly people who have a hard time affording premiums. And if you think they can afford the premiums, you ought to sit in on some of the hearings I have been sitting in lately.

MR. ODELL: Alan's statement concerning what the Academy might be doing is indeed what we have been doing up to this point.

MR. ALAN N. FERGUSON: I certainly agree with Paul about our falling asleep at the switch on the 50% and I guess the reason was that we all felt, or at least I felt, that it was not going to cause any problem and we could certainly live with that. It seems to me maybe what we should be pushing is not the idea of a prescribed loss ratio, but just like life insurance, the prescribed index or that the loss ratio had to be disclosed to the purchaser, and leave it up to the purchaser to decide whether he is buying a high cost or low cost contract, depending on the way it is marketed, and seeing if the benefits are reasonable in relation to the premium he is paying.

MR. ODELL: We wish to thank you for being with us and for this meaningful discussion, to thank our recorder, Roy Day, and also to thank our panel. We stand adjourned.

CONCURRENT SESSION
ACADEMY TESTIMONY ON H. R. 100

Moderator: JAY C. RIPPS. Panelists: HAROLD G. INGRAHAM, JR., ROBERT L. KNOWLES,
MAVIS A. WALTERS

MR. JAY C. RIPPS: It might be useful for me to start by answering the question, "what is H.R. 100?". H.R. 100 is the "Non-discrimination in Insurance Act", which was originally introduced into the House of Representatives by Congressman Dingle in 1980. It was reintroduced into the House in January of 1981 with roughly 75 cosponsors.

Before we talk about the Academy's testimony and what we tried to tell Congress about H.R. 100 and its consequences, it might be useful to look at a movie which gives a general indication of the concerns people have about insurance and insurance discrimination, and in particular the way we as actuaries go about our business. These concerns are widely held, and in some instances, are legitimate.

In Auto Insurance, a young black man talks with his insurance agent about auto insurance rates because he has noticed that he and his black friends are paying more than whites he knows for the same coverage. Neighborhood is used by the insurance company in calculating insurance risk. According to the young man, "the people who decide what factors to use really decide everything, and they are white".

MR. RIPPS: The movie demonstrates the level of the insurance discrimination debate and the emotionalism of the concerns that are often expressed. The two characters were speaking two different languages; this is a fairly common occurrence.

H.R. 100 is a response to the perception that insurance rates in some instances are unfair and discriminatory. It reads, in part, as follows: "The Congress, therefore, hereby declares that it is the policy of the United States that no insurer shall on the basis of race, color, religion, sex or national origin of any individual or group of persons 1) refuse to make insurance available to any applicant for insurance, 2) with respect to any insurance contracts to which this Act applies treat any such applicant or insured differently than any other applicant or insured with respect to the terms, conditions, rates, benefits or requirements of such insurance contract, or 3) commit any other discriminatory action prohibited by this Act."

I assure you that it is a serious bill that has fairly wide support. This is a bill that clearly is concerned with basic actuarial principles and one that the Academy's Committee on Risk Classification identified last year as a critical issue for the Academy to get involved in. Members of the Committee testified before Congress originally in August, 1980 and expressed some general concerns about the bill and what it was attempting to do. They also suggested rather forcefully that Congress should make a careful study of the economic impact of the bill. The inevitable happened: Congress

said that a careful study was a good idea and that we should do it! After some reluctance we agreed as a Committee to take on that task--primarily because the Academy wishes to have a role in debates about public issues, and this is one we really felt we could not avoid. Over the several months following the August, 1980 hearing we worked at estimating the economic impact; we presented our conclusions at a hearing in May of 1981, and we will discuss our report with you this morning. The four of us are members of the Academy's Committee on Risk Classification. The three Panel members, along with Bob Shapland, were the primary authors of the Report that we presented to Congress in May. Our first panelist is Bob Knowles, who will cover the question, "What did the Academy say at the hearing?"

MR. ROBERT KNOWLES: Thank you Jay. I'll also cover a little bit of what other witnesses had to say.

With the exception of the Academy, all of the witnesses at the Congressional hearing openly and clearly advocated either the enactment or the defeat of H.R. 100. The witnesses advocating this bill included representatives of an impressive array of civil rights, labor and professional organizations. These included the National Association for the Advancement of Colored People, the National Organization for Women, the Women's Equity Action League, the United Auto Workers, and the American Association of University Women. Commissioner Sheeran of the New Jersey Insurance Department also testified.

Some witnesses saw H.R. 100 as no more than the extension of a well established public policy prohibiting discrimination between men and women solely on the basis of gender. These witnesses argued that classifying insurance risks by sex is a violation of fundamental civil rights principles, regardless of any differences in actual claim experience or cost of insurance coverage. Some witnesses suggested that the same actuarial techniques and insurance company claim statistics that are used to justify sex-based risk classification could be equally effective in justifying insurance pricing practices based on race or religion. These witnesses argued that classification or pricing based on any of sex, race or religion should be illegal as a matter of public policy. Other witnesses supported H.R. 100 on what might be called economic or even actuarial grounds. The gist of their arguments was that the current practice of classifying insurance risks by sex is an arbitrary practice based on out-of-date stereotypes and maintained by convenience and inertia. These witnesses advanced arguments that differences between male and female mortality are really due to different lifestyles and not solely the result of gender. These witnesses most frequently pointed to smoking habits and occupation as perhaps better ways to classify life insurance risks.

Commissioner Sheeran suggested that classification of automobile insurance risks by sex was arbitrary. He emphasized a report that showed that women had more accidents per 100,000 miles driven than men. He did not mention that the same report showed that women had many fewer accidents than men within each grouping of number of miles driven annually.

Two panels represented the insurance industry and testified against the bill. They responded to the civil rights issues by arguing that cost-based pricing using statistically sound risk assessment methods is the best approach to pricing insurance. They suggested that mandatory unisex

pricing would result in cross-subsidies, adverse selection and a general reduction of equity in the insurance process. The industry panels, particularly Barbara Lautzenheiser representing the American Council of Life Insurers, did an excellent job of responding to many of the actuarial arguments advanced for H.R. 100.

An exchange between Barbara and Representative Mikulski of Maryland concerning the pricing and availability of disability insurance for homemakers seemed to me to show the legislative hearing process at its very best. Representative Mikulski was clearly interested in learning about this subject and not in scoring debating points. During that period of the testimony, I think virtually everybody in the room learned something about insurance principles and pricing practices.

The rest of the Academy statement is, of course, familiar to all of you as faithful readers of the Academy Newsletter. We did not take a formal position for or against H.R. 100, but rather appeared as trained specialists in evaluating the financial impact of such legislation. Our Committee started preparing testimony for these hearings by producing papers on the economic effects on each of life insurance, health insurance, property and casualty insurance and pensions. These were suitably technical documents with tables, appendices, qualifications, disclaimers, and so forth. Mr. William Hager, the Academy's chief counsel, complimented us on our scholarly efforts and gently suggested that congressmen are very busy people and that if we submitted our combined actuarial reports as the Academy's testimony, they would find few readers outside of our immediate families. With Bill's help, we boiled our testimony down to six pages that concentrated on the economic impact of H.R. 100 on the insuring public.

The key elements of our testimony were four exhibits. First, we estimated that the administrative costs associated with H.R. 100 would total approximately \$1.3 billion, primarily generated by the retroactive features of the bill.

Second, we provided a table showing the percentage change in average prices for men and women for life, health and automobile insurance. The key results from this exhibit include an average increase in life insurance prices for women of 6% at age 20 and 11% at age 40, with corresponding decreases of 2% at age 20, and 3% at age 40 for men. Medical expense costs went up for both men and women because of the effect of mandating full coverage of maternity-related expenses. The most dramatic increase was 56% for a male aged 20. The cost of disability coverages would increase about 24% for young men and decrease 21% for young women. One of our findings which aroused considerable interest was that automobile insurance prices would increase 37% for young women and decrease approximately 20% for young men if H.R. 100 were enacted.

The third exhibit was a table of aggregate effects on men and women, in dollars, of the enactment of H.R. 100. For example, we showed that after enactment of H.R. 100 women would pay an additional \$360 million a year for life insurance protection and men \$360 million less. Women would pay \$16 million more for medical expense insurance and men \$151 million per year more. This combined effect is a result of unisex pricing and additional coverage for maternity expenses. Women would save \$30 million a year on disability insurance; men would pay \$94 million a year more.

Finally, men would pay \$700 million a year less for automobile insurance; women would pay \$700 million a year more.

Our final exhibit concerned pension plans. We assumed that the conversion of all pension plans to a unisex basis would be accomplished by increasing the lower benefits in any situation where men and women receive different benefits. Our analysis showed that this would result in an additional cost to this country's pension arrangements of \$5.5 billion a year.

Our report also contained some information on the impact of this bill on the insurance industry and the various disruptions and shifts that could take place in the insurance marketplace. However, it was very clear that the information that was of interest was our information about cost effects on individual members of the insuring public.

I would like to make two final observations. First, the hearing process worked well. We did not get a chance to make our testimony orally because of timing and the scheduling of witnesses, but I feel that the official record of the hearing will provide to any congressman, congressional staff person, or anyone else interested in this issue a fairly complete analysis of the issues involved in evaluating H.R. 100 or similar legislation. Second, the supporters of this bill are extremely skilled, intelligent and well organized. If you have an image of civil rights lobbying organizations as being shoe-string operations opposing well-financed skilled business lobbies, forget it--at least with regard to this issue. The preponderance of full-time professional, highly skilled lobbyists at this hearing were pro H.R. 100 representing civil rights, consumer and labor groups. I am sure that the many years of actuarial training of our panel were very useful in helping us put our testimony together, but it was probably less important than the few hours of counseling received from Bill Hager of the Academy's staff, who has experience as an advocate in the Washington environment.

MS. MAVIS WALTERS: Let me add a couple of things to Bob's description. Although we did not get the opportunity to appear as a panel and present our report, something much more effective was done. Prior to the day of the hearing a few of us visited one of the congressmen who was going to be present at the hearing. We showed him an executive summary of our report and the numbers showing the economic effect of enactment of H.R. 100. He was flabbergasted at the numbers, probably because most of the proponents of H.R. 100 have suggested that banning the use of sex as a rating variable in any kind of insurance would benefit women with no negative side effects. When the hearing began the next day Congressman Scheuer had an opening statement that focused entirely on the report of the American Academy of Actuaries. He talked about the numbers and about the Academy itself in a very complimentary way. In fact, if we had written his opening statement we could not have done a better job! All of the other witnesses who subsequently came forward were confronted by Congressman Scheuer with the numbers; this added a useful dimension to the hearing.

MR. KNOWLES: We did indeed have our greatest effect in taking what had been viewed by many as essentially a women's rights and civil rights piece of legislation and highlighting its economic dimension. It is interesting to note that a gripping hypothetical scenario of a working woman struggling and needing auto insurance to get to her job can outweigh mountains of tables and correlation coefficients. That kind of anecdotal and

speculative discussion was generated by our report.

MS. WALTERS: Bob, I think you said in your opening remarks that there were proponents with actuarial arguments in favor of H.R. 100. I didn't hear any and I don't think there are any such arguments.

MR. KNOWLES: I deliberately did not assess the validity of their arguments. These people would consider as an argument that male and female mortality will converge at some point in the future, or that a driving record is a more valid variable than sex in auto insurance. These can be refuted or evaluated by actuarial methods. I was trying to distinguish them from the civil rights types of points of view which can be responded to but really cannot be refuted. For these types of public policy decisions, we actuaries have no special skill or knowledge. We can help evaluate what the cost and consequences are so that the public policy issues can be more accurately weighed against the economic consequences.

MR. DANIEL F. CASE: I was at the hearing, and I can confirm that the Committee's testimony was every bit as effective as you have said. Congressman Scheuer's approach to the subject was markedly different from the one he had taken at an earlier hearing on the same bill. It was clear that he had been jolted by the size of the estimated economic impact of the bill. My first thought at the time was: "isn't this what we have been striving for during all the years since the Academy was formed--to have someone really pay attention to us like this?" And my next thought was: "if we can get this kind of attention, that gives us an obligation to keep doing the best possible job we can, in order to continue to deserve that attention."

MR. PAUL SCHOTT: At the General Session this morning it was mentioned that there was a survey indicating that a lot of congressmen had a low opinion of actuaries. I wonder if any of you could indicate what Congress, in general, thought about actuaries before this matter and what Congress thinks of them now.

MR. KNOWLES: Congressman Scheuer and one or two others spoke in very complimentary terms about the Academy of Actuaries and, by implication, I think his comments extended to actuaries in general.

MS. WALTERS: I am familiar with the survey. There were only, I believe, 3 or 4 members of Congress at the hearing. We didn't make a big dent in the population of the U.S. Congress.

MR. RIPPS: We made some progress, but we still have a long way to go.

MR. JOHN COOK: I would like to ask Bob a short question just to bring out one point that I like to keep reminding people of. You told them that H.R. 100 would cause about \$1.3 billion in additional administrative expense. I hope you told them that it would be \$1.3 billion paid for by the insuring public, not by the life insurance companies.

MR. KNOWLES: I think that was clear. In fact, there was much concern with respect to the cost impact on government pension plans and insurance arrangements, since this hearing took place right around the time the Reagan tax bill was being debated, and budget considerations were of paramount interest.

MR. RIPPS: Harold, will you now address the question of the overall effect of the Academy's testimony?

MR. HAROLD G. INGRAHAM, JR.: The other panelists commented on what they observed the day of the hearing. I will talk about what I would call the "ripple effect" that we perceive and see in print as a result of the hearing.

The figures we presented impressed a lot of the right people. Congressman Scheuer has been quoted as saying, "Objective facts support the insurance industry's claim that it is acting in conformity with existing actuarial data". Congressman Scheuer concluded his comments to the House Subcommittee on Commerce, Transportation, and Tourism by saying that, "If the alarming conclusions of the Academy's report are accurate, I would suggest that we think long and hard before enacting this legislation". In other words, he had moved to a neutral position from one of advocating enactment.

Second, at the NAIC's June meeting, its Life, Accident and Health C(4) Technical Subcommittee recommended "that the NAIC endorse the use of a risk classification system which appropriately reflects cost differences by sex within a group for group insurance, as being in the best interest of buyers of insurance". In its recommendation, the C(4) Subcommittee made references to H.R. 100. It discussed some of the requisites of a viable insurance classification system and it quoted portions of our testimony on H.R. 100. Our full statement, including all of our cost estimates, was attached to the C(4) Committee's report. I hope that this recommendation will be adopted by the NAIC at its forthcoming December meeting.

Also, it appears that our testimony will be of material assistance in responding to the Office of Federal Contract Compliance Programs (OFCCP) in the Labor Department. On August 25 of this year, the OFCCP issued a proposed regulation which would require that government contractors provide equal benefits to similarly situated male and female participants in employee benefit plans. Comments on the proposed regulation are due by October 26. In addition to its obvious effect on defined contribution plans, the proposal would affect optional benefits in defined benefit plans that reflect differences in mortality by sex. The extent of the proposal's retroactive application is still unclear. The American Council of Life Insurers (ACLI) has presented estimates as to the cost of the OFCCP proposal, and they have drawn heavily on the detailed information provided in our report given in May. In discussions with the Labor Department, the ACLI learned that the Labor Department had done no such cost studies but "would be willing to consider such material in the review of the proposal".

I have a feeling that the Academy's testimony is likely to be quoted a great deal in the near future in a variety of environments. The September, 1981 Academy Newsletter will do so, and particularly the Dale Gustafson editorial. Gus commented that our testimony was timely, definitive and well documented. I think that is certainly true and I think we all can be proud of the enhancement of the Academy's image as a result of this and that the testimony was so well received.

MR. KNOWLES: Representative Scheuer's reactions have been quoted quite a bit. You might wonder why we were so impressed by them. Representative Scheuer cosponsored the bill originally; we felt it was particularly significant that he exhibited such movement.

MR. RIPPS: Mavis, will you address for us what can be learned for use in other public policy issues with significant actuarial dimensions?

MS. WALTERS: The key lesson we should apply in other circumstances is a tough one for us as a professional body to accept. That is, what we are trying to communicate is more important than the fact that we are a professional organization.

There were hearings on H.R. 100 under the prior Congress in August, 1980. The Academy was afforded the opportunity to testify and did so. At that time, we had a slightly different approach; we hadn't done our report, so we couldn't give the economic effect of the bill. We could, nevertheless, talk about what the problems were from an actuarial standpoint. In the introductory remarks of the Academy's testimony we spent about 5 or 10 minutes talking about the American Academy of Actuaries: how wonderful we were, what a marvelous professional group we were, how important we were, and why we were so different from anyone else. That type of testimony simply was not well received. There is no one who testifies before a Congressional committee that does not think they have a unique perspective.

For the second round of testimony, in May of this year, we had the benefit of seeing the mistakes that were made the first time. We recognized that we had a message and we did not need to wave the Academy's flag.

This was our message to Congress. The bill is a legitimate matter for a legislative body to discuss. It is a matter of public policy whether sex discrimination should be allowed in the pricing of insurance. We are simply telling you that, should you elect to go this route of passing H.R. 100, here are our best estimates of what the economic effects are going to be.

Again, I emphasize that it is important to focus on the bottom line whenever testifying before Congressional groups and to understand the audience. Many of us who are technically trained and who have worked for years as professional actuaries instinctively try to dot every "i" and cross every "t" as we do in our normal technical work. When dealing with Congressional committees or when giving public statements to non-technically oriented groups you clearly do not deliberately mislead, but you have to be prepared to make some direct statements and perhaps some judgements. You have to remember that ultimately a vote can only go two ways: "yes" or "no".

MR. KNOWLES: These people are really not interested in methodology or qualifications or disclaimers. We hate to oversimplify, but if we were to turn in 200 pages of carefully documented, qualified and disclaimed work, it would either be ignored or somebody else would simplify it. By creating our own bottom line figures, we are at least dealing with our own simplification. If we do not make a judgement, there would be at least a dozen witnesses prepared to say that there would be no major economic effect on the insurance industry or the insuring public if this bill were passed. As shocking as it may be to some of us, these issues of very great economic and social import are finally resolved by people who have not passed a single actuarial exam. And they are not even ashamed of it! You have to make a judgement as to what the key effects and figures are and summarize them very clearly in a very few statements or tables. Then you will have an impact.

MS. WALTERS: We do not like to think, as professionals, that a matter of presentation or style is more important than the subject. Generally, it is not. Nevertheless, in these kinds of environments it can be at least as important.

It is also important to note that we represented the American Academy of Actuaries, as independent professionals. We did not represent the insurance industry. We took no position on the bill, but presented some of the facts necessary for making an informed decision.

In making a presentation like ours, you must remember who you are and what your three or four most important points are. Do not be drawn into a discussion that is only ultimately defensive of the insurance industry. Remember that the ACLI and similar organizations are there to represent the insurance industry.

MR. RIPPS: That really is an important thing we learned. One of the things that happens physically at these hearings is that testimony is given in panels.

Initially, the congressional staff had set up the Academy to testify with representatives of the casualty insurance industry. We tried to have our own separate panel, because it was important that our testimony be perceived not as insurance industry testimony but rather as the assessment of a group that was not particularly associated with any industry group. We wanted not only to have a position of neutrality on the bill but also to reinforce the separation of Academy testimony from industry testimony--in terms of substance and in terms of appearance. This separation is important for the role that the Academy wishes to carve for itself.

MR. MICHAEL WINTERFIELD: I totally agree with the idea of a bottom line orientation. I do not quite understand why, in face of the obvious bottom line, we cannot get the women's rights groups to back off. I wonder whether the problem is that they hear the figures but simply feel that the numbers have been manipulated.

MR. KNOWLES: I am sure there is some element of mistrust, but attributing it all to mistrust or misinterpretation is really a disservice to some of the women's organizations. Some of the witnesses clearly understood that aspects of this law would work against women financially, and that other aspects of it would work for women. They were genuinely advocating a position that, as a matter of public policy, distinction on the basis of gender is not appropriate.

They do have a fair amount of evidence. They can point out that the preponderance of sex discrimination in this country has been to the disadvantage of women and to the advantage of men. A good number of the people who support this bill continue to fully support it even if they come to believe that it is not, at least in an economic sense, a pro-women's bill. The advocates taking the civil rights approach are not saying they want this bill because it will enrich them. They want this bill because they think people should be treated without regard to their sex.

MR. INCRAHAM: Last night I went out with a group of actuaries and their wives and we talked about the H.R. 100 bill and the issues involved. I

asked the wives of actuaries how they would feel about H.R. 100. Surprisingly, even after being told what the cost shift would be in the auto, life insurance, and pension areas, there was more than one actuary's wife who still supported H.R. 100.

MR. KNOWLES: At the 1980 hearings one advocate made a statement that "we do not want to be put on a pedestal". This position was that where discrimination means preferential treatment, it is still not acceptable.

MR. INGRAHAM: The sponsors of this bill do not seem to appreciate all the unintended effects, for example, the technical complications relative to different structures of defined benefit and defined contribution plans, the effect of early retirement benefits being equalized, and in particular, the awesome cost of increasing or "topping up" benefits.

MR. BENJAMIN R. WHITELEY: The Academy perhaps should use these events as a beginning and carry forward to educate the public so that in the future we will not have legislatures and congresses who support this sort of bill.

MS. WALTERS: There are still many women who perceive the idea of allowing sex to be recognized as a rating variable as invidious discrimination. Barbara Lautzenheiser and I have spent a lot of time talking about this. We have a theory that the organized women's movement and leaders of the women's groups feel much more strongly on these issues than the "rank and file". If the price differentials were widely recognized and separated from other issues such as availability of insurance to women, I am not so sure that the support of H.R. 100 would continue to be as strong as it is.

So, we must also take our message beyond the House of Representatives's hearing room. Even if we cannot convince the organized women's groups, we should be able to convince those who decide public policy issues. The elected officials in every state as well as in the U.S. Congress recognize that they have constituents who will be affected by this bill. They will appreciate the total dollars involved.

MR. RIPPS: We probably all now see how easy it is to slip from the neutral position of just providing cost information into the advocacy position of educating legislators as to why they should vote against legislation.

MR. KNOWLES: Mavis makes an important point about form as well as substance, but the substance certainly must be there.

Shortly after the testimony, we received a letter from Congressman Florio's office asking for documentation of our numbers. A more typical actuarial report, at least in thickness, was sent back to Congressman Florio. I am sure it is being pored over by Congressman Dingle's staff, in search of any evidence of bias in the direction of inflating cost effects. Getting your message across does require a focusing on end results rather than methodology, but one must also keep in mind that there are some very sharp people behind these hearings.

MR. CASE: That is a point that I think is very important. There are people out there who understand the issues quite well. You find them on the staffs of Congressional committees, in women's advocacy groups, and so forth. Thinking back on the film we saw here this morning, I find that I was impressed not by how little the young black man knew about the issues

involved, but by how much he knew. We will have to be prepared to deal more frequently with these issues in a meaningful way.

MR. KNOWLES: On that point, contrast two events that happened at the same time. An actuary testified in the Colby College case that forcing insured pension arrangements to ignore sex would cause some of the apocalyptic visions that some of us have been portraying in the past. At the same time, State Mutual actuaries held a press conference announcing the results of their smoker/non-smoker studies, and said that for many ages, smoking histories are indeed a more significant risk classification factor than sex. So, on the one hand we were talking about shaking industry foundations if sex were ignored, while on the other hand pointing out that another important factor had been ignored for decades without apparent catastrophe.

MR. PAUL D. YEARY: I hope that in trying to divorce the Academy's role from the industry we do not forget the importance of making it clear that insurance companies are not being run to milk the public and have the right to feel strongly that unisex pricing is not good. Their interest is the public interest.

MR. RIPPS: That is a good observation, and I would like to close with an observation of my own. The H.R. 100 experience has been an example of what the Academy can do.

The Academy is 16 years old and, as with many adolescents, there are many pressures and conflicts between the Academy and its parents. One power of the Academy is in its ability to speak about technical insurance matters that concern life insurance, health insurance, pensions, and casualty insurance in a coherent way that crosses all lines of insurance--in a way that none of its parent actuarial organizations can, because of their narrower focus on particular specialties.

We have now reached the end of our allotted time; so let's adjourn.

CONCURRENT SESSION LONG RANGE PLANNING REPORT

*Moderator: THOMAS P. BOWLES, JR. Panelists: HERBERT L. DEPRENGER,
STEVEN H. NEWMAN, GEORGE B. SWICK*

MR. THOMAS P. BOWLES, JR.: The Committee on Long Range Planning was appointed by Dale R. Gustafson in 1979 while he was President of the American Academy of Actuaries. Let me read to you the charges to the Committee: to identify the requirements of the actuarial profession in the United States; to define the role that the Academy should play in satisfying these requirements; and, to develop a plan of action for the Academy to utilize effectively its resources to fulfill the role as defined above.

MR. HERBERT L. DEPRENGER: The Committee in its Report identifies eight general requirements of the actuarial profession.

- (1) Assure an adequate supply of qualified actuaries.
- (2) Identify those who are qualified actuaries.
- (3) Advance the knowledge and the state of the art of the actuarial profession.
- (4) Assure high standards of professional conduct and practice.
- (5) Encourage and promote public understanding of actuarial science.
- (6) Contribute expertise to public discussions and considerations involving actuarial concepts.
- (7) Coordinate and interact with other professions and organizations in areas where joint participation can contribute to fulfilling public needs.
- (8) Provide an organizational structure in the U.S.A. with appropriate procedures so that the profession will fulfill these requirements.

MR. STEVEN H. NEWMAN: Each requirement is fairly self-explanatory and overlapping at times with some of the other items. The first broad requirement is to assure an adequate supply of qualified actuaries. There is no need to focus on what the need would be in a year or two but rather several years in the future, because it takes quite a while to become a qualified actuary. Having identified a demand, it is necessary to begin a recruiting process. This is a long term activity that requires focus at college and even high school level. It requires contact with guidance counselors and anyone who might be in the position to steer a potential candidate in our direction. We should strive to achieve an inclusion in various programs of probability, finance, and other actuarial subjects that have general application. In order to achieve anything, we do have to acknowledge what makes the profession

attractive. The profession is rewarding and the work is satisfying and important in real life.

Having assured a supply, it is important to identify who the qualified actuaries are -- both in the general sense and the specific sense -- as to ability to deal with certain kinds of problems. We need to determine appropriate qualifications, of course. Having done that, we have to assure that the various publics with whom we deal accept those standards. The publics would include employers, members of benefit plans, policyholders, and regulators. We need to have a means to demonstrate the qualifications; certainly the completion of actuarial examinations provides that. We have to provide access by the public to information as to qualified actuaries. This would be the yearbook and, of course, contact with our professional organizations. It may become necessary to seek accreditation or licensing as actuaries. Presumably that would only be necessary in the event that, for one reason or another, we or our various publics do not view the self-enforcement process as effective enough.

The third broad requirement is an obvious one. Advance the knowledge and the state of the art of the actuarial profession. The problems we deal with are constantly changing. There are new problems, new solutions to old ones, there are new products, new statutes and regulations, and some new interpretations of old statutes and regulations. It is necessary for all of us, if we are to view this profession, to keep abreast of those changes. So, a broad requirement of the profession is to assess the need for research, and to conduct it as necessary and then to disseminate knowledge and information at meetings and through publication and to provide a base, such as library material or reference material, to those who are interested in accessing that same information.

MR. GEORGE B. SWICK: The next requirement is standards of conduct and practice. This is a very vital issue to consulting actuaries. It is a very controversial issue. We have various guides and standards within the industry. One thing the actuarial profession has not done is to differentiate between guides of professional conduct and standards of practice. We now have guides and opinions to those guides which I would classify as professional conduct. Then we have recommendations and interpretations which I would classify as standards of practice. The Conference of Actuaries in Public Practice has decided that they will stay out of the standards of practice and I believe the Society of Actuaries either has gone along with this or is moving in the same direction. You might have differences in guides but it is almost impossible to have differences in standards of practice. In the Conference we do have committees on applied principles - committees in the pension area, life and health area, and the casualty area - to whom people can bring specific problems, and the committees would address those problems and provide answers. However, those committees have not been very active so far.

If the guides and standards are not acceptable to members, they are not going to be relied upon and they are not going to be used. So, the communication process, the exposure draft process, and the ultimate acceptance by the members of the profession are highly important.

Another important requirement concerns the public understanding about actuaries. My experience is that people are generally afraid of numbers. The computer has helped people to use numbers. People are afraid of actuaries; they do not understand them. They stand in awe of people who can live in the world of compound interest. We have a basic problem of getting an understanding in the public area of what actuaries do, and, to get people to understand what we do, we have to identify the areas in which people should look to us for expertise. My perspective is that people do not come to actuaries looking for assistance in studying social policy. People come to the actuarial profession for technical assistance. They do not listen to what we have to say in broad policy making areas.

How do we get our viewpoints across in public discussions? We are in the business of selling actuarial services, and that requires us to be very aware of what is going on in the world and to take positions. Then we get into the question of who is going to speak for the actuarial profession. Will individual actuaries be permitted to speak on their own? We have a lot of communication problems, not only with the outside world, but within the profession. How do we take positions on things; how do we handle minority opinions? The Academy is doing a lot of work in this area with a lot more to be done.

The next general requirement that we will take a brief look at is the requirement that we coordinate and interact with other professions and other organizations. In order to do that, we first must logically identify the areas of overlap or common interest. The requirement that we coordinate and interact is essential, but it involves detailed planning on the part of all parties involved to succeed in overcoming the hurdles inherent in interaction and coordination.

Logically last is the general requirement that the profession provide, for itself, some type of organizational structure in the U.S. We are talking about U.S. actuaries with appropriate procedures and mechanisms so that the organizations in the U.S. can, in fact, respond to these general requirements of the profession. There does not appear to be any reason to expect a merger of the various actuarial organizations at any time in the near future, even though the movement is toward a closer coordination among the organizations. It is going to take a close effort of coordination among the constituent bodies in order to sharpen the organizational mechanisms so that, in fact, the actuarial profession in the U.S. can respond to the needs of the public.

Now we invite your participation to particular questions raised about the Long Range Planning Report.

Why did the Report ignore the reorganization or reunification question? We ignored it because we were told to ignore it. That does not mean that we would not have ignored it anyway but our charge was set specifically to eliminate the emotional flavors and overtones and undertones which would accompany the Report had it injected itself again into the question of unification or reorganization. We were convinced, as a Committee, that if the profession stands back and takes a statesman-like view of its obligation to the public and defines what the requirements of the profession are in order to respond adequately to the public needs,

irrespective of discipline (life, casualty, or pension), then we could ignore organization or reorganization that is related thereto. This question really does not involve any input from you except to ask if you agree that the Committee should have ignored the reorganization of the profession? The Committee has leaned over backwards to divorce itself from any consideration of variations in disciplines, or distinctions of disciplines. We are looking at one actuarial profession, a profession which can justify its existence only if it responds adequately to public needs.

MR. DEPRENGER: Are there requirements of the profession that the Report does not recognize? I am going to suggest that there is one possible requirement that they did not recognize, but before doing so I would like to comment on two of the requirements that they did identify. The first requirement has to do with insuring an adequate supply of actuaries. I felt that the Report implied that the profession can and should control the supply of actuaries. I am not sure that was the intent but that is the interpretation we seem to get. I think that is presumptuous and I think it is dangerous. An oversupply of actuaries has not been our problem; primarily, it has been an undersupply. Employers provide much of the financing for the subsidies that have been necessary to increase the supply. I think perhaps the confusion is in the fact that these employers are generally represented by actuaries and can be controlled by actuaries in the case of consulting firms, and sometimes the profession itself gets credit which rightfully belongs to the employers. I do believe the profession should do everything possible to provide an adequate supply of qualified actuaries. As we know from experience, the government is quite willing to assume these responsibilities if they are not fulfilled by the private sector.

Now, commenting on the second requirement, which is to identify those who are qualified actuaries, I think this requirement includes a requirement by the profession to prevent the public practice of actuarial science by people who are not qualified. I think qualified actuaries deserve this protection and do expect their association to do its best to give them that protection, probably through legal means. The discussion in the Report does imply that that is the intention of the Committee, and in a sense recognizes there is an obligation to provide protection to qualified actuaries.

Finally, are there requirements of the profession that this Report does not recognize? I cautiously suggest the possibility that the profession should assume one more requirement - to define the profession. As I read through the Report, I see such terms as actuarial skills, actuarial concepts, actuarial content, elements of an actuarial nature, actuarial contributions, actuarial implications. I am not sure I understand these terms. Take for example the term actuarial concepts. Some of the concepts that are called actuarial concepts could just as accurately be called accounting concepts, despite what George has said. They are called actuarial concepts because the people who are using them like to be called actuaries. The Report also states that one of the requirements of the profession is to inform the public of the scope of the actuarial profession. If I had to perform this task, I would not know where to start and I am not sure if I would know where to end. The profession continues to expand its role. Not too many years ago actuaries ignored insurance investment policies. Yesterday I attended a session in which a

panelist said in so many words that actuaries have the obligation to dictate investment policy for an insurance company in terms of types of investment and kind of maturities. This continuous expansion of the activities makes it difficult to define the profession.

A related problem is the nature of our membership. Actuaries like their independence; they do not like to be told what to do, and even more, they do not like to be told how to do it. I believe the Committee to Study the Requirements of Professionalism and the committees on principles and practices will attest to this fact. Most of the published standards of practice which we called recommendations and interpretations were instigated by external forces. The membership has been quite reluctant to set some of these standards. So my suggestion that the profession should better define itself may not be practical, but I ask the Committee how it would apply the guides to professional conduct if we do not know the meaning of actuarial practice.

MR. GARY CORBETT: In long range planning you first must define the business you are in or the business you want to be in. I did note that this is deficient in the Report. I am not sure how you can address whether the requirements are sufficient until you have done this. For instance, if it is to expand in certain areas of investment, economics get involved; then it could be that education requirements are deficient. What jumps out at you is the intentional avoidance of trying to at least explore this. The Report might have said we find it impossible to do but it does not even acknowledge the problem of definition.

MR. BOWLES: Frederick W. Kilbourne, who was on the Committee, spent a lot of time discussing and presenting the same issues. We struggled with the definition of actuary. We consciously decided not to put it in; perhaps that was a mistake. Burt Jay, do you have any comments on the definition of profession or actuary?

MR. BURTON D. JAY: On insuring an adequate supply, our focus intended to be on the demand side. We think it is a professional responsibility to try to assess what the demands are today and what they will be in the future. We got a lot of help from employers and other users of actuaries in terms of what they do to help stimulate the supply through all kinds of employment rewards in times of increasing needs. But the focus is primarily on assessing the demand rather than anything else. As Tom pointed out, we did spend a lot of time in the area of defining an actuary. We looked at many possible definitions of what actuarial science is, or what an actuary is, and we could not find anything that we thought was an adequate definition. The profession is evolving into so many new things. Tomorrow some actuary will be doing something that is, what we know in our hearts to be, an actuarial activity, which will not be included in any predetermined definition. So, we did leave it out, but perhaps someone still can come up with a definition that will be useful for our purposes here.

MR. WILLIAM T. TOZER: I agree with Herb. I think that we need to really take another hard look at the definition of an actuary. I will admit that I have a bit of split loyalty here. I look back at another profession -- the underwriters. The underwriters have permitted that

word to be so used in so many other areas that it has practically no meaning today. I think if we do not watch out, anything can happen to the word actuary. On the other hand, one of the battles you are fighting on the Committee is that we are very concerned that if we attempt to define actuary, we are going to limit ourselves. It may be that this is a price we are going to have to pay. Over the years, in insurance companies, the actuary has had a profound influence on the accountants. We have a tendency to stick an actuarial label on a lot of accounting functions. We may be better off to finally recognize that certain functions are not actuarial functions but are accounting functions..or investment functions. If we try to sweep in all kinds of concepts under an actuarial definition, we are going to lose the thing that is most cherished by us and that is being an actuary and having the identity of being an actuary. The second thing I would like to bring up is that we need to do something to improve our image. I get the reaction from an awful lot of non-actuaries that an actuarial certification really does not mean that much. I think we have to address ourselves to this issue also.

MR. STEVE NEWMAN: The next question is: Do the requirements of the profession vary by discipline or by type of employment of the actuary? If so, what variance? In a word, no. The requirements do not vary. Professional requirements are requirements that are common to each of us despite our discipline and despite our type of employment. Some are more pertinent to us than others. George a moment ago indicated, on behalf of the Conference, that perhaps their highest priority was requirement number four. Were the Casualty Actuarial Society asked such a question, probably we would say that our center of gravity falls somewhere amongst requirements two, three, and four - identifying who is qualified, advancing knowledge and the state of the art, and standards of practice. The Casualty Actuarial Society, for its own part, perceives itself in an academic orientation as a learned society, and does not seem to come to grips with public issues and communicating with the public.

MR. SWICK: The next question asks how each actuarial organization should relate to the requirements. Basically, this follows up on the last question, are there differences? Representing the Conference, I feel that the differences between actuaries in public practice and those working for companies create some major problems. Rather than ask you, I thought you might be interested in what the Conference has already done. The Conference had a planning committee. We have a planning report and our planning report was built upon the Academy's Report. We took the requirements which the Academy came up with - not only the eight broad categories but the subsidiary categories that we looked at earlier - and we said, which of these areas are primary interests to actuaries in public practice? Requirements one and two did not take much of our attention. We are not a primary educational organization but we consider ourselves very valuable to continuing education. We are proud to co-sponsor the Enrolled Actuaries meeting each year, for example. We feel that in our particular conference we cover the whole spectrum of casualty, life and health, and pensions. At least, we want to. Probably, by background, we are oriented more to pensions than to life and health, and casualty, but we concede the needs of consulting actuaries in all three of those specialties. There are obviously going to be some tough issues that are going to have to be addressed

indefinitely. Hopefully, the Conference can play a role in identifying some of these areas and can help to coordinate so that people can do what they think should be done.

I have a problem with one of the comments that was made just a few minutes ago. Those of us in the public practice in the consulting area are probably more interested in an expansion of the actuarial profession than we are in the contraction of it. That may be just a personal opinion. I found from my 30 years of consulting practice that there are many things that actuarial expertise can be brought to bear upon that nobody ever thought of. It would be very unfortunate if the profession said: "This is our field of endeavor. We are not going to get into these other areas". I think the area of investment policy is vital to actuarial matters. I do not know whether I speak for the Conference on this but as an individual and as a consulting actuary, I am concerned that the profession would limit my areas of activity where I would rather see them enlarged.

MR. CORBETT: The question of defining an actuary in terms of defining scope of actuarial activity is somewhat different from the question of what standards to write for the profession as a whole. Unquestionably, actuarial education and experience equips one to deal well in fields that are shared by others. For instance, the use of probability, the feeling for probability, the time value of money, may well enable one to provide a new look at some adjustment problem. For us to then try to write standards, or guides to conduct, when somebody is working in a new area is impossible. If we treat everything that actuaries are equipped to do as being part of the actuarial profession, we will never get an understanding by the public of what our profession is and we will never be able to define guides as to how one practices in our particular field.

MR. NEWMAN: Will the profession in the U.S. be enhanced by a reasonable response of each organization to the requirements? George mentioned that the Conference had a long range planning committee and I gather George was triggered by the work of the Academy's long range planning committee. The Casualty Actuarial Society had a committee in place before the Academy started work and was busy in doing the same thing. The Academy dealt with the broadest possible issues. The various actuarial organizations should follow through and more clearly define what it is that they will be focusing on, leaving for the Academy what it should be focusing on. Although we have not discussed it, that apparently has already been acknowledged in the Long Range Planning Report, namely that the Academy's focus should be on the public interface side. That is my opinion, is there anybody who would like to express theirs?

MR. CORBETT: There must be a reasonable response and we cannot expect the other organizations to necessarily accept everything that came out of the Academy's Report. We recognize the linkage of membership and of course that many members of the Society were indeed on that committee. I personally have some difficulty and I simply state it that way without implying positive or negative feelings about this whole area of guides for professional conduct and practice. Who should be prescribing standards of conduct and standards of practice needs searching examination by the constituent bodies.

MR. DONALD SONDERGELD: We are talking about the actuarial profession and in the past there have been sessions where we have focused more on the word profession than what a profession is. I do not know how many actuarial professions we have. I would like to think we have one actuarial profession and we have a number of actuarial bodies within that profession. We do not need to define what an actuary is other than that an actuary is a person who is a member of the actuarial profession.

MR. DEPRENGER: What action is desirable to obtain the benefit of a coordinated response to the requirements? Referring to Walter L. Grace's letter which prefaced the Report put out by the Academy, it appears that a very logical action has already been taken. According to Walter's letter, the governing bodies of the other two and probably three actuarial organizations in North America had been given copies of this report. There has been some preliminary response and as we heard George report, the Conference has gone through the Report and identified those requirements where they feel they have some response on it. Also in Walter's letter, he indicates that the Board has taken some action. Most of us have now received an exposure draft on the proposed statement of purpose of the Academy which came out of this Committee. Walter states that the recommendations of the Committee relative to what the Academy should be doing will be addressed during this next year by the Academy Board of Directors. All of those are good actions. When the Academy Board addresses these recommendations of the Committee, they should take into consideration the viewpoints of the other organizations before they implement these plans of action.

MR. SWICK: Is it reasonable to expect agreement on the role each organization should play in satisfying the requirements? The simple answer to that is no. Each actuarial body has a certain role to play and the role it plays will be determined by its governing body. The Counsel of Presidents enables those of us leading these organizations to discuss these issues together and to understand where the different constituent bodies are coming from and what their problems are. Certainly the interface is more with the Academy than with the Society or the Casualty Society, but we are vitally concerned with what the Academy does and we will monitor it very closely. The Conference intends to exercise whatever influence it can bring to bear on the Academy leadership when we feel they are heading off in an area that is detrimental to the interest of the consulting actuaries. We feel it is an extremely important role for the Conference to play and we are going to continue to do exactly that. We should expect the constituent bodies to be in agreement and to cooperate. However, can they be in absolute agreement? I repeat, my answer is no.

CONCURRENT SESSION
ACADEMY ACTIVITY IN SOCIAL INSURANCE AND
PENSION MATTERS

*Moderator: A. NORMAN CROWDER, III. Panelists: PRESTON C. BASSETT,
DONALD E. FUERST, JAMES R. SWENSON*

The Academy has been active in public issues involving pensions and social insurance. The panel members will briefly summarize these activities and discuss current issues in three key areas:

1. The profession's response to proposed Social Security changes and other social insurance matters
2. Fallout from the President's Commission on Pension Policy
3. Current status of the FASB Discussion Memorandum

MR. JAMES R. SWENSON: We've all heard the ominous prediction that Social Security is going bankrupt: taxes will have to be raised, benefits will have to be cut. The Social Security program is not as financially sound as it should be. However, there are reforms available to restore financial health to the program. It is apparent that strong, bi-partisan action is needed to enact those reforms before the problems grow much worse.

Because the actuarial profession largely exists to help people meet their financial security needs, it recognizes the critical role served by Social Security. Therefore, the profession supports the program, and the Academy of Actuaries has been actively urging reform that will enable it to effectively serve its function, not only for this generation, but for future generations as well.

The program faces four major problems. First, there is the lack of public understanding as to its purpose, nature and financing. The complexity and variety of benefits provided by the program contributes to this problem. In addition, those who wanted to expand Social Security helped to create confusion by employing rhetoric describing it as an "insurance program." For example, they led people to believe that their contributions, a euphemism for taxes, were set aside in trust funds to pay their own benefits.

Second, largely because of this low level of public understanding, there is a lack of public confidence in the program. Younger and middle-aged workers are very skeptical. One recent poll indicated that three of every four people age 25 to 44, have little or no confidence that they will receive promised benefits when they need them in future years. Older people now drawing benefits are terrified. In the face of uncertainty about legislative changes, they visualize far greater negative impact on their monthly checks than any responsible individual or group has recommended. A recent decision of our elected officials to avoid facing the significant financial difficulties of the program will only contribute to the lack of public confidence.

Third, the program faces short term cash flow problems. The largest of the three trust funds, the one that pays retirement benefits, is expected to

run out of money by the end of 1982. This problem developed despite assurances following the 1977 amendments that the program would be financially sound well into the 21st century. The primary cause of this cash flow problem has been the fact that since 1977, the increases in the Consumer Price Index have substantially exceeded average wage increases. Benefits grew much more rapidly than revenues, because benefits were linked to the more rapid CPI increases.

Fourth, there are even more significant long range financial problems confronting the program. The short range cash flow problems result from unexpected adverse economic conditions and can be solved without major changes in the basic program. The long range problems are the result of demographic developments, and their solution requires more significant reform legislation. Once the baby boom generation retires, there will be fewer workers supporting many more beneficiaries. This is the combined result of improving longevity, the post-World War II baby boom and the subsequent "baby bust." Unless significant changes are made, my children are likely to face ultimately a total payroll tax burden projected to range from 22% to 38% of their payroll. That is not a legacy that I wish to leave them.

It is apparent that actions must be taken to solve each of these four major problems. To solve the first problem, a lack of public understanding, more effort is needed so that the public understands the program and realizes the necessity for enacting reforms. It is an intergenerational transfer program designed to meet social objectives. The true cost of the program now and in the future must be communicated. This is an essential function to which you and the actuarial profession could make a very significant contribution.

To solve the second problem, the lack of public confidence, legislative action must be taken as soon as possible to substitute confidence for uncertainty. Legislation beyond the temporary "band-aid" solution likely to be enacted in 1981 is needed to place the program on a financially sound basis for both the short and long term future. The changes that are needed are not as dire as many people have been led to believe. Honest and direct communication with the public is essential as the future of the program depends upon public confidence.

The short term cash flow crisis, the third problem, has been described as critical but manageable. I agree with this description. If the trust fund paying retirement benefits were permitted to borrow from the other two more solvent funds, one paying disability benefits, the other medicare hospital benefits, the short term cash flow problems would be substantially alleviated. Interfund borrowing has been advocated by virtually everyone and is likely to be the "band-aid" solution enacted this year. Assuming that interfund borrowing is permitted, projections of the extent of the remaining short term problem largely depend upon economic forecasts. If economic conditions are favorable, as they were during the 60's, there would be no cash flow problems -- interfund borrowing would be sufficient by itself. However, if economic conditions are unfavorable, as they were during the 70's, there would be a deficit of approximately \$85 billion during the next five years.

Interfund borrowing, the "band-aid," will probably enable the program to scrape by for at least a couple of years. However, it is quite likely that Congress will again be faced with short term financial problems in 1983.

Therefore, Congress will be faced with a choice of either raising taxes or reducing benefits. There is very little sentiment to raise payroll taxes. Payroll taxes have increased by two thousand percent since 1950 and the maximum tax more than quadrupled just during the 1970's. Therefore, the major choice will be either to use general revenue, which is tantamount to a tax increase, or to reduce benefits. Most of the business community, the administration and many congressmen strongly oppose general revenue financing. They agree with Senator Chiles of Florida that, "You can't fund a deficit with a deficit, unless you make it up in the volume." Any further increase in the already substantial deficit would weaken the economy and increase inflation problems.

There are a variety of proposals available to reduce benefits. The administration had proposed several reforms which the business community generally supported, such as tightening up the disability program, eliminating windfall benefits and phasing out certain benefits that are more effectively provided by other programs. The administration also proposed a modification of the bend points in the benefit formula which would gradually reduce benefit levels by approximately 5% to 10% for future retirees. On the other hand, there was very little support for the administration's proposal for a drastic and immediate reduction in early retirement benefits, as those changes would be too much, too soon for too few. Similarly, their recommendation to eliminate the retirement earnings test was met with considerable opposition. Both liberal and conservative students of Social Security were disappointed that the administration did not recommend that benefit increases be limited to the lesser of wage or price increases. That limitation represents a valuable safety valve to protect the solvency of the program from adverse economic conditions. If the 1977 amendments had included such a provision, short term cash flow problems would not have developed. Also, it is not fair that workers have to bear a disproportionately high burden of price increases caused by external forces, such as large OPEC price increases.

A number of the reforms described to solve the short term cash flow problems would also help to solve the fourth problem -- the more substantial long term problem. In addition, many have recommended a gradual increase in the eligibility age for full benefits from 65 to 68, beginning sometime between 1990 and the turn of the century. This would recognize substantial improvements in life expectancy and would eliminate a large portion of the long term financial deficit. A recent CBS and New York Times poll indicated that the public favors a gradual increase in retirement ages by a margin of 5 to 4.

It was discouraging that Congress and the administration have evidently decided to avoid enactment of significant and needed Social Security reforms this year. I was personally disappointed since I had presented testimony before Congress on behalf of the American Academy of Actuaries on three occasions this year. While I believe that Congress was fully aware of the actions that were needed, the issues became politicized for a number of reasons.

First, Tip O'Neal desperately needed an issue on which to gain a political victory. This prevented action in the House of Representatives despite the fact that Representative Pickle, who is the Chairman of the Social Security subcommittee, favored action by that organization. Second, a disproportionate number of key senators are up for re-election next year. They pre-

ferred to postpone the tough decisions until after 1982. Third, several of the administration's Social Security proposals were designed more to balance the budget than to restore financial viability to the Social Security program. A balanced budget is essential for a strong economy, but Social Security is too popular a program to be used for such a purpose. Legislative changes affecting Social Security can be adopted if they preserve and strengthen the Social Security program but not if they balance the budget at the expense of those who can least afford it. Fourth, the senior citizen lobby became very vocal and deluged Congress both in person and with letters, even though the impact of the changes being seriously considered by Congress hardly affected them. On the other hand, the Social Security taxpayers, who outnumber the beneficiaries by a margin of more than three to one, and the business community were generally silent with some notable exceptions.

One of those notable exceptions was the American Academy of Actuaries. The Congressional testimony furnished on behalf of the Academy did not generally favor or oppose specific legislative proposals, because the Academy is a professional organization whose role is to provide expert information not to take social and political positions. Instead, the testimony presented the results of actuarial projections involving the program and discussed the financial implications of legislative proposals being considered by Congress. In addition, the testimony strongly recommended that Congress enact changes to restore both short and long term financial viability to the program. The changes Congress is enacting this year merely postpone the short term problems and avoid the more troublesome and significant long term financial problems. No amount of logic, analysis and common sense prevails where politics is involved.

Among the proposals discussed were:

- (1) A gradual future increase in normal retirement age from 65 to 68. Most current proposals would phase in the increase over a twelve year period beginning sometime between 1990 and the turn of the century. This is a change which I expect to see adopted by Congress sometime prior to the end of the decade.
- (2) Mandatory, universal Social Security coverage. This is a highly politicized issue. Coverage of all workers by Social Security would improve both the short and long term financial conditions of the Social Security program. This may never be enacted, but at least Congress seems willing to eliminate the windfall benefits being received by the so-called "double-dippers."
- (3) Limiting automatic benefit increases to the smaller of wage or price increases. If this type of provision had been enacted in 1977, short term cash flow problems would not have developed. Unfortunately, CPI increases exceeded average wage increases by 3.1% in 1979 and by 5% in 1980.

I also indicated that it was impossible to exactly predict future economic conditions. As a consequence, I suggested that Congress pay more attention to actuarial projections based on the full range of assumptions, including

the so-called pessimistic assumptions. Finally, the testimony indicated that the Academy strongly recommends that the Social Security Act be amended to enable the public to enjoy the same benefit of professional actuarial certification as is required by ERISA for private plans and for pension plans covering federal employees.

MR. EDWIN B. LANCASTER: I support the idea that the normal retirement age should be moved gradually from 65 to 68, but I disagree with the proposals which increase the early retirement age from 62 up to 65. In the course of my work, I have seen many people who wear out before age 65. They just cannot hack their job. That is one of the reasons why we have subsidized early retirement provisions. I advocate keeping the early retirement age at 62, with an actuarial reduction from 68 down to 62 so that the plan is neither hurt nor helped, I believe it would be more acceptable to organized labor, but labor is not my major consideration. I support age 62 early retirement for social reasons, which I think is the basic purpose of Social Security.

MR. WARREN B. LUCKNER: I was wondering how much weight should be given to the results of the survey completed by the Peter Hart Associates for the National Commission which seemed to indicate that there was some willingness on the part of the general public to pay additional taxes in lieu of benefit cuts. The survey also indicated that there was probably more understanding of the Social Security system than many people realized.

MR. SWENSON: The most recent survey that was conducted asked the question "If the choice was between an increase in taxes or a reduction in benefits to solve Social Security financing problems, which would you prefer," and that survey indicated the reduction in benefits was favored by a margin of 2 to 1. There are increases in taxes which are already scheduled and I believe that the public will be able to tolerate increased taxes because of the basic popularity of the program. Most people recognize that there is a need for some form of an intergenerational transfer. The long term problem caused by the baby boom generation is going to have to be solved through, perhaps, some revision in the benefit expectations or certainly the retirement age expectation. I would agree that there is an improving degree of understanding.

MR. STEPHEN E. BAIRD: We seem to keep hearing that the CPI overstates the retiree's cost of living. A retired persons group recently countered that assertion by saying that indeed the CPI might understate the retiree's cost of living because it does not appropriately reflect the cost of medical expenses for retirees. There seems to be a remarkable lack of knowledge as to whether or not the CPI is appropriate.

MR. SWENSON: There have been some studies made comparing the specially designed CPI reflecting the market basket of elderly citizens compared with the general CPI. The results of those studies indicate that over a fairly long period of time there are really no significant differences. In some years the CPI for the elderly increases more rapidly than the general CPI and the reverse also is true. The reverse has been true recently, primarily because of the housing component. Many economists are now saying that the CPI in general overstates the true cost of living increase because it is biased upwards with its out-of-date fixed market basket. The personal consumption expenditure deflator of the GNP deflator is an index available that does not have the two problems that the CPI generally has, that is the

treatment of housing and the fixed market basket. The Prudential uses that index to evaluate what type of benefit increases we should be granting to our retired participants. During the 1960's there was very little difference between the personal consumption expenditure deflator and the CPI. During the 1970's, however, because of the upward bias in the CPI and the accelerating rate of inflation, the personal consumption expenditure deflator for the first five years fell below the CPI by about 1%, and during the latter five years it fell below it by 2% to 3% per year.

MR. A. NORMAN CROWDER III: I'd like to turn now to a discussion of the President's Commission on Pension Policy and some other legislative activities. Preston Bassett has been an actuary on the staff of the President's Commission.

MR. PRESTON C. BASSETT: My topic is the fallout from the President's Commission on Pension Policy Report, and I guess the fallout is that it dropped dead. There has been no activity on the report as such, and politics may be involved. Peter McCullough, the chairman of the President's Commission on Pension Policy, is a heavy Democratic supporter. If we had had a different election last November, I am quite confident that this whole report would have been on the legislative agenda. However, when the report was presented in February, President Reagan immediately denounced several parts of it. The report was built around the idea that public pensions, private pensions and individual savings would be coordinated into a package that would be consistent and would provide an adequate income for the retired. But as a package, it is dead. It will not survive or come back. However, many of the ideas that were proposed are being studied. Parts have already been legislated, parts are still being considered, and others have been rejected or ignored.

The objective of the report was to set forth a procedure to provide all retirees, survivors and disabled people in the United States with an adequate income at retirement or at the time they could no longer earn a livelihood. Adequacy was defined in the report as a continuation of the pre-retirement standard of living. This has been criticized as a rather generous goal to be achieved, and some people question whether the economy can afford it. I would like to defend this proposition. The report said the goal is to continue the same pre-retirement standard of living. It did not mandate or require that this goal be met. The report did mandate a minimum level of income somewhat above Social Security, since it required some private pension plan supplementation. It also suggested a favorable tax environment so that private pensions and individual effort combined could meet this objective.

The recommendations to encourage individual effort have been supported by the present administration. Already in the legislation that has been enacted, several of the Commission's recommendations have been adopted. The Commission recommended that there be tax deductions for employee contributions to their own retirement savings through the extension and liberalization of Individual Retirement Accounts. Also, the new All-Savers Certificate, which is given favorable tax treatment on investment income up to \$2,000, is in the direction that the Commission was going, encouraging individuals to save.

The Commission also recommended that elderly people be given an opportunity to continue in the labor force, and the present administration certainly

does not oppose this view. I suggest that President Reagan's proposal to reduce the incentive to retire early is the counterpart of trying to keep people in the labor force a little longer. The present administration recommended the elimination of the post-retirement earnings test under Social Security, so again, that would encourage people to stay in the labor force.

Concerning private pensions, certainly the present administration supports the private pension system. They flatly reject the mandatory private pension system which has been rejected by the business community and many others. As a matter of fact, my personal view is that other than the Minimum Universal Pension System (MUPS), the Commission's report was a good report, and I support almost everything but that one issue.

The Commission recommended that vesting remain at the present ERISA standards. They also did not recommend any change in the retirement age except that ERISA be amended to make a normal retirement age not 65, but the same retirement age as under Social Security.

The MUPS has certainly been rejected on Capitol Hill. John Erlenborn has introduced his ERISA amendments bill, but did not incorporate the recommendations of the President's Commission. Senator Nichols has introduced a bill in the Senate nearly identical to the Erlenborn bill and hearings on that bill will begin next month. There will be action in the pension field but not the recommendations of the President's Commission.

Concerning Social Security, the President's Commission basically agreed with the proposals of the National Commission on Social Security and the Advisory Council on Social Security. They recommended that the CPI be reviewed by the Bureau of Labor Statistics to see if it was appropriate for the retired. The Commission recommended certain changes in regard to spouse's benefits and divorced couple's benefits which have not been incorporated into any of the suggestions on Capitol Hill in regard to Social Security changes. They also recommended that the retirement age be increased by three years starting in 1990, so it would reach age 68 in the year 2002. They agreed Social Security should continue to be financed solely by taxes paid for equally by the employee and the employer, and that there be provision for interfund borrowing, as it now appears will be the case. They recommended a review of the students' benefits, and it appears that this will be eliminated. They recommended universal coverage for all public employees which is a political issue and it is doubtful that this will get through.

The Committee on Economic Development (CED) is a non-profit research organization of business executives and educators that was making a study at the same time as the President's Commission. They have published a report on their recommendations on retirement in the United States which covers the issues of Social Security, private pensions and individual savings. I'm pleased to say that their report substantially supports everything that the President's Commission on Pension Policy recommended, with the obvious exception of the mandatory private pension.

MR. SWENSON: You mentioned that the President's Commission on Pension Policy indicated a recommendation that the retirement earnings test be eliminated, but I believe that there was a condition attached to that.

MR. BASSETT: Yes, they recommended that Social Security taxes be tax deductible, and that all benefits paid under Social Security be fully taxed. This was immediately picked up by the American Association of Retired Per-

sons and others as being a terrible proposal, because all these present Social Security recipients would now have to start paying a tax. That was not the proposal. The Social Security taxes would become tax deductible immediately, but the tax on benefits would have to be phased in so that a retired person would be taxed only on the benefits for which he had made tax deductible contributions. The Commission said that if benefits became taxed, and only if, then the Commission was in favor of removing the earnings test after retirement.

MS. JUDITH E. LATTA: I was curious about this elimination of the earnings test. It seems contrary to the purpose of the program to have people receiving Social Security while they are earning substantial incomes. I do not agree with the proposal to totally eliminate the earnings test. If the objective is to encourage later retirement, you could work better with a delayed retirement credit. We are scheduled to have an increase in the delayed retirement credit to 3% in 1982. But what happens to this delayed retirement credit with the proposed retirement age of 68? Will the cut off now go up to 75?

MR. BASSETT: When the Commission proposed moving the retirement age from 65 to 68 everything goes up in tandem, so the delayed retirement credit would start at 68. To answer your first question about the earnings test, it is a matter of whether people feel Social Security is a social program or whether it is an insurance program. If you look at it as an insurance program, you say, "I paid my contributions for forty years, I'm entitled to a benefit whether I work or not. This is an insurance program, I've reached 65, and I'm now entitled to the benefits." On the other side of the coin, Social Security is a program designed to provide benefits to people who no longer work, and therefore you are not entitled to any benefit until you quit working. Whether you continue the earnings test depends on how you balance these two sides, and everybody has their own opinion.

MR. JOHN W. WOOD: The National Commission on Social Security studied the issue of the retirement earnings test, and they concluded that the retirement earnings test should be retained. As a matter of fact they recommended that instead of eliminating the retirement earnings test to encourage people to remain in the work force, that the delayed retirement credit be increased to a much higher rate, one that is very close to the actuarial equivalent. And interestingly enough, their recommendation was one that would have very little cost effect on the Social Security program because of the fact that there are so few people that work beyond age 65 currently. If you wanted a no-cost actuarial adjustment factor after age 65 you could reduce the age 62 retirement factor from 80% to 78 1/2%, a very modest reduction, and provide an improvement in the delayed retirement credit to something in the neighborhood of 6% to 8% per year. This increase would have a very significant effect on encouraging people to remain in the work force.

MR. JAMES L. COWAN: I want to take exception with something you said on the insurance issue. As far as I'm concerned, the annuities paid under retirement income policies are not insurance, they are savings. I take exception to classifying them as insurance. I think Social Security benefits are more like true insurance than retirement income policies. I think that the insurance industry's expression that social insurance is not insurance is causing many misconceptions about Social Security.

MR. CROWDER: Don Fuerst has been a member of an Academy committee which has responded this summer on behalf of the profession with respect to the Financial Accounting Standards Board (FASB) Discussion Memorandum on pension plan accounting.

MR. DONALD E. FUERST: The Financial Accounting Standards Board is an independent body established to set standards for the accounting profession, primarily for financial accounting. It is comprised of seven board members who are drawn from various industry segments. The FASB is supported by a large staff in Stamford, Connecticut which is drawn from the accounting professions and securities analysts and is augmented by task forces assigned to particular projects, such as the pension accounting project. The current project went on the FASB agenda in the early 70's even before ERISA was passed, not long after APB 8 was promulgated. They have been long in issuing actual documents, and they are not finished yet. In February they issued a Discussion Memorandum on pension plan accounting of almost 200 pages and asked for comments in writing by June. There was a public hearing in July of this year. The Board expects to issue some tentative conclusions by late 1981, publish a second exposure draft in 1982, and issue a final statement on accounting for pensions in 1983. Whether or not they will meet that timetable is certainly subject to some question. As of two weeks ago, the Board had not yet taken a formal vote on the issues that they have currently presented.

The Academy committee that addressed this issue is a diverse group. We have actuaries from insurance companies, consulting firms, accounting firms, and representatives from private industry. When we first started considering the Discussion Memorandum, we had quite a few diverse opinions. Over the course of a few months we managed to reach a consensus. We submitted our comments to the FASB in June and testified at the public hearings in July. Basically, we commented that the Discussion Memorandum was a very good document, very thorough, but that it was perhaps a bit too theoretical and did not take into account many of the practical considerations that we saw as important.

Some of the central questions that the discussion memo addressed were: What should a firm recognize as a liability for pension plans? What obligation does a company have regarding its pension plans? How should that liability be measured? How should the expense for pension plans each year be measured and reflected in a company's income statement? What effect should gains and losses have on that measurement and the income statement? How should changes in plans be effected? What disclosures are necessary on the balance sheet or on the income statement? What additional disclosures should be made? Finally, what other post-retirement benefits or post-employment benefits should be considered -- medical benefits, life insurance, anything that continues on past the severance of employment?

In our comments to the FASB, we tried to address certain accounting principals that they quoted in their Discussion Memorandum. The following is quoted from the FASB Discussion Memorandum and from some of the documents that they have drawn up which constitute what they call the conceptual framework for financial accounting.

The primary focus of financial reporting is information about earnings and its components.

Relevance and reliability are the two primary qualities that make accounting information useful for decision making.

Revenues are inflows or other enhancements of assets that constitute the entity's ongoing major or central operations.

Expenses are outflows or other using up of assets...that constitute the entity's ongoing major or central operations.

Liabilities are very important, but a focus on liabilities should not be permitted to distort one's perception of the impact on earnings of the company. Pension plans are significant, but the financial operations of a pension plan should not obscure the results of a company's primary function.

The Discussion Memorandum also asks questions such as: Is the company's obligation to provide benefits to individuals or just simply to make the required contributions to the plan? We thought the plan is really a conduit through which the plan sponsor makes his contributions for the ultimate payment of benefits to individuals. We do not believe it is possible to give a clear cut decisive answer to that question. Is the employer's obligation to the employee group, or is it to the plan? We believe the obligation is to both; the two function very much together.

What exchange actually takes place in the performance of service of an employee group? When is a liability created? The position of the Academy committee on this matter is that when a plan sponsor adopts a pension plan, he is looking prospectively into the future. He is looking to the revenues which he is going to earn in the future and the service which employees are going to perform for him in the future. He is going to provide for the expenses for that plan out of those revenues. That led us to the conclusion that the expense of a pension plan should be recognized over the future after the plan is adopted. At adoption, the plan should not immediately create a liability which would go into the balance sheet. Many people have said that plan assets should appear on the balance sheet of an employer. The addition of pension plan assets to the balance could severely distort the actual financial picture of a company. The company has a fiduciary responsibility with respect to those assets, to use them for the benefit of the plan participants. The company does not have any direct control over plan assets with regard to the ongoing central operations of the company.

One of the other areas addressed is how should the expense be recognized each year. Should there be a single actuarial method for all companies that would facilitate comparability between companies? Should companies with identical employee groups and identical plans use the same method? We looked at all the funding methods and found that they meet the criteria that the accounting profession itself establishes for allocating expenses in reasonable rational systematic manner to various periods of time. No one of the methods is a perfect solution for any plan. Some are much more appropriate for some plans than others. Some of the methods appear to be appropriate for most plans, but it is very difficult to say that there is only one method which is appropriate for all pension plans.

There have been proposals to say that gains and losses be recognized immediately. We found these proposals most disconcerting, particularly because we do not believe that our measurement of a gain or loss for a particular

year is so accurate that it should be reflected in the income statement. We expect gains and losses each year and we hope that they will be offsetting over the long run. To reflect them immediately in the income statement would produce considerable variability in the actual charge to income for the pension plan.

The other major area that the FASB discussed was disclosure. What should be disclosed in addition to the income and balance sheet items? Disclosure should be useful and it should pass a cost/benefit test. The cost of providing additional disclosure in annual statements should provide some additional benefit that is worth the cost of providing it. We followed a general principle that the disclosures should only include items that are in a regular valuation now, not anything that would necessitate significant additional calculations. The disclosures we recommended were: a general statement as to the existence of plans, the types of plans, the types of employee groups covered, the pension expense for the current year and the two previous years, both the dollar amount and as a percentage of payroll, and the actuarial method that was used to determine that amount. With respect to liabilities or present values of accrued benefit numbers, such as the current FAS 35 and 36 numbers, we expressed some reservation as to the possible misunderstanding of these numbers. We doubt that the users of financial statements really understand what these numbers are. If something has to be disclosed, we feel that the appropriate number at this time is the FAS 36 present value, without any use of a salary scale. In addition, pension plan disclosure should include the market value of assets, the interest rate used in the calculations of the expense and the present value of accumulated benefits, and any significant changes that have taken place in the past accounting periods that would affect the pension expense in the various years. The users of financial statements need to be able to understand what changes have taken place in past years and what these changes might portend for the future.

We urged that the actuary's statement regarding this plan be included in the disclosures. This position has been presented to the FASB before in the preliminary hearings on FAS 35, and it has been rejected by the FASB. We restated again that the actuary should sign off on the financial statement, since it is really an actuarial statement. In lieu of that actually being adopted, because at this late date we did not think the FASB is going to change their opinion, we suggested that the Enrolled Actuary for the plan be given final approval on any note to be included in a company's financial statements. He is the one who most understands what is going on in that statement.

Finally, in the area of post employment benefits, we basically said it is an area that should be addressed, but there is just not enough information at this time. To a certain degree we begged the issue and put it off a little bit. We felt that it is an important issue, that it could possibly represent a significant impact but there is a lack of significant information at this time to promulgate standards.

The Financial Accounting Standards Board is a body which promulgates accounting standards, not law. But anyone who prepares financial statements which purport to comply with generally accepted accounting principles does have to comply with these standards. That, in effect, is almost as strong as law. So, major corporations that are required to produce financial statements will need to comply with such statements as this.

Companies that do not prepare financial statements, perhaps small closely held corporations, will not necessarily have to comply. Also, these standards, as in any accounting standards, apply only to items which are material. For most major corporations the pension expense certainly is a material item.

MR. MARTIN J. ZIGLER: First, would you say at this point that it is a foregone conclusion that there will be some measure of liability on the balance sheet? And is it a question of what that liability will be? Also it is a little scary when you look at these numbers on financial statements, and companies that had a billion dollars in unfunded liability one year have zero unfunded the next year because of an increase in the interest rate from 6% to 12%. Many people are using these statements and drawing conclusions from these sorts of numbers. Does the Academy have a position or has the FASB come out with anything clear on the criteria for choosing that investment return assumption?

MR. FURST: With respect to your first question, it is not a foregone conclusion that there will be something on the balance sheet. Within the FASB there is a large segment of the staff which would like to see that happen, but the Board is much more pragmatic. They recognize many of the problems that would ensue and the changes that would be necessitated. There is a good possibility we will not see something on the balance sheet. With respect to the investment return question, the FASB staff on this project has deferred the issue of the measurement with respect to assumptions. They have said they will try to address that issue in a separate part of this project. They have addressed this a little bit in Statement 35. And as you say, we have seen quite a bit of variability. Although, I think if you look at financial statements of most major companies, you will find that the overwhelming majority fall within a certain range -- 6 1/2% to 9 1/2%. Three percent is a wide range, it can have quite an impact. The Academy has not promulgated any standards regarding that.

STATEMENTS OF THE ACADEMY RELEASED IN 1981

Each year's Journal includes the full text of the Statements released by the Academy in that year. Although most of the Statements are self-explanatory, knowledge of the circumstances giving rise to the Statement helps provide perspective. The following Summary of Statements section provides background information, including any cross-references to previous Statements. For purposes of cross-referencing and indexing, Statements have been assigned numbers by calendar year and by order of release in that year, e.g., 1981-1 was the first Statement released during 1981. The summary also gives the page number on which the full text begins.

Statements made before 1977 were not compiled, but copies of such Statements may be requested from the Executive Office of the Academy, Suite 515, 1835 K Street, N.W., Washington, D. C. 20006.

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Statements of the Academy are not expressions of official positions embraced by the membership as a whole. Rather, they are intended as relevant responses to situations which appear to require a professional statement on actuarial matters.

SUMMARY OF 1981 STATEMENTS

Index Code: 1981-1

To: American Institute of Certified Public Accountants

Date: January 8, 1981

Length: 2 pages beginning on page 94

Concerning: Reinsurance accounting and auditing

Background: This statement was submitted to the AICPA Reinsurance Auditing and Accounting Task Force in connection with its study in this area. This statement follows two previous Academy submissions dated January 8, 1980 and July 1, 1980 (see statements 1980-1 and 1980-20).

Drafters: The Task Force on Reinsurance Accounting, chaired by Ronald E. Ferguson.

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Index Code: 1981-2

To: American Institute of Certified Public Accountants

1981-2 (Cont.)

Date: January 14, 1981

Length: 2 pages beginning on page 96

Concerning: Accounting for mortgage guaranty insurance

Background: This statement was submitted to the AICPA Insurance Companies Committee in response to an Exposure Draft of a proposed Statement of Position on "Accounting for Mortgage Guaranty Insurance" dated October 15, 1980.

Drafters: The Committee on Property and Liability Insurance Financial Reporting Principles, chaired by Donald E. Trudeau.

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Index Code: 1981-3

To: American Institute of Certified Public Accountants

Date: January 29, 1981

Length: 6 pages beginning on page 98

Concerning: Accounting for medical malpractice loss contingencies

Background: This statement was submitted to the Medical Malpractice Self-Insurance Task Force of the AICPA in response to an Issues Paper on "Accounting for Medical Malpractice Loss Contingencies of Health Care Providers and Related Issues" dated October, 1980.

Drafters: The Task Force on Self-Insured Trust Funds, chaired by James O. Wood.

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Index Code: 1981-4

To: President's Commission on Pension Policy

Date: February 3, 1981

Length: 10 pages beginning on page 104

Concerning: Funding standards

Background: This letter was a further submission to the President's Commission on Pension Policy subsequent to the Academy testimony of November 14, 1980 (see statement 1980-30). This letter was sent in response to a letter dated January 7, 1981 to the Commission from Donald J. Kirk, Chairman of the Financial Accounting Standards Board (copy attached to statement). The

1981-4 (Cont.)

letter of May 15, 1980 from Ronald L. Bornhuetter and Mr. Kirk's response of May 19, 1980 were attached to the letter.

Drafters: President Walter L. Grace.

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Index Code: 1981-5

To: House Committee on Ways and Means

Date: February 27, 1981

Length: 6 pages beginning on page 114

Concerning: Social Security legislation

Background: This statement was submitted at a public hearing on Social Security legislation held by the Subcommittee on Social Security of the House Committee on Ways and Means.

Drafters: The Committee on Social Insurance, chaired by James R. Swenson.

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Index Code: 1981-6

To: Financial Accounting Standards Board

Date: March 12, 1981

Length: 2 pages beginning on page 120

Concerning: Conceptual framework project

Background: This statement was submitted to the FASB in response to the Discussion Memorandum on Reporting Funds Flows, Liquidity, and Financial Flexibility dated December 15, 1980. This Discussion Memorandum is part of the FASB conceptual framework project.

Drafters: The General Committee on Financial Reporting Principles, chaired by Stephen D. Bickel.

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Index Code: 1981-7

To: Health Care Financing Administration

Date: March 17, 1981

Length: 3 pages beginning on page 122

Concerning: Minimum loss ratios for Medicare supplement policies

1981-7 (Cont.)

Background: This statement was submitted to the Health Care Financing Administration in connection with proposed regulations for Medicare supplement policies. The proposed regulations appeared in the Federal Register on January 21, 1981 (46 FR 6296-6307). These regulations were issued pursuant to section 507 Social Security Disability Amendments Act of 1980 (commonly referred to as the "Baucus amendment").

Drafters: The Committee on Health Insurance, chaired by W. H. Odell.

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Index Code: 1981-8

To: American Institute of Certified Public Accountants

Date: May 5, 1981

Length: 3 pages beginning on page 125

Concerning: Accounting for medical malpractice loss contingencies

Background: This statement was submitted to the Medical Malpractice Self-Insurance Task Force of the AICPA and is supplementary to the previous Academy submission on January 29, 1981 (see statement 1981-3).

Drafters: The Task Force on Self-Insured Trust Funds, chaired by James O. Wood.

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Index Code: 1981-9

To: House Committee on Energy and Commerce

Date: May 20, 1981

Length: 9 pages beginning on page 128

Concerning: Risk Classification

Background: This report was presented at a public hearing of the Subcommittee on Commerce, Transportation and Tourism of the House Committee on Energy and Commerce. The subject of the hearing was H.R. 100, the Nondiscrimination in Insurance Act, sponsored by Rep. John D. Dingell. The Academy had previously testified on this proposed legislation on August 29, 1980 (see statement 1980-24). The purpose of this subsequent report was to present the results of the study of the economic impact of H.R. 100 which the Subcommittee had asked the Academy to perform.

Drafters: The Committee on Risk Classification, chaired by Jay C. Ripps.

SUMMARY OF 1981 STATEMENTS

Index Code 1981-10
To: Securities and Exchange Commission
Date: May 26, 1981
Length: 3 pages beginning on page 137
Concerning: Insurance company financial statements
Background: This statement was submitted to the Securities and Exchange Commission in response to proposed regulations affecting insurance company financial statements. The proposed regulations would amend Articles 7 and 7A of Regulation S-X and appeared in the Federal Register on April 8, 1981 (46 FR 21020-21027).
Drafters: The Committee on Life Insurance Financial Reporting Principles, chaired by Burton D. Jay.

- - -

Index Code: 1981-11
To: House Committee on Ways and Means
Date: May 28, 1981
Length: 4 pages beginning on page 140
Concerning: Social Security legislation
Background: This letter constitutes a supplementary submission to the Subcommittee on Social Security of the House Committee on Ways and Means to the Academy statements on February 27, 1981 (see statement 1981-5). This letter contains proposed language to institute an actuarial certification for Social Security which was proposed by the earlier statement.
Drafters: The proposed language was developed by the Committee on Social Insurance, chaired by James R. Swenson, and the transmittal letter was drafted by Executive Director Stephen G. Kellison.

- - -

Index Code: 1981-12
To: NAIC Life Insurance (C3) Subcommittee
Date: June 2, 1981
Length: 12 pages beginning on page 144
Concerning: Dividend principles and practices

1981-12 (Cont.)

Background: This statement was presented at a meeting of the Task Force on Manipulation, Lapsation, Dividend Practices and Annuity Disclosure of NAIC Life Insurance (C3) Subcommittee as a status report of the activities of the Committee on Dividend Principles and Practices. This statement follows previous submissions on this subject to the NAIC (see statements 1979-14, 1980-18, and 1980-32).

Drafters: The Committee on Dividend Principles and Practices, chaired by John H. Harding.

- - -

Index Code: 1981-13

To: NAIC Life, Accident and Health Insurance (C4) Technical Subcommittee

Date: June 9, 1981

Length: 4 pages beginning on page 156

Concerning: Risk classification

Background: This document is a report on risk classification approved by the NAIC Life, Accident and Health Insurance (C4) Technical Subcommittee. The Academy statement on risk classification which was presented to Congress on May 20, 1981 (see statement 1981-9) was attached to the NAIC Subcommittee report. The Academy participated in the drafting of the Subcommittee report and endorsed it at a public meeting of the Subcommittee.

Drafters: Executive Director Stephen G. Kellison on behalf of the Academy and others on behalf of other organizations.

- - -

Index Code: 1981-14

To: Senate Special Committee on Aging

Date: June 16, 1981

Length: 13 pages beginning on page 160

Concerning: Social Security legislation

Background: This statement was submitted at a public hearing on Social Security legislation held by the Senate Special Committee on Aging. This statement follows two earlier statements to the House Committee on Ways and Means (see statements 1981-5 and 1981-11). Attached to the statement is a supplementary letter dated June 30, 1981 which addresses certain questions posed at the public hearing.

SUMMARY OF 1981 STATEMENTS

1981-14 (Cont.)

Drafters: The Committee on Social Insurance, chaired by James R. Swenson.

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Index Code: 1981-15

To: Financial Accounting Standards Board

Date: June 16, 1981

Length: 30 pages beginning on page 173

Concerning: Accounting for pension plans

Background: This statement was submitted to the FASB in response to the "Discussion Memorandum on Employers' Accounting for Pensions and Other Postemployment Benefits" dated February 19, 1981. The Academy had filed numerous previous statements with the FASB on accounting and reporting by defined benefit pension plans (the last of which was statement 1979-23).

Drafters: The statement was prepared by the Subcommittee on Pension Accounting Matters of the Pension Committee. The respective chairmen of the above groups are Edwin F. Boynton and Douglas C. Borton.

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Index Code: 1981-16

To: NAIC Competition (B3) Subcommittee

Date: June 17, 1981

Length: 2 pages beginning on page 203

Concerning: Competitive rating for property and liability insurance

Background: These two letters put in writing oral testimony which was presented at an open meeting of the NAIC Competition (B3) Subcommittee concerning the adoption of the proposed Model Open Competition Rating Law for property and liability insurance which was being developed by the Subcommittee. The Academy had previously testified on this proposal (see statement 1980-33).

Drafters: One letter was from the Committee on Property and Liability Insurance, chaired by Warren P. Cooper, while the other letter was from General Counsel William D. Hager.

SUMMARY OF 1981 STATEMENTS

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Index Code: 1981-17

To: Senate Committee on Commerce, Science and Transportation House
Committee on Energy and Commerce

Date: June 25, 1981

Length: 2 pages beginning on page 205

Concerning: Risk retention groups

Background: This statement was presented to the Senate Committee on Commerce,
Science and Transportation and to the House Committee on Energy
and Commerce in connection with the Product Liability Risk
Retention Act of 1981.

Drafters: General Counsel William D. Hager, in consultation with Warren P.
Cooper, Chairman of the Committee on Property and Liability
Insurance.

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Index Code: 1981-18

To: Senate Committee on Finance

Date: July 9, 1981

Length: 14 pages beginning on page 207

Concerning: Social Security legislation

Background: This statement was submitted at a public hearing on Social
Security legislation held by the Subcommittee on Social Security
of the Senate Committee on Finance. This statement follows three
earlier statements in 1981 on Social Security legislation (see
statements 1981-5, 1981-11, and 1981-14).

Drafters: The Committee on Social Insurance, chaired by James R. Swenson.

- - -

Index Code: 1981-19

To: American Institute of Certified Public Accountants

Date: July 10, 1981

Length: 2 pages beginning on page 221

Concerning: Reinsurance accounting and auditing

Background: This statement was submitted to the AICPA Reinsurance Auditing
and Accounting Task Force in connection with its study in this
area. This statement follows three previous Academy submissions
(see statements 1980-1, 1980-20 and 1981-1).

1981-19 (Cont.)

Drafters: The Task Force on Reinsurance Accounting, chaired by Ronald E. Ferguson.

- - -

Index Code: 1981-20

To: Financial Accounting Standards Board

Date: July 13, 1981

Length: 20 pages beginning on page 223

Concerning: Pension terminology

Background: The final report of the Joint Committee on Pension Terminology, dated July 1, 1981, was formally submitted at a public hearing of the FASB in connection with the "Discussion Memorandum on Employers' Accounting for Pensions and Other Postemployment Benefits." This report is being recommended for the FASB's consideration in connection with terminology in its various pronouncements relating to pension plans. The Board of Directors of the Academy endorsed this terminology by Board resolution. The Academy had previously filed a written statement on other aspects of the Discussion Memorandum (see statement 1981-15).

Drafters: The witness at the public hearing was Michael J. Tierney, Chairman of the Joint Committee on Pension Terminology.

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Index Code: 1981-21

To: Financial Accounting Standards Board

Date: July 14, 1981

Length: 2 pages beginning on page 243

Concerning: Accounting for pension plans

Background: These remarks are the opening statement of President Walter L. Grace at a public hearing of the FASB on the "Discussion Memorandum on Employers' Accounting for Pensions and Other Postemployment Benefits." In these remarks, President Grace expresses the Academy endorsement of the report of the Joint Committee on Pension Terminology (see statement 1981-19). President Grace was followed by Edwin F. Boynton, James F.A. Biggs and Paul A. Cewirtz, who summarized the Academy written statement which had been previously submitted (see statement 1981-15).

Drafters: President Walter L. Grace made the introductory statement. Messrs. Boynton (Chairman), Biggs and Gewirtz are members of the

1981-21 (Cont.)

Subcommittee on Pension Accounting Matters of the Pension Committee, chaired by Douglas C. Borton.

Index Code: 1981-22

To: Health Care Financing Administration

Date: July 23, 1981

Length: 2 pages beginning on page 245

Concerning: Minimum loss ratios for Medicare supplement policies

Background: This letter was written to the Health Care Financing Administration in connection with its research study on Medicare supplement policies. This letter follows a previous Academy submission to HCFA in connection with proposed regulations in this area (see statement 1981-7).

Drafters: The Committee on Health Insurance, chaired by W. H. Odell.

Index Code: 1981-23

To: House Committee on Energy and Commerce

Date: July 29, 1981

Length: 34 pages beginning on page 247

Concerning: Risk Classification

Background: This report constitutes the full submission to the Subcommittee on Commerce, Transportation and Tourism of the House Committee on Energy and Commerce on H.R. 100, the Nondiscrimination in Insurance Act. The previous Academy submission on this subject (see statement 1981-9) at a public hearing of the Subcommittee was an executive summary of this complete report.

Drafters: The Committee on Risk Classification, chaired by Jay C. Ripps.

Index Code: 1981-24

To: American Institute of Certified Public Accountants

Date: August 5, 1981

Length: 4 pages beginning on page 281

1981-24 (Cont.)

Concerning: Accounting for medical malpractice loss contingencies

Background: This statement was submitted to the Medical Malpractice Self-Insurance Task Force of the AICPA in response to an Issues Paper on "Accounting for Medical Malpractice Loss Contingencies of Health Care Providers and Related Issues," dated June 1981. The statement follows previous Academy submissions to the AICPA concerning this subject on January 29, 1981 and May 5, 1981 (see statements 1981-3 and 1981-8).

Drafters: The Task Force on Self-Insured Trust Funds, chaired by James O. Wood.

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Index Code: 1981-25

To: Securities and Exchange Commission

Date: August 21, 1981

Length: 2 pages beginning on page 285

Concerning: Independence/self-review

Background: This letter was sent to the Securities and Exchange Commission in reaction to the SEC announcement of its intention to withdraw Accounting Series Release No. 264 and soliciting comments on rescinding Accounting Series Release No. 250. The Academy filed numerous statements on the independence/self-review issue with the SEC and other groups during 1977-1979 (see statement 1979-25 for the most recent example).

Drafters: President Walter L. Grace

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Index Code: 1981-26

To: Financial Accounting Standards Board

Date: September 29, 1981

Length: 1 page beginning on page 287

Concerning: Accounting for foreign currency translation

Background: This statement was submitted to the FASB in connection with an FASB Exposure Draft entitled "Foreign Currency Translation" released on June 30, 1981. The Academy had previously submitted statements to the FASB on this subject (see statements 1977-19 and 1980-29).

Drafters: The Committee on Life Insurance Financial Reporting Principles, chaired by Burton D. Jay.

SUMMARY OF 1981 STATEMENTS

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Index Code: 1981-27

To: House Committee on Ways and Means

Date: October 2, 1981

Length: 8 pages beginning on page 288

Concerning: Pro-competition health legislation

Background: This testimony was presented at a public hearing on pro-competition health legislation held by the Subcommittee on Health of the House Committee on Ways and Means. The Risk Classification Statement of Principles released by the Academy in 1980 was included as part of the statement (see statement 1980-19).

Drafters: The Committee on Health Insurance, chaired by W. H. Odell.

Index Code: 1981-28

To: Health Care Financing Administration

Date: October 5, 1981

Length: 3 pages beginning on page 296

Concerning: Minimum loss ratios for Medicare supplement policies

Background: This letter was written to the Health Care Financing Administration as a follow-up to the previous letter on this subject on July 23, 1981 (see statement 1981-22). Attached to this letter was a copy of pages 205-226 of the 1981 Record of the Society of Actuaries, which contains a transcript of a panel discussion on this subject at the Society of Actuaries meeting on April 9-10, 1981.

Drafters: The Committee on Health Insurance, chaired by W. H. Odell.

Index Code: 1981-29

To: Financial Accounting Standards Board

Date: October 16, 1981

Length: 15 pages beginning on page 299

Concerning: Accounting for employee benefit plans

Background: This submission to the FASB consists of the final report of the Task Force on Post-Retirement Health and Welfare Benefits released earlier in 1981. It was submitted as an addendum to earlier Academy statements to the FASB on this subject (see

1981-29 (Cont.)

statements 1981-15, 1981-20, and 1981-21).

Drafters: The Task Force on Post-Retirement Health and Welfare Benefits, chaired by Neal N. Stanley.

Index Code: 1981-30

To: Equal Employment Opportunity Commission

Date: October 30, 1981

Length: 8 pages beginning on page 314

Concerning: Risk Classification

Background: This statement was presented to the Equal Employment Opportunity Commission in response to proposed regulations which appeared in the Federal Register on September 1, 1981 (46 FR 43848-43852). These regulations were issued under the Equal Pay Act and would affect classification by sex under employee benefit plans.

Drafters: The Committee on Risk Classification, chaired by Jay C. Ripps.

Index Code: 1981-31

To: Senate Committee on Labor and Human Resources

Date: November 9, 1981

Length: 25 pages beginning on page 322

Concerning: Pension legislation

Background: This testimony was presented at a public hearing on S. 1541, the Retirement Income Incentives and Administrative Simplification Act. This bill is an omnibus ERISA amendments proposal.

Drafters: The Subcommittee on ERISA of the Pension Committee. The respective chairmen are Gerald Richmond and Douglas C. Borton. Executive Director Stephen G. Kellison presented the testimony at the public hearing.

Index Code: 1981-32

To: National Association of Insurance Commissioners

Date: November 9, 1981

1981-32 (Cont.)

Length: 10 pages beginning on page 347

Concerning: Statements of actuarial opinion

Background: This submission to the NAIC Accident and Health (B) Committee consists of proposed drafts of additions to the NAIC Instructions to the Annual Statement Blanks with respect to: (1) Hospitals, Medical and Dental Service Corporations, and (2) Health Maintenance Organizations. These two proposed drafts parallel to a considerable degree the existing statements of actuarial opinion contained in the Life and Accident and Statement Blanks. These drafts were also submitted separately to the NAIC Actuarial Advisory Group (Health).

Drafters: The Committee on Health Insurance, chaired by W. H. Odell.

Index Code: 1981-33

To: All Insurance Commissioners

Date: November 13, 1981

Length: 1 page beginning on page 357

Concerning: Risk retention groups

Background: This letter was sent to all state insurance commissioners subsequent to the passage of the Product Liability Risk Retention Act of 1981 by Congress. The Academy had previously submitted material to Congress during its deliberations on this bill (see statement 1981-17).

Drafters: Executive Director Stephen G. Kellison

Index Code: 1981-34

To: Securities and Exchange Commission

Date: November 30, 1981

Length: 4 pages beginning on page 358

Concerning: Independence/self-review

Background: This statement was submitted to the Securities and Exchange Commission in reaction to its announcement of the withdrawal of Accounting Series Release No. 264 and the proposed withdrawal of Accounting Series Release No. 250. These actions were announced in the Federal Register on August 27, 1981 (46 FR 43181-43185).

1981-34 (Cont.)

This statement follows a previous letter to the SEC on this subject (see statement 1981-25).

Drafters: Executive Director Stephen G. Kellison

Index Code: 1981-35

To: Senate Committee on Labor and Human Resources

Date: December 3, 1981

Length: 7 pages beginning on page 362

Concerning: Pension legislation

Background: This statement supplements the previous Academy statement on S. 1541, the Retirement Income Incentives and Administrative Simplification Act, which was filed on November 9, 1981 (see statement 1981-31). Statement 1981-35 addressed Title VI of the bill, whereas statement 1981-31 addressed the first five Titles of the bill.

Drafters: The Subcommittee on PBCC (Single Employer Plans) of the Pension Committee. The respective chairmen are Norman W. Clausen and Douglas C. Borton.

Index Code: 1981-36

To: NAIC Manipulation, Lapsation, Dividend Practices and Annuity Disclosure (A) Task Force

Date: December 10, 1981

Length: 2 pages beginning on page 369

Concerning: Dividend principles and practices

Background: This statement was presented to the NAIC Manipulation, Lapsation, Dividend Practices and Annuity Disclosure (A) Task Force as a status report of the activities of the Committee on Dividend Principles and Practices. This statement follows previous submissions on this subject to the NAIC (see statements 1979-14, 1980-18, 1980-32, and 1981-12).

Drafters: The Committee on Dividend Principles and Practices, chaired by John H. Harding.

Index Code: 1981-37

To: American Institute of Certified Public Accountants

Date: December 21, 1981

Length: 7 pages beginning on page 371

Concerning: Audit guide on employee benefit plans

Background: This statement was submitted to the AICPA on the chapter of the Audit Guide on Employee Benefit Plans dealing with health and welfare plans. The Academy had previously commented on other chapters of the Audit Guide (see statement 1980-26).

Drafters: The statement was prepared by the Subcommittee on ERISA Health and Welfare Plans of the Committee on Health Insurance. The respective chairmen are Anthony J. Houghton and W. H. Odell.

Index Code: 1981-38

To: American Institute of Certified Public Accountants

Date: December 29, 1981

Length: 2 pages beginning on page 378

Concerning: Discounting claim liabilities

Background: This statement was submitted to the AICPA in response to the Issues Paper on "Discounting Claim Liabilities of Insurance Companies" released on November 20, 1981. The Academy had previously commented on this subject to the AICPA (see statement 1980-23).

Drafters: The Committee on Life Insurance Financial Reporting Principles, chaired by Burton D. Jay.

STATEMENT 1981-1

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

January 8, 1981

Mr. Brian Zell
American Institute of
Certified Public Accountants
1211 Avenue of the Americas
New York, New York 10036

File Reference 3155

Dear Mr. Zell:

The American Academy of Actuaries Liaison Group appreciates this opportunity to comment on the AICPA draft (dated November 10, 1980) on Auditing Property and Liability Reinsurance. As you will no doubt appreciate, the views we have previously expressed on this subject and will express below can only be attributed to the several members of our committee. All of our committee members are knowledgeable about reinsurance, but we cannot claim that our views are representative of the entire Academy. The short time fuse you have put on this project plus the general logistical problems we face make it impractical for us to respond other than as a committee.

It is the consensus of our Liaison Group that the AICPA Task Force has cured many of the defects that existed in prior versions of the AICPA Auditing Property and Liability Reinsurance report. We thus have very few comments to offer on the specific language contained in the November 10, 1980 draft. We do however have a few general or global comments we would like to offer even though it is late in the game.

We note that the current draft now mentions loss reserves. As you may know, loss reserves are without a doubt the most critical component in the balance sheet of an insurance company, particularly a property/casualty reinsurance company. It would seem that this subject, while at least introduced, may not have been given the prominence it deserves.

Some members of our committee wish to bring to your attention, as other respondents have, some of the possible practical implications of the proposed audit guide. It seems likely that the proposed audit guide would impose additional burdens and costs on U.S. reinsurers, thus perhaps creating a competitive disadvantage. These additional burdens may at least in some small way exacerbate the problem U.S. reinsurers face when they compete with their non-U.S. counterparts many of which operate in more relaxed accounting and regulatory environments.

As a follow-on to the preceding point, we hope the Task Force appreciates the substantial amount of regulation that already exists in this arena. The various state regulators do of course monitor reinsurance arrangements in various ways. To give you some idea of at least the potential scope of this regulatory net, we enclose for your perusal a copy of Part 5 of the NAIC Examiners Handbook.

In addition to the regulatory framework mentioned above, there are other screens already in place. First of all, in most cases we are talking about situations where we have knowledgeable and sophisticated parties on both

AMERICAN ACADEMY OF ACTUARIES

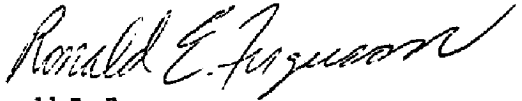
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Mr. Brian Zell
January 8, 1981
Page Two

sides of the transaction. A second screen, at least in the case of life companies, is the certification that a qualified actuary must sign. The statement the actuary signs would seem to be broad enough to include most, if not all, of the concerns implied by the AICPA draft. While such a certification is not yet standard procedure in the property and casualty industry, it would appear that it is just around the corner.

We commend the Task Force on the way it has responded to the various points raised by the various Liaison Groups. We look forward to working with the Task Force on the next step of this project as well as any future related projects.

Sincerely,



Ronald E. Ferguson
Chairman
AAA Task Force on Reinsurance Accounting

REF:jw

STATEMENT 1981-2

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

January 14, 1981

Brian Zell, Manager
Auditing Standards Division
File 3166
AICPA
1200 Avenue of the Americas
New York, New York 10036

Dear Mr. Zell:

On behalf of the Property and Casualty Committee on Financial Reporting Principles of the American Academy of Actuaries, we are pleased to comment on the exposure draft of a proposed statement of position, Accounting for Mortgage Guaranty Insurance. Our comments will be directed to each section of the exposure draft in their chronological order.

Premium Revenue Recognition

No matter how premium is collected, whether it be single or annual there will be total anticipated premium to be received over the life of a policy. We believe it should be optional as to how the anticipated premium is earned. If a recognized incidence of loss pattern is available, then premium should be earned coincident with such pattern. It makes little difference if earned premium exceeds collected premium, since ample precedence has been set in the Audit Guide for Property and Casualty Insurance Companies where earned but unrecorded premium is allowed in the section under premium revenue recognition.

Acquisition Costs

We believe that costs allocated to whatever method of premium is used for collection be deferred and amortized in accordance with how the total anticipated premium is earned over the life of the policy.

Premium Deficiencies

Premium deficiencies should be recognized by writing off any unamortized deferred acquisition costs to the extent required under the principles of premium revenue recognition and acquisition costs we have espoused in our comments above.

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Page Two

January 14, 1981

Losses

We believe that expected losses for a given group of policies should be a function of the earning distribution for those policies. We also believe that losses should not be accrued as of the initial default date but as of some date subsequent to that date based upon historical experience.

We will not comment on the issue of recognizing the time value of money in the area of loss reserves on premium deficiency reserves since as the exposure draft points out, this issue is being discussed in other forms.

Sincerely,

Donald E. Trudeau
Donald E. Trudeau
Chairman of the Property and Casualty
Committee on Financial Reporting
Principles

DET/alr

STATEMENT 1981-3

January 29, 1981

The Medical Malpractice Self-Insurance Task Force
American Institute of Certified Public Accountants

Gentlemen:

We appreciate the opportunity provided to discuss your proposed Issues Paper. The following paragraphs highlight some general areas of concern; attached are specific comments regarding the Issues Paper. Note that the comments pages are followed by a copy of the Issues Paper bracketed for each reference.

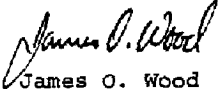
The general areas of concern are:

- Interpretation of FAS 5. While the amount of future malpractice claim payments is difficult to estimate with precision, the events that malpractice accruals, captives, trust funds, etc., are designed to cover have occurred as of the statement date. It would seem that the most appropriate interpretation of FAS 5 is that an accrual must be made. The difficulty of making the estimate does not imply that the liability does not exist.
- Use of outside data. The quality of the estimate of malpractice liabilities is materially improved if data from insurance industry sources is utilized. This is entirely consistent with insurance industry ratemaking and reserving practice. In our view, the appropriate use of outside data, together with the provider's own experience, results in the reasonable estimate of the amount of loss required by FAS 5, paragraph 8b).
- Mismatching of revenue and expense. The advisory conclusions would result in a severe mismatching of revenue and expense, since losses would generally be accrued only several years after the revenue had been recognized.
- Pay as you go funding. Failure to accrue estimated liabilities would be a further step toward pay-as-you go funding, which already has several important institutions, such as Social Security, in financial difficulty.

The Medical Malpractice Self-Insurance Task Force
American Institute of Certified Public Accountants
January 29, 1981
Page Two

Hopefully these comments will provide a basis for discussion at our
January 30 meeting.

Sincerely,



James O. Wood

JOW/bjw

Enclosure

cc: AAA Task Force on Self-Insurance Trusts
Mr. Steven G. Kallison
Mr. Warren P. Cooper

Comments Regarding Issues PaperAccounting for Medical Malpractice Loss Contingencies of
Health Care Providers and Related Issues

<u>Issue</u>	<u>Page</u>	<u>Item</u>	<u>Comment</u>
1	3	1	Should be by a third party.
		2	Not clear - should be an incident that has not been identified by the provider or reported by a third party.
	5	3	Estimates by claims managers generally consist of estimated liabilities for reported incidents and asserted claims, i.e., known incidents or claims. Actuaries generally test case reserving adequacies or redundancies and estimate the liability for unreported incidents (IBNR).
	5	4	The reverse of this statement is (or should be) true. That is, the annual contribution is directly related to actual experience.
6, 7		5	Accountants rarely, if ever, request such a statement. If they did, it is quite likely that the actuary would say that the funding recommendation was in accordance with FAS 5. Perhaps the larger problem is in the area of interpretation of FAS 5. Specific interpretations of FAS 5 vary significantly.
	7	6	Funding requirements are determined at the beginning of a year so that the health care provider can anticipate costs before they occur. This same philosophy applies to insurance premiums. The fact is, health care providers need to budget in advance for anticipated costs. Adjustments to all funding recommendations are applied retrospectively.
	7	7	The actuarial procedures that should be used are well defined in the actuarial literature. The practice of actuaries is to use the health care provider's data supplemented with industry data. To the extent that the health care provider's data is credible, the health care providers data is used. This practice is consistent with all insurance premiums.

<u>Issue</u>	<u>Page</u>	<u>Item</u>	<u>Comment</u>
7, 8		8	<p>A margin for adverse deviation is generally included and has, associated with the given margin, a probability level. For example, a funding recommendation may be determined that provides a 75% confidence level that actual losses will not exceed the fund - this implies that there is a 25% chance that actual losses will exceed the fund. This procedure should be compatible with FAS 5, unless specific probability levels are assigned to FAS 5. What is "reasonable"?</p> <p>It would be easy to present funding recommendations without the specific margins. The determination of expected costs produces a statistical expectation on which to base the funding recommendation. The expected cost is a statistic, not a funding recommendation.</p>
9		9	<p>This could be the "shot heard round the world" for actuaries and accountants.</p> <p>From an actuarial standpoint a single health care provider's experience will probably never provide enough data to use as a sole information source. Also, the past is not always the best predictor of the future for a single health care provider (or for a large insurer). This requirement would eliminate, for the most part, the use of sound actuarial and statistical projection procedures, and is totally inconsistent with both insurance and self-insurance principles.</p> <p>Another important implication of this requirement is that the funding levels so determined would <u>not</u> be in conformance with the Medicare guidelines, thus, the provider could lose reimbursement from Medicare. This could put health care provider managements into untenable positions, expose them to D&O liability and threaten their employer's solvency.</p> <p>If accruals cannot be made by a health care provider due to a lack of "adequate information", the providers management would, almost certainly, have to purchase insurance.</p> <p>This requirement would impact most self-insured hospitals, resulting in the possible release of current funds held for self-insurance. This situation could cause many problems for the current auditors and actuaries. Budget problems would be a direct result.</p>

<u>Issue</u>	<u>Page</u>	<u>Item</u>	<u>Comment</u>
			Is this requirement consistent with "Audits of Fire and Casualty Insurance Companies"? Page 39 of the audit guide suggests comparison of company results with industry results. The audit guide also suggests that a margin is appropriate and the use of credibility procedures necessary. FAS 5 also refers to the use of outside data as appropriate (pp. 25 & 30).
	9	10	Is it appropriate to note a contingency that could be funded for if the previous requirement were changed? Would this result in a qualified opinion?
		9&10	If health care providers are not allowed to earmark funds for self-insurance, those with budgets open to public/political scrutiny risk losing use of these funds for self-insurance.
2	10	1	This point is true and when considered with Issue 1, page 9, item 1, suggests that most self insurance plans will be improperly funded if only provider data is utilized.
	11	2	This item is generally true, however, claims adjustors rarely reflect anticipated investment income. Also, a number of Medicare auditors require that investment be considered if the providers want reimbursement.
	12	3	Discounting should only be considered when there are appropriate investments.
	12	4	Malpractice premiums rarely take into consideration explicitly the time value of money.
	12	5	Pension expense is a good example of a long term imprecise liability that is discounted, but also is estimated using statistical techniques and broad averages developed from outside data and which contains a margin for the risk of adverse deviation.
	12	6	Investment rates and loan rates are quite different!
	12	7	Is it consistent to apply insurance company committee results to Issue 2 and not Issue 1? It should also be noted that a calculated self-insurance fund undiscounted without a margin is quite likely to be greater than a discounted fund with a margin.

<u>Issue</u>	<u>Page</u>	<u>Item</u>	<u>Comment</u>
3	16	1	Is this consistent with Issue 1, page 9, Item 10? A contingency does exist, just as surely as in this instance. A contingency exists with respect to the purchase of tail coverage, availability of tail coverage and the unfunded liability.
	16	2	Tail coverage for prior years and occurrence coverage for the current year will be expensed in the same year, a very poor matching of expense and revenue.
4	17	1	How large is a group?
	18	2	Wouldn't the transfer of risk depend on the maximum and minimum premium ratios of the particular retro agreement?
	18	3	Would 5 fifty (50) bed hospitals be a group and subject to this treatment while one 750 bed hospital with more predictable experience than the group be treated as above? How large is a group?
5	23	1	See Issue 1 comments.
6	25	1	See Issue 4 comments and Issue 1 comments.
	26	2	See Issue 4 comments.
7	29	1	See Issue 1 comments.
	30	1	See Issue 1 comments.
		2	Since an individual provider may not be able to purchase tail coverage due to cost, availability, etc., disclosure should probably always be required if it is required in this instance.
	31	3	How does this impact Medicare reimbursement?

STATEMENT 1981-4

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

WALTER L. GRACE, M.A.A.A., President
c/o MASSACHUSETTS MUTUAL LIFE INS. CO.
1295 STATE ST.
SPRINGFIELD, MA 01111
413/788-8411

February 3, 1981

Mr. C. Peter McColough, Chairman
President's Commission on Pension Policy
736 Jackson Place, N.W.
Washington, D.C. 20006

Dear Mr. McColough:

On January 7, 1981, Mr. Donald J. Kirk wrote to you "delineating the role and responsibilities of the FASB as they relate to pensions."

As President of the American Academy of Actuaries, I believe a response to Mr. Kirk's letter is appropriate.

First, I want to state clearly that the Academy recognizes the responsibilities of the FASB to "establish standards of financial accounting and reporting," and that we recognize, and appreciate, the extensive "due process" procedures employed by the FASB. Furthermore, the Academy does not take the position that "the need, by itself, to involve actuaries should be a constraint on the content of financial statements."

While Mr. Kirk's letter refers to extensive cooperation between the Academy and the FASB, in which the Academy was certainly pleased to participate, unfortunately, from the Academy's perspective, the cooperation was primarily at a technical level.

On the broad philosophical level, the Academy's public position has been stated consistently from 1973, through the issuance of FASB Statement No. 35, and on through Mr. Swick's testimony on November 14, 1980, before your Commission.

Mr. Swick's testimony to your Commission sets forth the actuarial profession's long-term concern about our public responsibility for making an understandable statement of the plan's funding status to interested parties. Our profession feels that the statement of the funding status of the plan is the one of major import on behalf of plan participants. The differing objectives of the two professions as to disclosure is clearly part of the problem. The actuarial profession will continue to discuss this problem with the FASB, the accounting profession, and others, since it seems clear that the public interest deserves continued attention to these major issues.

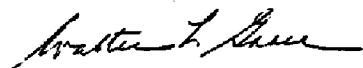
Mr. C. Peter McColough

February 3, 1981

This major concern of Academy members with Statement No. 35 was expressed directly to Mr. Kirk by letter dated May 15, 1980, from Mr. Ronald L. Bornhuetter, then President of the Academy. A copy of this letter and Mr. Kirk's reply are enclosed.

I trust you will find this letter to be a helpful clarification of the role of the Academy with respect to FASB Statement No. 35.

Sincerely,



Walter L. Grace

Enclosures

cc: Mr. Stephen G. Kellison
Mr. Donald J. Kirk
Mr. Thomas C. Woodruff

May 15, 1980

Mr. Donald J. Kirk, Chairman
Financial Accounting Standards Board
High Ridge Park
Stamford, Connecticut 06905

Dear Don:

We have received some questions and comments from our members concerning the FASB Statement of Position #35 and its accompanying press release. The inquiries pertain to the overall position of the Academy on the inclusion of actuarial statements within the financial statements.

In reviewing the matter, we felt it necessary to write an article in our "in-house" newsletter publication clarifying our part and current position on this point. A prerelease copy of this article is attached for your information.

We believe this article explains the passage of events as we see them and, hopefully, as you do also. We do look forward to continued dialogues between our organizations, as one of the main purposes of the Academy is to assist organizations such as the Board on all actuarial matters, be it life, health, casualty or pension topics.

Thanks again for listening to our views.

Cordially,

Ronald L. Bornhuetter

RLB:ism
Attachment

bcc: Mr. W. L. Grace
Mr. S. G. Kellison
Mrs. M. Adams
Mr. E. F. Boynton

FASB Issues Standard on Pension Plan Accounting

In late March the Financial Accounting Standards Board released the long-awaited Statement No. 35 entitled "Accounting and Reporting by Defined Benefit Pension Plans." This standard is the culmination of over five years of investigation, public hearings, meetings with interested parties, and extensive consideration of approximately 1000 written comments on two earlier exposure drafts. Also in this issue is the FASB's summary of the major provisions of this standard.

In announcing the new standard, FASB Chairman Donald J. Kirk described the standard as one of "great social importance" and is "a breakthrough in that it eliminates the broad diversity of ways in which plans up to now have provided financial information that might be used in assessing a plan's present and future ability to pay employees' benefits when due." He went on to add that "it represents substantial agreement among the FASB, American Academy of Actuaries, and the U.S. Department of Labor regarding the financial reporting practices of private pension plans."

The Academy contributed extensive discussions and several position papers over the past years as this standard was being developed. Much of this activity has been reported in the Newsletter and the Enrolled Actuaries Report. The results of this dialogue have been gratifying in that significant changes in earlier FASB drafts have occurred which incorporate recommendations made by the Academy.

The Academy position, from the beginning, has been that inclusion of actuarial values in the financial statements of the plan is unnecessary, since the enrolled actuary's report contains the required actuarial information. Moreover, confusion may result from one set of actuarial numbers in the actuary's report (for funding purposes) and another set in the accountant's report (for financial reporting purposes).

Thus, the substantial agreement of the Academy referred to in the press release is under the assumption that the FASB will require the financial statements of the plan to include actuarial values of benefits.

It is interesting to observe that the final standard was adopted by a 4-3 vote. The statement filed by the three dissenters states that the standard "improperly includes what they consider to be actuarial statements within the financial statements rather than as supplementary information outside the financial statements" as one of the bases for the dissent.

In summary, the Academy prefers that no actuarial data be contained in the accountant's report. However, if such information is to appear, the final standard contains a reasonable approach to developing such information and does recognize the professional role of actuaries in providing the required information.

The FASB should be commended for its willingness to consider the views of the actuarial profession and to make many improvements as a result of these views. The Academy has developed a much stronger working relationship in recent years with the FASB and our views are being given careful consideration and often adopted. We believe that this type of continuing dialogue is of great importance to both the FASB and to the actuarial profession.

Financial Accounting Standards Board

HIGH RIDGE PARK STAMFORD CONNECTICUT 06905 203-329-8401



DONALD J. KIRK, Chairman of the Board

May 19, 1980

Mr. Ronald L. Bornhuetter
General Reinsurance Corp.
600 Steamboat Road
Breenwich, CT 06830

Dear Ron:

Your draft article accurately describes my understanding of the position on inclusion of accumulated benefit information in financial statements that was taken by the Academy during the period in which Statement 35 was being developed.

As you know, the Board worked hard to ensure that our final Statement appropriately recognized the professional role of actuaries in providing the required information, and I am pleased that the Academy has concluded that if the information is to be reported in financial statements, Statement 35 represents "a reasonable approach."

We, too, look forward to continuing dialogue between the Board and the Academy.

Sincerely,

Donald J. Kirk

/jal

Financial Accounting Standards Board

HIGH RIDGE PARK STAMFORD CONNECTICUT 06905 203 329-8401



January 7, 1981

Mr. C. Peter McColough, Chairman
President's Commission on Pension Policy
736 Jackson Place, N.W.
Washington, DC 20006

Dear Mr. McColough:

Pursuant to discussion with Thomas C. Woodruff, we are writing to comment on the November 17, 1980 letter to you from George B. Swick, Chairman, Buck Consultants, Inc.

In that letter, Mr. Swick notes that, with the increasing importance of pension funding in the United States, adequate and appropriate disclosure is essential. He expresses the belief that such disclosure will be developed only if a clear mandate is given to require that:

- o actuarial disclosure be the primary disclosure;
- o other disclosure, under regulation or generally accepted accounting principles, be clearly designated as supplemental disclosure;
- o the actuarial profession promulgate specific rules for such disclosure, with appropriate public exposure in the development process.

Mr. Swick expresses the belief that a clear call for such a mandate by the President's Commission would be a major step in the public interest.

The meaning of the term "actuarial disclosure" is not clear, though Mr. Swick's written statement to the Commission states that, generally, most actuaries would consider the emerging progress against the funding pattern to be the most important actuarial disclosure. Nor is it clear in what context Mr. Swick considers that actuarial disclosures should be the primary disclosures. Possibilities include funding or financial reporting. In



Mr. C. Peter McColough

January 7, 1981

responding to the issue raised in his November 17 letter, therefore, we have concentrated primarily on delineating the role and responsibilities of the FASB as they relate to pensions.

Background About FASB

As noted in our written Statement to the President's Commission, the FASB is the recognized accounting standard-setting body in the United States. It is an independent, seven-member board that operates under the oversight of a private foundation, the Financial Accounting Foundation. That foundation is sponsored by six national organizations representing accounting academicians, public accountants, security analysts and investment advisors, corporate financial executives, management accountants, and investment bankers and brokers.

FASB pronouncements establish standards of financial accounting and reporting. Those standards are geared to general-purpose external financial reporting by enterprises, rather than to special reporting such as to regulators. The FASB's standards are recognized under the Rules of Conduct of the American Institute of Certified Public Accountants and under the CPA licensing statutes, regulations, or practices of the 50 states, and are officially recognized as authoritative by the Securities and Exchange Commission (SEC Accounting Series Release 150).

Before it issues a Statement, the Board is required by its rules to follow extensive "due process" procedures which in many ways are more stringent than the requirements of the Federal Administrative Procedures Act. The Board's deliberations are open to the public, and a complete public record is maintained.

FASB and Pensions

In the pension area, matters relating to plan accounting and financial disclosures, as set forth in FASB Statement No. 35, Accounting and Reporting by Defined Benefit Pension Plans, and financial accounting disclosures by employers, as set forth in FASB Statement No. 36, Disclosure of Pension Information, are clearly within the scope of the Board's authority. The same is true for the Board's examination of the accounting by employers for pensions and other postemployment benefits, currently under way. Conversely, matters relating to the auditing or funding of pension plans are clearly outside the scope of the Board's authority. The former is the province of the public accounting profession and the latter that of the actuarial profession.



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January 7, 1981

The Board recognizes the essential role of the actuary in developing certain financial information. However, the Board does not accept the view that, if the preparation of information does not fall within the professional qualifications of accountants, it is outside the scope of financial accounting. There are many instances in which financial information presently disclosed in financial statements is prepared exclusively by, or with the assistance of professionals other than accountants. For example, the use of appraisers is common in establishing the value of nonmonetary assets acquired in a business combination accounted for as a purchase. Also, preparation of financial accounting information often requires assistance from the engineering or legal professions. Hence, the Board rejects the notion that the need, by itself, to involve actuaries should be a constraint on the content of financial statements.

Funding and Accounting for Pension Plans

Actuaries use any of several techniques in determining the amounts of employer contributions required to provide for pension costs, in other words, required to "fund the plan." The problem of funding a pension plan is similar -- but not identical -- to the problem of accounting for the periodic pension expense and the obligation that exists at the end of a period. The funding problem involves assumptions about the same future events affecting the amount of future pension expenditures. Based on those assumptions, actuaries can develop a schedule of employer payments or contributions to the fund. When the contributions are accumulated and combined with investment return, the total must be sufficient to provide the benefits promised to participants.

The similarity of the basic problems obscures an important distinction between the two activities. Similar calculations are involved in funding and financial reporting, but each is guided by different objectives. The funding objective is to determine an acceptable budget for financing the estimated ultimate cost of a pension plan. This is essentially a financial task and must be conducted in a way consistent with the financial needs of the employer, the financial position of the plan, and if covered by ERISA, the requirements of that law. For example, the actuary must develop a funding pattern that is satisfactory to an employer desiring to have level and predictable funding requirements rather than fluctuating requirements. Or, the employer may wish to minimize funding requirements because a higher return can be earned within the business than would be earned on the pension fund investment.



Mr. C. Peter McColough

January 7, 1981

The accounting objective is to provide users with information useful in making rational economic decisions, including information about resources and claims to those resources, and information about financial performance. Accountants must use actuarial calculations to provide a reasonable measure of the periodic pension expense and of the obligation that exists at the balance sheet date.

Cooperation Between FASB and the Actuarial Profession

During the development of Statement 35, the FASB worked in close cooperation with both the American Academy of Actuaries and individual representatives of the actuarial profession in resolving many issues. That cooperative relationship spans a period of almost six years, from the development of the initial Discussion Memorandum, published in October 1975, through two Exposure Drafts of a proposed Statement, issued in April 1977 and July 1979, to publication of the final Statement 35 in March 1980.

There are many examples of the benefits derived from this extended cooperative effort. For instance, it resulted in an agree-upon fundamental basis for determining the actuarial present value of accumulated plan benefits. As a result, Statement 35's approach to determining accumulated plan benefits for disclosure in plan financial statements is consistent with the recommendations of the American Academy of Actuaries set forth in the Academy's Interpretation No. 2. The approach is also consistent with that used by the Department of Labor in determining the present value of vested and nonvested plan benefits reported on Schedule B of the annual reports submitted by plans covered under ERISA. In that regard, in commenting on the 1979 Exposure Draft the Academy stated:

"We are also pleased that the determination of the amount of the accrued benefit will follow the Academy's Interpretation 2. We recognize the difficulty which the Board faced in dealing with the complex questions regarding the use of salary projection factors in such determinations, and endorse the Board's decision, consistent with Interpretation 2, that for this purpose the use of salary projection factors is not appropriate."

Also, in recognition of technical and practical problems identified by the Academy and others, the Board, in the 1979 Exposure Draft modified its original position by providing for presentation of plan benefit and associated plan asset information as of the beginning of a plan year, as an alternative to end-of-year presentation.



Mr. C. Peter McColough

January 7, 1981

As a further example, in its initial Exposure Draft the Board proposed the use of Pension Benefit Guaranty Corporation (PBGC) interest and mortality rates in measuring the present value of accumulated plan benefits. Responding to comments of the Academy and others that the use of PBGC raters implies plan termination, the Board concluded that the use of assumptions that reflect a plan's expected experience would result in more appropriate benefit information. Discussions with members of the actuarial profession following publication of the 1979 Exposure Draft led to additional clarification as to the appropriate interest rate to be used in determining plan benefit information.

As the foregoing examples indicate, the Board, in accordance with its due process procedures, has sought and benefited from the advice of both the Academy and individual members of the actuarial profession. The Board will continue to seek such advice as it proceeds with the examination of accounting by employers for pension and other postemployment benefits. However, financial accounting and reporting standards are the responsibility of the FASB. They are, in effect, the rules governing the preparation of financial reports. The Board has the designated authority to establish those rules and must use its best judgment in exercising that authority in order to fulfill its responsibilities in the public interest.

We will be glad to discuss this matter further, if you so desire.

Very truly yours,

A handwritten signature in cursive script that reads "Donald J. Kirk".

Donald J. Kirk

DJK/192W

cc: George B. Swick
Thomas C. Woodruff
Stephen G. Kellison

STATEMENT 1981-5

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

STATEMENT TO THE SUBCOMMITTEE ON SOCIAL SECURITY
OF THE HOUSE COMMITTEE ON WAYS AND MEANS
JAMES R. SWENSON, CHAIRMAN OF THE
COMMITTEE ON SOCIAL INSURANCE
OF THE
AMERICAN ACADEMY OF ACTUARIES

February 27, 1981

Mr. Chairman and distinguished members of the Subcommittee, my name is James R. Swenson. I am the Chairman of the Committee on Social Insurance of the American Academy of Actuaries. On behalf of the Academy, I wish to thank you for the opportunity to discuss financing issues affecting the Social Security program.

The American Academy of Actuaries is a professional organization 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. It includes members of three founding organizations -- the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

Requirements to become a member of the Academy can be summarized under two broad headings: (1) education and (2) experience. At the present time, the education requirements for membership can be satisfied by passing certain professional examinations given either by the Casualty Actuarial Society or the Society of Actuaries or by becoming an "enrolled actuary" under the Employee Retirement Income Security Act of 1974 (ERISA). The experience requirement consists of three years of responsible actuarial work.

As of the end of 1980, the Academy membership exceeded 6,200. The Academy is unique as the national actuarial organization for actuaries in all areas of specialization. These actuaries have a variety of types of employment, including insurance organizations, consulting firms, academic institutions, and government. A large majority of those individuals who have satisfied the education and experience requirements of the Academy have, in fact, joined the Academy.

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, liaison with other professions and public relations.

Actuarial science involves the evaluation of the probabilities of uncertain future events, often over long periods of time, and the financial impact which these events involve. The computation of financial values for insurance and pension programs in both the public and private sectors is a major application of actuarial techniques. The actuarial nature of the financing arrangements for Social Security has been recognized since the inception of the program in 1935. In recognition of the extreme importance to society of maintaining the financial integrity of the Social Security system the Academy formed its Committee on Social Insurance several years ago. The Committee includes some of the most eminent actuaries in the United States with a wealth of experience in both the public and private insurance and pension programs.

Since I am representing a professional organization comprised of individuals who hold diverse political views, this statement will not generally favor or oppose specific legislative proposals. Instead, the statement will discuss the financial implications of various alternatives to assist you in your deliberations. It is apparent that legislation needs to be enacted to resolve the predicted short term financing problems of the OASI portion of the program. The Academy believes that it is equally important that long term financing issues be addressed at the same time to help assure the financial viability of the program and to restore public confidence in the program.

The short term financing problems would be substantially alleviated if proposals permitting inter-fund borrowing were enacted. However, the margins protecting the program from adverse economic conditions would be very modest unless other steps are taken as well.

Adverse economic conditions are the primary cause of the short term financing problems. Unfortunately, CPI measured price increases exceeded average wage increases by 3.1% in 1979 and preliminary estimates indicate that such price increases exceeded wage increases by 5.0% in 1980. If the 1977 Social Security Amendments had provided that benefit increases be based upon the smaller of wage or price increases, short term cash flow problems would not now be upon us.

The relative unpredictability of the economy indicates that more emphasis should be placed on financial projections based upon pessimistic assumptions. It should be noted that projections based upon pessimistic assumptions indicated

the potential for short term cash flow problems shortly after the 1977 Amendments were enacted. Virtually no publicity was given to that fact at the time.

Long term financing issues pose an even greater challenge to the program. Since the Social Security program is an intergenerational transfer program, funded essentially on a pay-as-you-go basis, the demographic influences of increasing life expectancy combined with the post World War II baby boom and subsequent baby bust will require substantial increases in future payroll tax rates. The financial viability of the program depends upon the willingness and the capability of persons who are working to pay taxes sufficient to support promised benefits.

Official actuarial estimates predict OASDHI benefit costs ranging from 20% to 36% of payroll by the year 2030. In addition, long term projections based upon intermediate assumptions indicate that OASDI benefit disbursements will exceed scheduled taxes by an average of 1½% during the next 75 years.

Proposals to increase the age at which full Old-Age benefits are to be paid would reduce the tax levels required to be paid by future generations of workers. For example, proposals to gradually increase the retirement age from 65 to 68 would generally eliminate approximately two-thirds of the 75 year OASDI financing deficit. To further assist you in your deliberations, it should be noted that today life expectancy at age 68 is greater than it was at age 65 in 1935 when the latter age was selected as the original retirement age under

the program. Moreover, actuarial projections indicate that by the year 2000, individuals in their early 70's are expected to have the same life expectancy as individuals age 65 had in 1935.

As you are aware, Universal Social Security Coverage has been recommended by many commissions, advisory panels and study groups. If Universal Social Security Coverage is enacted, it is important that the benefit structure of existing programs be coordinated with the Social Security program. This will pose a complex problem, but the actuarial profession is prepared to offer assistance so that the coordination can be accomplished in a rational manner. If Universal Social Security Coverage is not enacted, the actuarial profession has suggested methods to remedy the unintended "windfall benefit" situation.

The current financing problems of the program illustrate the continuing need for independent, professional actuarial analysis. The Office of the Actuary of the Social Security Administration and the actuaries employed in the Health Care Financing Administration are uniquely qualified to provide such analysis. They must be given the latitude to select a range of appropriate assumptions independent of "official" economic forecasts.

It should be noted that the Employee Retirement Income Security Act of 1974 (ERISA) requires that valuations of private pension plans be certified by qualified actuaries. A similar actuarial certification is required by P.L. 95-595 for pension plans covering federal employees. In each situation, the actuary must certify that the assumptions used are reasonable in the aggre-

gate, representing the best estimates of anticipated experience, and that methodology is proper. The American Academy of Actuaries recommends that the Social Security Act be amended to enable the public to enjoy the same benefit of professional actuarial certification for the Social Security program. This recommendation has also been made by the National Commission on Social Security.

Consistent with this recommendation, the Board of Directors of the American Academy of Actuaries has adopted the following resolution:

"Whereas actuarial projections and cost estimates based on work of the highest professional quality and integrity have been an important force for fiscal prudence in the historical development of social insurance programs; and

"Whereas the growth of these programs and their commitments to future generations of beneficiaries makes it more important than ever that these programs be managed in a fiscally prudent manner;

"Therefore, be it resolved that this organization believes that it is in the best interests of the public that (1) the actuaries who are responsible for the projections and cost estimates be free to use their best professional judgment and expertise independent of pressures for political expediency, and (2) the actuaries ultimately responsible for their work be required to issue an opinion letter accompanying the appropriate annual report stating whether the actuarial assumptions used in the projections contained therein are (a) in the aggregate reasonable taking into account the experience and expectations of the plan and (b) represent their best estimates of anticipated experience under the plan."

In conclusion, the Academy hopes this testimony has been helpful, and we would welcome the opportunity to be of further assistance as you proceed with your important deliberations.

STATEMENT 1981-6

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

March 12, 1981

Director of Research & Technical Activities
File Reference 1026-013
Financial Accounting Standards Board
High Ridge Park
Stamford, Connecticut 06905

RE: FASB Discussion Memorandum on Reporting Funds Flows,
Liquidity, and Financial Flexibility, dated
December 15, 1980

Dear Sir:

The following comments are submitted with respect to the above on behalf of the General Committee on Financial Reporting Principles of the American Academy of Actuaries. Our comments relate primarily to financial reporting by the insurance industry.

We believe it is noteworthy that the first two possible functions of the Funds Flows information as listed in Chapter 2, contain the phrases "to provide a basis for assessing future cash flows..." and "assessments of future income." This clearly indicates the information provided would be designed to aid users in projecting future cash flows.

Our comments on the questions raised in paragraph 295 are as follows:

- A. Our committee is most supportive of reasonable efforts in the direction of identifying cash flows (past and future), and financial flexibility. The definition of funds as cash appears to be the most useful.

The direct approach of presenting premiums, investment income, claims, expenses, and investment transactions on a cash basis is more meaningful in that it clearly identifies the sources of cash. Under the reconciliation approach, we do not think it is meaningful to identify separately benefit reserve increases, amortization of acquisition costs, or deferral of acquisition costs. All three items represent the portion of cash flow which must be held as deferred income because of future obligations to policyholders.

It is appropriate to deduct deferred acquisition costs in computing cash flow. Such costs are normal operating expenses, the bulk of which typically represent contractual

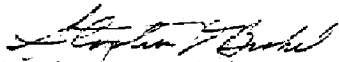
commitment to agents. We believe that most life insurance company actuaries also feel that it is appropriate to deduct the net increase in policy loans.

- B. Since the balance sheet of most insurance companies, particularly life insurance companies, contain substantial reserve liabilities for benefits payable for many years into the future, any assessment of potential future cash flow available for distribution or expansion must involve an examination, not only of existing assets, but also:
1. The future cash flow requirements arising from future claims and the maturing of other policy obligations,
 2. The future changes in reserve liabilities for unincurred or incurred but unreported claims, and
 3. The future cash flow of premium and investment income, particularly as it relates to policies already in force.

The timing of the maturity of either assets or liabilities is only significant when both are taken together. Therefore we believe paragraphs 315-320 of the discussion memorandum understate the need for, and the complexity of identifying the amount and timing of cash flow requirements arising from existing liabilities.

- C. An insurance company's need for asset liquidity and financial flexibility is determined by the anticipated maturity of liabilities. Anticipating the timing of the maturity of such liabilities is one of the functions for which actuaries are trained. The Academy has been studying this topic as it relates to the responsibility of the professional actuary, and would be glad to offer any assistance where appropriate.

Sincerely,


Stephen D. Bickel
Chairman, General Committee
Financial Reporting Principles

cc: Walter Grace
Stephen Kellison
Richard Robertson
David Stonecipher
General Committee on Financing Reporting Principles

STATEMENT 1981-7

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

March 17, 1981

Administrator
Health Care Financing Administration
Department of Health & Human Services
Post Office Box 17073
Baltimore, MD 21235

RE: BPP-91-P

Dear Mr. Administrator:

The American Academy of Actuaries appreciates the opportunity to comment on the proposed regulations to implement Section 507 of the Social Security Disability Amendments of 1980 as they appeared in the Federal Register of Wednesday, January 21, 1981, and supplementary drafts supplied by George Calat, Actuary.

We have three general observations. We also offer suggestions or comments on three areas. We think these will enable you to further improve the regulation and avoid unnecessary misinterpretation, effort, and expense.

The three observations:

1. The regulation gives evidence of much thoughtful effort. Technical items are addressed. An attempt has been made to define terms carefully. Paragraph 403.224 is a good example. We believe efforts taken to carefully prepare this type of regulation will ease the administrative load and help the actuary understand requirements.
2. We note the requirement in paragraph 403.245 for an "actuarial certification". In concept, we believe this is a reasonable requirement because the information to be reviewed and the evaluation to be made concerns an area of expertise where actuaries are uniquely qualified. We do suggest, however, that the words "statement of actuarial opinion" be substituted for the words "actuarial certification". We believe the term "certification" misrepresents the nature of the opinion by implying a level of exactness and precision which is inappropriate in this situation. On the other hand, we believe the term "statement of actuarial opinion" more accurately characterizes the required opinion. It is analogous to professional opinions which are issued routinely in law, medicine, accounting and other professions. More over, precedent for use of the term "statement of actuarial opinion" is readily available:

see for example the statement required for the NAIC Life and Accident and Health Statement blank with regard to policy reserves and other actuarial items as well as the NAIC Fire and Casualty Annual Statement blank with regard to casualty loss reserves. Both call for a "statement of actuarial opinion". In addition, the term is time honored in the profession.

3. We believe the requirement in paragraph 403.245 for actuarial participation is extremely desirable. The information to be reviewed and the evaluation to be made concern areas of expertise in which actuaries are uniquely qualified. We support the specific recognition of the American Academy of Actuaries in paragraph 403.227. As you know the Academy was formed, among other reasons, to assist responsible government officials in identifying qualified actuaries.

There are three areas on which we offer suggestions or comments:

1. We suggest paragraph 403.224(d) be changed to read:

"(d) Discounting may be ignored for periods not exceeding twelve months."

We understand the concern is to provide assurance that in the case of one year term policies discounting will not be required over the one year term period. We believe the proposed wording will accomplish this objective. The present wording might be misconstrued to require that long-term policies have a loss ratio each and every year at least equivalent to the minimum loss ratio. The law specifically refers to "...as estimated for the entire period for which rates are computed to provide coverage..." in paragraph section 1882(c)(2).

2. Use of interest: Loss ratio calculations in the past, as have been required by various states, have been on a no interest basis. There are potential problems involved in utilizing interest in this type of calculation especially for long-term policies. If it is decided to utilize interest in the calculations, the Academy stands ready to help you in the definition of actuarial practices for the purpose of interpreting the loss ratio requirement of law.
3. Paragraph 403.226(3) asks for an explanation of why the policy meets or fails to meet considerations as an individual policy. Another paragraph requires submission of a policy form. Since the question of whether or not the policy is individual or group should be answered by the contract itself we suggest deletion of 403.226(3). Whether a contract is individual or group should be determinable from the contract itself and any explanation would not change the result.

We may have additional observations on the supplementary drafts supplied by George Calat after further study of them.

If you have any questions concerning the above please feel free to contact the undersigned or the Academy's Washington office (address and phone above). Incidentally, there are three areas in particular where we may be able to help you: 1)with regard to any hearings you may hold on these regulations; 2)in connection with any technical questions which may arise during the course of the studies of certain plans of health insurance you plan to undertake; and 3)with unanticipated questions that are almost sure to arise as this regulation is implemented.

Very truly yours,

Committee on Health Insurance

W. H. Odell, Chairman
E. Paul Barnhart
Kenneth J. Clark
Robert H. Dobson
Robert J. Dymowski
Anthony J. Houghton
James K. Hutchison
Richard J. Mellman
James L. Purdy
Harry L. Sutton, Jr.
Vernon Switzer
Peter M. Thexton
Gordon R. Trapnell

cc: Mr. George Calat

STATEMENT 1981-8

May 5, 1981

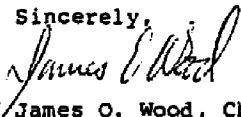
Mr. Loren B. Kramer
AICPA Medical Malpractice
Self-Insurance Task Force
Kramer Consulting Services
222 N. Michigan Avenue
Chicago, Illinois 60601

Dear Loren:

Attached is a suggested draft for the Issue No. 1 conclusions in your Task Force's proposed guidelines. You already have my suggestions for modifying the discussion portion of this issue (January 29, 1981 letter). Also we would be happy to work with your Task Force in rewriting any portion of your guidelines to agree with the Issue No. 1 conclusions.

If you should have any questions, please call.

Sincerely,


James O. Wood, Chairman
AAA Task Force on Self-Insured Trust Funds

JOW/bjw

Enclosure

cc: AAA Task Force on Self-Insured Trust Funds
Mr. Stephen G. Kellison

ISSUE NO. 1

What is the appropriate basis for determining when self-insured asserted and unasserted malpractice claims should be accrued?

ADVISORY CONCLUSIONS

The cost of malpractice claims, including the effects of anticipated future inflation, should be accrued as the incidents that give rise to them are incurred on a "best estimate" or actuarial basis.

The actuarial funding determination should be based on the provider's historical exposure and claim experience to the extent it is actuarially credible. To the extent such experience is not credible, the actuarial funding will incorporate relevant hospital industry and/or insurance industry actuarial data, assumptions, etc. The source of such external information will frequently be compiled by national insurer statistical agents, or large insurance companies providing coverage in a particular state. For workers' compensation, the source of external exposure and claim information should be the rating and statistical organization authorized by the state in question.

Funding adjustments for prior periods will routinely be made so as to reasonably reflect emerging actual experience, and should be based on sound actuarial techniques. Funding for current and prior periods will be established to reflect a reasonable and predetermined level of statistical confidence of adequacy.

Depending on provider practice, the current period may be a period already underway or one which is about to begin. Prior periods include those whose term has already ended or is about to end.

Actuarial funding will routinely take into account the discounted or present value of estimated future claim payments on expected losses occurring in both current and prior periods.

For a discussion of appropriate actuarial considerations, see the American Academy of Actuaries guidelines regarding the preparation of funding recommendations for self insurance plans.

STATEMENT 1981-9

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

STATEMENT OF THE AMERICAN ACADEMY OF ACTUARIES
COMMITTEE ON RISK CLASSIFICATION
TO THE
HOUSE SUBCOMMITTEE ON COMMERCE, TRANSPORTATION AND TOURISM
REGARDING
THE ECONOMIC IMPACT OF H.R. 100

MAY 20, 1981

BACKGROUND

IN AUGUST, 1980, THE AMERICAN ACADEMY OF ACTUARIES' COMMITTEE ON RISK CLASSIFICATION TESTIFIED BEFORE THE SUBCOMMITTEE ON CONSUMER PROTECTION AND FINANCE REGARDING H.R. 100 — THE NONDISCRIMINATION IN INSURANCE ACT OF 1980. AT THAT TIME, WE RECOMMENDED A CAREFUL STUDY OF THE ECONOMIC IMPACT OF THIS PROPOSED LEGISLATION. IT WAS SUGGESTED THAT SUCH A STUDY OUGHT TO BE MADE BY THE ACADEMY.

WE HAVE DONE SO, AND THIS REPORT SUMMARIZES BRIEFLY OUR ANALYSIS. OUR ASSESSMENT OF THE BILL'S IMPACT SHOULD BE CONSIDERED APPROXIMATE RATHER THAN PRECISE, NO STUDY OF THE POTENTIAL IMPACT OF SUCH FAR-REACHING LEGISLATION CAN ACCURATELY GAUGE THE PRACTICAL EFFECTS OF IMPLEMENTING REGULATIONS, MARKETPLACE REACTIONS, JUDICIAL INTERPRETATIONS, ETC. NEVERTHELESS, WE CAN GIVE YOU A GENERAL ASSESSMENT—— OUR BEST JUDGMENT AS TO THE PROBABLE IMPACT.

MAJOR CONCLUSIONS

1. MOST ASPECTS OF H.R. 100 WOULD HAVE LITTLE ECONOMIC IMPACT—— SPECIFICALLY, PROVISIONS RELATING TO RACE, COLOR, RELIGION, AND NATIONAL ORIGIN; AND PROVISIONS RELATING TO THE AVAILABILITY OF INSURANCE WITHOUT REGARD TO SEX.
2. PROVISIONS RELATING TO PRICING DIFFERENCES BY SEX AND THE MANDATING OF PREGNANCY BENEFITS WOULD HAVE SOME SIGNIFICANT EFFECTS. THE IMPACT ON INDIVIDUAL INSURANCE CONSUMERS VARIES BY TYPE OF INSURANCE AND DEPENDS ON INDIVIDUAL CIRCUMSTANCES. THE EFFECTS ON INDIVIDUAL MALE AND FEMALE PURCHASERS IS GENERALLY SUMMARIZED IN THE FOLLOWING TABLE:

TYPE OF INSURANCE	<u>% CHANGE IN PRICE</u>					
	<u>INCREASE (+) OR DECREASE (-)</u>					
	<u>MALE</u> <u>AGE 20</u>	<u>MALE</u> <u>AGE 40</u>	<u>MALE</u> <u>AGE 65</u>	<u>FEMALE</u> <u>AGE 20</u>	<u>FEMALE</u> <u>AGE 40</u>	<u>FEMALE</u> <u>AGE 65</u>
LIFE INSURANCE	-2	-3	N/A	+6	+11	N/A
HEALTH INSURANCE						
- MEDICAL EXPENSE						
UNISEX RATING	+18	+13	0	-12	-7	0
FULL MATERNITY	+38	+1	0	+26	+1	0
TOTAL	+56	+14	0	+14	-6	0
- DISABILITY						
UNISEX RATING	+4	+2	0	-26	-21	0
FULL MATERNITY	+20	-	0	+20	-	0
TOTAL	+24	+2	0	-6	-21	0
AUTOMOBILE INSURANCE	-20	0	0	+37	0	0
INDIVIDUAL ANNUITIES	+6	+6	+6	-6	-6	-6

3. EXTRAPOLATING FROM INDIVIDUAL EFFECTS TO TOTALS OF INSURANCE IN FORCE, WE PROJECT THE FOLLOWING TOTAL ANNUAL DOLLAR IMPACT:

TYPE OF INSURANCE	<u>INCREASE (+) OR DECREASE (-)</u>	
	<u>AGGREGATE</u>	<u>AGGREGATE</u>
	<u>ANNUAL</u>	<u>ANNUAL</u>
	<u>COST IMPACT</u>	<u>COST IMPACT</u>
	<u>ON MEN</u>	<u>ON WOMEN</u>
	<u>(\$ IN MILLIONS)</u>	
LIFE INSURANCE	-360	+360
HEALTH INSURANCE		
- MEDICAL EXPENSE		
UNISEX RATING	+69	-69
FULL MATERNITY	+82	+85
TOTAL	+151	+16
- DISABILITY		
UNISEX RATING	+37	-37
FULL MATERNITY	+57	+7
TOTAL	+94	-30
AUTOMOBILE INSURANCE	-700	+700

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4. THE IMPACT ON PENSION PLANS WOULD MOST LIKELY BE TO MANDATE BENEFIT INCREASES TO WOMEN UNDER DEFINED CONTRIBUTION TYPE PLANS, AND TO MEN IN CERTAIN CIRCUMSTANCES UNDER DEFINED BENEFIT TYPE PLANS. IT IS NOT CLEAR TO US WHETHER MEN OR WOMEN WOULD GAIN MORE IN PENSION BENEFITS FROM H.R. 100.
5. IMPLEMENTATION COSTS WOULD BE APPROXIMATELY \$1.3 BILLION. THE LONGER THE PERIOD ALLOWED FOR IMPLEMENTATION, THE SMALLER WOULD BE THE MARGINAL IMPLEMENTATION COSTS. THE 90-DAY IMPLEMENTATION PERIOD CALLED FOR BY THE BILL IS NOT POSSIBLE AT ANY COST.
6. MUCH OF THE IMMEDIATE IMPLEMENTATION COSTS AND OTHER FINANCIAL EFFECTS COULD BE AVOIDED BY HAVING H.R. 100 AFFECT FUTURE INSURANCE ONLY.
7. MOST OF THE ADVERSE ECONOMIC EFFECTS OF H.R. 100 — BOTH DIRECT COSTS AND POTENTIAL MARKETPLACE DISRUPTIONS — COULD BE AVOIDED BY PROHIBITING ONLY THOSE SEX-BASED PRICING DIFFERENCES WHICH ARE NOT SUPPORTED BY STATISTICALLY DEMONSTRATED COST DIFFERENCES.

WE HOPE THAT THIS REPORT IS USEFUL TO YOUR COMMITTEE; WE STAND READY TO PROVIDE FURTHER ASSISTANCE OR ADVICE IF YOU SO DESIRE.

Jay Ripps

JAY Z. RIPPS, FSA, MAAA, EA
CHAIRMAN
COMMITTEE ON RISK CLASSIFICATION
AMERICAN ACADEMY OF ACTUARIES

OTHER PRINCIPAL AUTHORS:

HAROLD INGRAHAM, FSA, MAAA, EA
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ROBERT SHAPLAND, FSA, MAAA
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SUMMARY OF ECONOMIC IMPACT OF H.R. 100A. OVERALL APPROACH

FIRST, AS WE INDICATED IN OUR TESTIMONY LAST AUGUST, INSURERS DO NOT NOW GENERALLY DIFFERENTIATE IN INSURANCE PRICING OR AVAILABILITY ON THE BASIS OF RACE, COLOR, RELIGION, OR NATIONAL ORIGIN. INSURERS ALSO DO NOT GENERALLY DIFFERENTIATE BETWEEN THE SEXES AS TO THE AVAILABILITY OF INSURANCE. THE GREATEST EFFECT OF H.R. 100, THEREFORE, WOULD BE THE PROHIBITION OF DIFFERENCES BETWEEN THE SEXES IN THE PRICING OF INSURANCE, AND WE HAVE CONFINED OUR ANALYSIS TO THE ECONOMIC IMPACT OF THAT PROHIBITION AND TO THE MANDATING OF FULL MATERNITY BENEFITS IN ALL HEALTH POLICIES. IN OUR VIEW, THE ECONOMIC IMPACTS OF THE OTHER ASPECTS OF H.R. 100 ARE NOT SIGNIFICANT.

THERE ARE FOUR AREAS OF MAJOR POTENTIAL IMPACT:

- 1) THE ADMINISTRATIVE COSTS INCURRED IN IMPLEMENTING H.R. 100,
- 2) CHANGES IN INSURANCE COSTS TO INDIVIDUALS,
- 3) "RIPPLE" EFFECTS ON PRIVATE INSURANCE MARKETS,
- 4) FINANCIAL EFFECTS ON THE INSURERS (BOTH INSURANCE COMPANIES AND OTHER INSURERS).

WE HAVE EXAMINED THESE EFFECTS SEPARATELY FOR FOUR MAJOR TYPES OF INSURANCE — LIFE INSURANCE, HEALTH INSURANCE, CASUALTY AND PROPERTY INSURANCE, AND RETIREMENT INSURANCE (I.E. PENSION PLANS). THERE ARE SIGNIFICANT DIFFERENCES BETWEEN THE RISKS COVERED BY THESE TYPES OF INSURANCE, IN THE WAY SEX IS USED IN PRICING, AND IN THE WAY THE INSURANCE IS SOLD OR OTHERWISE PROVIDED TO THE CONSUMER. CONSEQUENTLY, THE IMPACT OF H.R. 100 ON EACH TYPE IS DIFFERENT.

B. ADMINISTRATIVE IMPLEMENTATION COSTS

THESE ARE THE COSTS INVOLVED IN SUCH ACTIVITIES AS ESTABLISHING NEW "UNISEX" RATES, AMENDING INSURANCE POLICIES AND CONTRACTS, CHANGING COMPUTER PROGRAMS AND OTHER SYSTEMS AND PROCEDURES, AND RECALCULATING BENEFITS WHERE NECESSARY. THE ADMINISTRATIVE COST IMPACT DEPENDS VERY HEAVILY ON THE TIME FRAME MANDATED FOR IMPLEMENTATION. THE 90-DAY IMPLEMENTATION PERIOD CALLED FOR BY H.R. 100 IS SIMPLY NOT POSSIBLE AT ANY COST, IN VIEW OF THE AMOUNT OF INTERNAL WORK INSURERS WOULD HAVE TO PERFORM AND THE EXTENSIVE STATE REGULATORY FILINGS REQUIRED. A LONGER IMPLEMENTATION PERIOD WOULD ALLOW THE CHANGES TO BE MADE LARGELY IN THE CONTEXT OF NORMAL PRODUCT UPDATING CYCLES. WE HAVE ANALYZED IN OUR REPORT THE APPROXIMATE ADMINISTRATIVE COST FOR A TIMETABLE MIDWAY BETWEEN THE IMPOSSIBLY SHORT AND THE LOW-IMPACT LONG — A 2-5 YEAR LAG BETWEEN PASSAGE OF THE BILL AND ITS EFFECTIVE DATE. THESE COSTS ARE SUMMARIZED AS FOLLOWS:

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<u>TYPE OF INSURANCE</u>	<u>(\$ IN MILLIONS)</u>
LIFE INSURANCE	\$870
HEALTH INSURANCE	200
CASUALTY & PROPERTY INSURANCE	75
RETIREMENT PLANS	<u>200</u>
TOTAL COSTS	\$1,345

ONE WAY TO REDUCE THE ADMINISTRATIVE COSTS WOULD BE TO HAVE H.R. 100 AFFECT ONLY INSURANCE ISSUED AFTER ITS EFFECTIVE DATE, THE RETROACTIVE FEATURES OF THE BILL GENERATE MUCH OF THE ADMINISTRATIVE IMPLEMENTATION COSTS, SINCE THOSE FEATURES REQUIRE REVISIONS TO MILLIONS OF OUTSTANDING INSURANCE POLICIES AND CONTRACTS.

C. CHANGES IN INDIVIDUAL INSURANCE COSTS

MUCH OF THE INSURANCE COVERAGE IN THIS COUNTRY IS PROVIDED TO INDIVIDUALS THROUGH GROUP PLANS. FOR EXAMPLE, AT LEAST 75% OF PRIVATE HOSPITAL/MEDICAL INSURANCE TO THOSE UNDER AGE 55 IS ON A GROUP BASIS, VIRTUALLY NONE OF THE PROPERTY-CASUALTY COVERAGE (AUTOMOBILE INSURANCE IN THIS CONTEXT) IS PROVIDED ON A GROUP BASIS, EXCEPT FOR GROUP PENSION PLANS, WHERE THE IMPACT OF H.R. 100 IS SOMEWHAT COMPLICATED. THE EFFECT OF H.R. 100 ON THE INSURANCE COSTS PAID DIRECTLY BY INDIVIDUALS COVERED UNDER GROUP PLANS OR ON THE SIZE OF THEIR BENEFITS WOULD BE NEGLIGIBLE OR NIL, CONSEQUENTLY, OUR ANALYSIS OF THE IMPACT ON INDIVIDUAL POCKETBOOKS PERTAINS LARGELY TO INSURANCE SOLD DIRECTLY TO INDIVIDUALS — I.E., NOT THROUGH GROUP PLANS.

FOR SOME TYPES OF INSURANCE, H.R. 100 WOULD CAUSE WOMEN TO PAY LESS AND MEN MORE; FOR OTHER TYPES MEN WOULD PAY LESS AND WOMEN MORE. THE IMPACT OF H.R. 100 ON ANY PARTICULAR INDIVIDUAL OR FAMILY WOULD VARY WIDELY ACCORDING TO THE PARTICULAR INSURANCE COVERAGE INVOLVED AND THE PARTICULAR CIRCUMSTANCES OF THE PERSONS INSURED — IN ADDITION TO THEIR SEX. BROADLY, HOWEVER, THE AVERAGE EFFECTS ARE SUMMARIZED IN THE FOLLOWING TABLE.

<u>TYPE OF INSURANCE</u>	<u>% CHANGE IN PRICE</u>					
	<u>INCREASE (+) OR DECREASE (-)</u>					
	<u>MALE</u> <u>AGE 20</u>	<u>MALE</u> <u>AGE 40</u>	<u>MALE</u> <u>AGE 65</u>	<u>FEMALE</u> <u>AGE 20</u>	<u>FEMALE</u> <u>AGE 40</u>	<u>FEMALE</u> <u>AGE 65</u>
LIFE INSURANCE	-2	-3	N/A*	+6	+11	N/A*
HEALTH INSURANCE						
- MEDICAL EXPENSE						
UNISEX RATING	+18	+13	0	-12	-7	0
FULL MATERNITY**	+38	+1	0	+24	+1	0
TOTAL	+56	+14	0	+14	-6	0
- DISABILITY						
UNISEX RATING	+4	+2	0	-26	-21	0
FULL MATERNITY**	+20	-	0	+20	-	0
TOTAL	+24	+2	0	-6	-21	0
AUTOMOBILE INSURANCE****	-20	0***	0	+37	0***	0
INDIVIDUAL ANNUITIES*****	+6	+6	+6	-6	-6	-6

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*RELATIVELY LITTLE LIFE INSURANCE IS SOLD ON AN INDIVIDUAL BASIS TO PEOPLE AGE 65.

**THIS IS THE IMPACT OF REQUIRING FULL MATERNITY COVERAGE (I.E. COVERAGE FOR NORMAL PREGNANCIES AND DELIVERIES, AS WELL AS COVERAGE FOR COMPLICATIONS OF PREGNANCY).

***SOME INSURERS NOW CHARGE WOMEN BETWEEN THE AGES OF 30 AND 64 WHO ARE THE SOLE OPERATORS OF THEIR CARS APPROXIMATELY 10% LESS THAN SIMILARLY SITUATED MEN. THE PRICE OF AUTO INSURANCE FOR THESE WOMEN WOULD INCREASE SLIGHTLY AND THE PRICE FOR MEN WOULD FALL SLIGHTLY, BUT THE IMPACT IS DIFFICULT TO PREDICT AND WOULD BE SMALL IN ANY EVENT.

****EFFECTS SHOWN ARE FOR MEN AND WOMEN WHO ARE PRINCIPAL DRIVERS OF THE INSURED CAR.

*****PAYMENTS COMMENCING AT AGE 65, WITH REFUND FEATURES.

EXTRAPOLATING THESE INDIVIDUAL EFFECTS TO TOTALS OF INSURANCE IN FORCE, WE PROJECT THE FOLLOWING TOTAL ANNUAL DOLLAR IMPACT:

<u>TYPE OF INSURANCE</u>	<u>INCREASE (+) OR DECREASE (-)</u>	
	<u>AGGREGATE ANNUAL COST IMPACT ON MEN</u>	<u>AGGREGATE ANNUAL COST IMPACT ON WOMEN</u>
	(\$ IN MILLIONS)	
LIFE INSURANCE	-360	+360
HEALTH INSURANCE		
- MEDICAL EXPENSE		
UNISEX RATING	+ 69	- 69
FULL MATERNITY	+ 82	+ 85
TOTAL	+151	+ 16
- DISABILITY		
UNISEX RATING	+ 37	- 37
FULL MATERNITY	+ 57	+ 7
TOTAL	+ 94	- 30
AUTOMOBILE INSURANCE	-700	+700

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D. EFFECT ON PENSION BENEFITS

THE IMPACT OF H.R. 100 ON PENSION PLANS WOULD BE SOMEWHAT DIFFERENT. MOST PENSION PLANS ARE PROVIDED THROUGH EMPLOYER SPONSORSHIP; ERISA REGULATIONS, COLLECTIVE BARGAINING AGREEMENTS, AND PARAGRAPH (C) (2) OF SECTION 4 OF H.R. 100 MAKE IT LIKELY THAT THE MAJOR EFFECT OF H.R. 100 ON PENSIONS WOULD BE A MANDATED INCREASE IN BENEFITS FOR EITHER MEN OR WOMEN — DEPENDING ON THE SPECIFICS OF THE PLAN.

IN GENERAL, PERIODIC PAYMENTS TO WOMEN WOULD INCREASE UNDER DEFINED CONTRIBUTION PLANS.

UNDER THE MORE PREVALENT DEFINED BENEFIT PLANS, THE EFFECTS WOULD BE MIXED. IN THESE PLANS, STANDARD BENEFITS AT NORMAL RETIREMENT AGE FOR SIMILARLY SITUATED MEN AND WOMEN ARE IDENTICAL; HOWEVER, BENEFITS AT EARLY RETIREMENT AND MOST OPTIONAL FORMS OF BENEFITS ARE OFTEN HIGHER FOR WOMEN. THEREFORE, IN PLANS WHICH NOW USE SEX-DIFFERENTIATED OPTION AND EARLY RETIREMENT FACTORS, H.R. 100 WOULD REQUIRE BENEFITS AT EARLY RETIREMENT AND BENEFITS ELECTED IN MOST OPTIONAL FORMS OF PAYMENT TO BE INCREASED FOR MEN.

THE COST OF THE INCREASED BENEFITS IN BOTH TYPES OF PENSION PLANS WOULD BE SIGNIFICANT — APPROXIMATELY \$5.5 BILLION PER YEAR IN MANDATED EXTRA BENEFITS FOR ALL PLANS COMBINED. IT IS NOT CLEAR TO US HOW MUCH OF THE ADDITIONAL \$5.5 BILLION PER YEAR WOULD ACCRUE TO MEN AND HOW MUCH TO WOMEN; FURTHER STUDY WOULD BE NEEDED TO GAIN SOME INSIGHT INTO THIS QUESTION.

E. MARKETPLACE EFFECTS

THE IMPACTS OF H.R. 100 ON INSURANCE MARKETS ARE VERY DIFFICULT TO PREDICT AND IMPOSSIBLE TO QUANTIFY PRECISELY. MANDATED CHANGES IN PRICING PRACTICES OFTEN HAVE UNEXPECTED EFFECTS, AND, ALTHOUGH THESE EFFECTS ARE NOT ENTIRELY QUANTIFIABLE, THEY ARE NONETHELESS POTENTIALLY VERY SIGNIFICANT AND WORTHY OF CONSIDERATION. HERE ARE SOME OF THE MORE IMPORTANT POSSIBLE EFFECTS, SUMMARIZED VERY BRIEFLY:

- (A) AN INCREASE IN THE AVERAGE PRICE OF INSURANCE IN GENERAL, AS INSURERS ARE FORCED TO TAKE ON THE ADDITIONAL RISK THAT THE SEX DISTRIBUTION OF THOSE INSURED WILL BE DIFFERENT FROM WHAT IS ASSUMED IN PRICING;
- (B) INCREASED EMPHASIS ON SELLING INSURANCE FOR THE ARBITRARILY OVERPRICED RISKS, ALONG WITH POSSIBLE STEPS TO AVOID SELLING INSURANCE FOR RISKS THAT ARE KNOWN TO BE RELATIVELY UNDER PRICED;

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- (C) INCREASED REGULATORY EFFORTS AND COSTS TO ASSURE EQUAL AVAILABILITY OF COVERAGE, ESPECIALLY TO THOSE FOR WHOM INSURANCE PRICES ARE ARBITRARILY REDUCED;
- (D) ADOPTION OF NEW CLASSIFICATION FACTORS OR PRODUCT MODIFICATIONS, SOME OF WHICH MAY HAVE THE EFFECT OF DIFFERENTIATING RISKS BY SEX;
- (E) DIVERSION OF RESOURCES TO THE IMPLEMENTATION OF UNISEX RATING, AT THE EXPENSE OF NEW INSURANCE PRODUCT DEVELOPMENT EFFORTS OR INVESTIGATION OF OTHER NEW PRICING TECHNIQUES.

F. FINANCIAL EFFECTS ON INSURERS

IT IS IMPORTANT TO NOTE THAT THE "INSURERS" AFFECTED BY H.R. 100 INCLUDE NOT ONLY PRIVATE INSURANCE COMPANIES BUT ALSO ORGANIZATIONS WHICH "SELF-INSURE," THROUGH "SPECIALLY ESTABLISHED TRUST FUNDS OR OTHER MEANS, AMONG OTHERS, "INSURERS" IN THIS CONTEXT INCLUDE VARIOUS LEVELS OF GOVERNMENT — FEDERAL, STATE, AND LOCAL — AND A VARIETY OF OTHER SELF-INSURERS, IN MANY CASES PENSION OR WELFARE FUNDS ESTABLISHED THROUGH COLLECTIVE BARGAINING AGREEMENTS.

WHILE H.R. 100 ALLOWS FOR CHANGES IN PRICES, IT ALSO STIPULATES THAT BENEFITS MAY BE INCREASED BUT MAY NOT BE DECREASED. THIS STIPULATION COULD HAVE PARTICULARLY SERIOUS ADVERSE CONSEQUENCES TO THE INSURERS OF RETIREMENT PLANS — NOT JUST INSURANCE COMPANIES BUT ALSO ALL OTHER "INSURERS." THE EXTRA MONEY REQUIRED TO INCREASE RETIREMENT BENEFITS TO MEN OR WOMEN, DEPENDING ON PLAN SPECIFICS, WOULD HAVE TO COME FROM SOMEWHERE — ADDITIONAL APPROPRIATIONS IN THE CASE OF MANY PENSION PLANS FOR GOVERNMENT EMPLOYEES, ADDITIONAL CONTRIBUTIONS FROM EMPLOYERS OR THEIR EMPLOYEES IN THE CASE OF PRIVATE SECTOR PLANS, ETC.

AS IS THE CASE WITH IMPLEMENTATION COSTS, MOST OF THE ADVERSE IMPACT ON "INSURERS" IS ASSOCIATED WITH THE RETROACTIVE ASPECTS OF H.R. 100. CONSEQUENTLY, THE FINANCIAL EFFECTS ON "INSURERS" WOULD BE GREATLY REDUCED BY HAVING THE ACT AFFECT ONLY INSURANCE ISSUED ON OR AFTER ITS EFFECTIVE DATE.

CONCLUSIONS

CONGRESS, THE COURTS, AND THE PUBLIC MUST AT SOME POINT DECIDE WHAT IS MEANT BY "EQUAL TREATMENT" IN THE CONTEXT OF INSURANCE, UNLIKE OTHER ARENAS, NO OBJECTIVE TESTS (LIKE HEIGHT OR STRENGTH) ARE AVAILABLE TO ASSESS WITH CERTAINTY AN INDIVIDUAL'S INSURANCE RISK. IT IS PRECISELY THIS UNCERTAINTY THAT LEADS TO THE NEED FOR INSURANCE, THEREFORE, SOME

ASPECTS OF "EQUAL TREATMENT" APPLICABLE IN OTHER CONTEXTS MAY NOT BE APPROPRIATE OR POSSIBLE IN THE INSURANCE CONTEXT.

IT IS GENERALLY THE POSITION OF THE ACTUARIAL PROFESSION THAT INSURED INDIVIDUALS ARE TREATED EQUALLY IF THEY ARE CHARGED PRICES WHICH EQUITABLY REFLECT THE VALUE OF THE RISKS THEY TRANSFER TO THE INSURANCE POOL — NOT SIMPLY AS A MATTER OF THEORETICAL PREFERENCE BUT AS A NECESSARY CONDITION TO THE SOUND OPERATION OF INSURANCE PROGRAMS. DETERMINING THE VALUE OF THE RISKS TRANSFERRED NECESSARILY INVOLVES THE USE OF AVERAGES AND CLASSIFICATION VARIABLES; THEREFORE, THE USE OF AVERAGES AND CLASS GROUPINGS IS FUNDAMENTAL TO INSURANCE. CONSIDERATION OF WHAT IS FAIR OR UNFAIR IN INSURANCE MUST TAKE PLACE WITHIN THAT CONCEPTUAL FRAMEWORK.

FROM OUR ANALYSIS OF THIS PARTICULAR LEGISLATION, WE DRAW SEVERAL GENERAL CONCLUSIONS:

1. H.R. 100 WOULD HAVE A SIGNIFICANT ECONOMIC IMPACT IF ENACTED.
2. THE EFFECT ON INDIVIDUAL INSURANCE CONSUMERS WOULD DIFFER ACCORDING TO THEIR INDIVIDUAL CIRCUMSTANCES AND ACCORDING TO THE TYPE OF INSURANCE COVERAGE INVOLVED. ON BALANCE, IT APPEARS THAT WOMEN AS A WHOLE WOULD PAY MORE FOR INSURANCE (LIFE, HEALTH, AUTOMOBILE, AND ANNUITIES) IF H.R. 100 IS ENACTED.
3. THE EFFECT ON PENSION BENEFITS IS UNCLEAR. H.R. 100 WILL MANDATE INCREASES IN BENEFITS. UNDER DEFINED CONTRIBUTION PLANS, WOMEN'S BENEFITS WOULD INCREASE; UNDER MOST DEFINED BENEFIT PLANS, EARLY RETIREMENT BENEFITS AND OPTIONAL FORMS OF BENEFITS FOR MEN WOULD INCREASE.
4. THE 90-DAY IMPLEMENTATION PERIOD STIPULATED IS NOT PRACTICAL. THE LONGER THE IMPLEMENTATION PERIOD, THE SMALLER WOULD BE THE ADDITIONAL IMPLEMENTATION COSTS.
5. MUCH OF THE IMMEDIATE ADMINISTRATIVE COSTS AND THE ADVERSE FINANCIAL IMPACT ON INSURERS (DESCRIBED IN SECTIONS B AND F) COULD BE AVOIDED BY HAVING H.R. 100 AFFECT ONLY INSURANCE ISSUED OR RENEWED ON OR AFTER THE ACT'S EFFECTIVE DATE. THE OTHER ECONOMIC EFFECTS WOULD STILL BE FELT.
6. VIRTUALLY ALL OF THE ECONOMIC IMPACT COULD BE AVOIDED BY CHANGING H.R. 100 TO PROHIBIT ONLY THOSE SEX-BASED PRICING DIFFERENCES WHICH ARE NOT SUPPORTED BY STATISTICALLY DEMONSTRATED COST DIFFERENCES.

5/20/81

STATEMENT 1981-10

May 26, 1981

Mr. George A. Fitzsimmons, Secretary
Securities & Exchange Commission
Washington, D. C. 20549

Re: File #S7-879

Dear Sir:

The Academy of Actuaries is responding to your invitation for comments concerning proposed revisions to Articles 7 and 7A of Regulation S-X.

Generally, we are in favor of the combination of the present Articles 7 and 7A into a single new Article 7, which would be applicable to property and liability insurance companies as well as life insurance companies. Specifically, we endorse the elimination of rules that duplicate matters encompassed by generally accepted accounting principles, application (by failure to specifically exclude applicability) of the rule requiring disclosure of assumptions for future policy benefits and claim and settlement liabilities which are stated at present value to the property and liability industry, and the modifications made to the schedules in Article 12 that apply specifically to insurance companies. There are, however, several areas in which we believe the Commission's purposes will not be served by the proposed revisions. These matters are the proposed elimination of the reconciliation of statutory and GAAP financial statements, the proposed disclosure of the net gain or loss on nonrecurring reinsurance transactions and the manner in which certain segment information is required to be disclosed.

The revised rules indicate that the present reconciliation of statutory and GAAP financial statements will cease to be a required disclosure item. We believe that statutory surplus and earnings continue to be a significant aspect of an insurance company's financial condition and recommend that the reconciliation be retained. In addition to controlling a company's ability to continue on a going concern basis, the statutory amounts influence the funds which can be made available for dividends to stockholders and can act as a constraint on a company's ability to write new business. Finally, we believe the reconciliation allows users of financial statements to better understand the relationships between statutory and GAAP amounts and can provide information useful in deducing certain characteristics of the quality of a company's earnings.

Mr. George A. Fitzsimmons, Secretary

May 26, 1981

The proposed revised rules, in Section 210.7-03.13(c)(2), require that footnote information concerning the general nature of reinsurance transactions be provided and is to include the net gain or loss on nonrecurring insurance transactions. We strongly urge the elimination of this requirement for the following reasons.

The reinsurance activities of insurance companies are a significant and continuing area of operations. Reinsurance agreements may be entered into for a variety of reasons and the need for reinsurance arrangements at any particular time is dependent upon a number of factors. We believe that the identification as nonrecurring of the prominence of a specific need at a certain moment during the long-term operating cycle of an insurance company is inappropriate. In a very real sense, reinsurance activities are continuous and we believe that considerable practical difficulties will be encountered if an effort is made to identify those reinsurance transactions which are "nonrecurring."

In addition to this basic conceptual objection, we believe that significant implementation problems will be experienced. First, the rule does not appear to include a materiality criteria. If a reasonable and appropriate definition of "nonrecurring" can be developed, we believe that the rule should be applicable only to those transactions which are material to the company's operations.

Finally, the net gain or loss in a given reinsurance transaction may not be as easily determined as is implied. Reinsurance transactions benefit companies in many ways and it may be difficult to evaluate the overall impact on operations produced by a single transaction. In addition, the proper recognition of items such as the implicit or explicit loss of investment income and the proper allocation of expenses may not be easily or uniquely determinable.

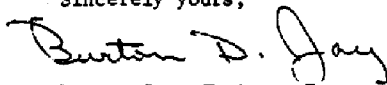
Several of the proposed rules require that balance sheet and income statement information relating to property/liability, life and accident and health insurance be separately stated in the financial statements or in notes thereto. In addition, the proposed schedule 210.12-16, Supplementary Insurance Information, requests some similar and certain additional information to be presented separately for each segment. When taken together, the information present in the statements, notes or schedules would enable the reader to develop estimates of operating income for each line of business. If it is the Commission's intent to provide this ability, we believe that this objective would be best achieved by including all relevant information in a separate schedule. This would remove the need to provide significant details in the body of the financial statements, but would provide readers the ability to estimate operating income and identify significant assets and liabilities by line of business.

Mr. George A. Fitzsimmons, Secretary

May 26, 1981

We appreciate the opportunity to comment upon the revised rule revisions and hope that these suggestions will be helpful.

Sincerely yours,

A handwritten signature in cursive script that reads "Burton D. Jay".

Burton Jay, Chairman
American Academy of Actuaries
Committee on Life Insurance
Financial Reporting Principles

STATEMENT 1981-11

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

STEPHEN G. KELLISON, M.A.A.A.
EXECUTIVE DIRECTOR

May 28, 1981

The Honorable J.J. Pickle, Chairman
Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Pickle:

As you recall, we have expressed an interest in an amendment to the current Social Security Act, which in effect would require a statement of opinion by the Chief Actuary of the Social Security Administration and the Chief Actuarial Officer of the Health Care Financing Administration that the techniques and methodology used in preparing the actuarial status of the Trust Funds and the cost estimates and the assumptions used with respect to such Funds are reasonable and conform with generally accepted actuarial principles.

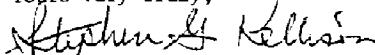
After careful deliberation, the Academy's Committee on Social Insurance, chaired by James R. Swenson, is now offering the attached amending language and recommends it to the Social Security Subcommittee for its careful consideration. I believe you will find the amendment technically accurate and the underlying policy clear; but, if you have any follow-up questions, please let me know. The sections of the Social Security Act affected by the amendment include: § 201(c), § 1817(b) and § 1841(b).

You may also be interested to know that this requirement would be similar in concept to that provided in P.L. 95-595 enacted in 1978. P.L. 95-595 amended the Budget and Accounting Procedures Act of 1950 to require, in part, that an annual financial statement and an annual actuarial statement be furnished to Congress and the Comptroller General with respect to the more than 60 pension plans for officers and employees of the federal government and its agencies and instrumentalities.

The language is also consistent with the recommendation contained in the final report, dated March 1981, of the National Commission on Social Security (see page 23, recommendation number 12 attached). In addition, similar actuarial certification is required by the Employee Retirement Income Security Act of 1974 (ERISA) for pension plans in the private sector.

As I have indicated earlier, please feel free to contact me if you need any further information or help with respect to this amendment. Thank you for your consideration of this amendment.

Yours very truly,


Stephen G. Kellison

SGK:clt

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PROPOSED AMENDMENT

Section 201(c) of the Social Security Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuary of the Social Security Administration expressing his or her opinion:

(1) that the techniques and methodology used in preparing the actuarial status of the Trust Funds are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and expectations of the program, including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(b) Section 1817(b) of such Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuarial Officer of the Health Care Financing Administration expressing his or her opinion: (1) that the techniques and methodology used in preparing the actuarial status of the Trust Fund are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and the expectations of the program,

including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(c) Section 1841(b) of such Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuarial Officer of the Health Care Financing Administration expressing his or her opinion: (1) that the techniques and methodology used in preparing the actuarial status of the Trust Fund are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and the expectations of the program, including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(d) The amendments made by this section shall be effective on January 1, 1982.

Final Report
National Commission on 23
Social Security

- (11) The operations of the OASI, DI, HI, and Supplementary Medical Insurance Trust Funds should be removed from the unified budget of the United States government.
- (12) The chief actuarial officers should provide a certification in the annual Trustees Reports as to the assumptions and methodology used in preparing their actuarial cost estimates and valuations.
- (13) No changes should be made in the financing of the Supplementary Medical Insurance program, because it is now adequately funded.
- (14) Payments to the Railroad Retirement Account under the financial interchange provisions between the Social Security and Railroad Retirement programs should not be made in those cases where the Railroad Retirement program does not pay benefits to the individuals for whom such payments are made (e.g., divorced widows).

B. Retirement Age under Social Security

- (1) Beginning in the year 2001, the minimum age at which unreduced retirement benefits are available should be increased gradually from 65 to 68, reaching 68 in 2012. The corresponding minimum ages for other types of benefits (including those for spouses, widows, and widowers) should similarly be increased, and this should also be done in tandem for persons claiming reduced benefits at earlier ages.

STATEMENT 1981-12

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

June 2, 1981

TO: National Association of Insurance Commissioners' Task Force on Manipulation, Lapsation, Dividend Practices and Annuity Disclosure

FROM: John H. Harding, Chairman - Committee on Dividend Principles and Practices

SUBJECT: Report of the Committee on Dividend Principles and Practices

It is a pleasure to tell you that this Report constitutes our formal presentation to the NAIC of suggested modifications to existing regulations concerning dividend practices. As reported to you in December, the American Academy of Actuaries has formally adopted standards of practice with respect to dividend payment and dividend illustration. The primary focus of these standards, which are formally called Recommendations Concerning Actuarial Principles and Practices in Connection with Dividend Determination and Illustration, is on disclosure. The American Academy of Actuaries, by adopting the Recommendations, is requiring that actuaries responsible for the determination of dividend scales disclose to their companies all relevant considerations used in determining their recommended dividend scales. Of course, the Academy of Actuaries cannot compel companies to disclose publicly the relevant content of this report. The NAIC, however, can make such requirements. This presentation to you identifies the form and substance of what the Academy Committee believes should be reported by companies about how they pay and illustrate dividends.

Brief History

In June of 1980, the Committee on Dividend Principles and Practices published its report. This report contained a general historical background, which is summarized here.

It has been traditional in the life insurance industry to illustrate dividends to prospective policyholders. Such illustrations have been called upon to provide an indication of the company's current performance and to give a reasonable indication of the probably relative performance in the future, as dividends were actually paid. It is also been generally accepted that there must be equitable apportionment of dividends among all classes of policyholders, in spite of a temptation for a company to favor more recent policyholders at the expense of others. In the early 1970's, there was concern regarding the apparent proliferation of bases for paying dividends and illustrating them. There was also concern that departure from a close relationship between dividends paid and dividends illustrated may have taken place for some companies.

In the mid-1970's, the Society of Actuaries circulated a questionnaire designed to develop information concerning dividend practices. Analysis

of the results showed that there was a much broader range of practices than previously had been thought to exist.

The Society of Actuaries established, in early 1976, the Committee on Dividend Philosophy to explore possible courses of action to deal with this problem. In 1978, this Committee recommended that the best solution would be to establish standards of dividend payment and illustration and that the actuary responsible for recommending a dividend scale provide a written opinion to corporate management.

The Society Committee published Draft 7 of its Recommendations in the fall of 1979. Finally, the Society Committee completed Draft 11 in May of 1980. This Draft covered all participating policies issued by mutual life insurance companies and some participating life policies issued by stock companies. The Society Committee is still working on remaining stock life insurance company issues. In addition, deferred annuities are under consideration.

The American Academy of Actuaries' Committee on Dividend Principles and Practices was formed in late 1978. It has worked closely with the Society Committee since that time. There is a mutual understanding between the Board of Governors of the Society and the Board of Directors of the Academy that the Society should develop the suggested Recommendations and that the Academy use that framework to adopt a formal set of Recommendations, with subsequent interpretations as necessary. In addition, the Academy would develop the appropriate framework for implementation of these Recommendations. This framework is what is being suggested today.

The Academy Committee published a slightly modified version of Draft 11 for comment, as a part of its June, 1980 report. Essentially, the Academy version makes the Recommendations mandatory for mutual companies and optional, at this time, for stock companies. However, stock companies who do not elect to conform should disclose that fact to regulators and to the public. On October 31, 1980, the Academy Board of Directors adopted the Recommendations. The final version was published in February, 1981.

Since that time, the Academy Committee has been developing improved versions of its suggestions to the NAIC. These suggestions include the possible modification of what is now Schedule M of the Annual Statement, modifications in language in the Life Insurance Buyer's Guide and modifications in the language required to be included with dividend illustrations.

Regulatory Disclosure

The Committee believes that the best disclosure for regulatory purposes would be a qualitative extract of the actuary's report. The actuary who signs that report should also sign the statement of opinion and answers to the interrogatories in the proposed modification of Schedule M of the Annual Statement. However, this actuary would not necessarily be the same one who signed the statement of opinion with regard to policy reserves and related items.

Our primary concern is that the actuary's report will include proprietary company information with respect to experience factors and how these are translated into product pricing. Such information in great detail would be of little value to regulators, but of substantial value to competitors. The giving away of legitimate techniques of product pricing is unnecessary

for appropriate regulation and would diminish, rather than enhance, the price competitive nature of the life insurance industry.

A properly written actuarial report would not enhance a layman's understanding of the dividend process. Further, few state insurance departments could afford to develop the expertise to interpret all such reports in a meaningful manner. Even if such interpretation were made, it is not clear what could be done with the information. The primary role of regulators and the supervision of dividend practices should be directed toward obvious manipulation, solvency questions, general concern about equitable distribution and the avoidance of improper discrimination.

The suggested modifications to Schedule M focus on an extract of the actuary's report. This extract is intended to be helpful to the regulators in their supervisory role. The report requires a summary of practices used, a highlighting of changes in practices, a quantification of changes in dividend scale and a certification by the actuary that the dividends have been determined, except as disclosed, in accordance with the Recommendations Concerning Actuarial Principles and Practices in Connection with Dividend Determination and Illustration.

Consumer Disclosure

The suggested changes to the Buyer's Guide incorporate several new ideas. First, while the current Buyer's Guide describes the concept of cost and identifies the differences between illustrations of cost of participating and nonparticipating policies, the redraft recognizes the existence of cost illustrations of products recently introduced.

Second, the suggested modifications identifies the difference between investment generation and portfolio average methods in the determination of dividends. At the suggestion of the NAIC Advisory Committee on Manipulation, dividends based on investment generation methods are identified as being more sensitive to changes in current interest rates.

Finally, the suggested modifications recognized the existence of the newly adopted Principles and Practices and warns the prospective insured to be aware of any exception language which may be required on the illustration.

Suggested language which should accompany the illustration, must necessarily be brief. We believe, however, that in all cases there should be an identification of the method of investment income allocation used, because of the significantly different illustrative result. In addition, each required exception statement that appears in the suggested Schedule M would also need to be briefly summarized.

The primary focus of dividend illustrations, of course, is on new sales. However, the proposed disclosure language is intended to be used both with illustrations of dividend scales for new policies and also on illustrations for policies currently in-force.

Conclusion

The Academy Committee on Dividend Principles and Practices believes that we have now progressed to a stage where it would be possible and appropriate for the NAIC to make use of our suggestions for modifications which

are described above and attached as Exhibits B and C.

Exhibit A has already been distributed. These are the Recommendations which were adopted in October of 1980 and published in February of 1981. Additional copies can be obtained from the American Academy of Actuaries.

We recognize that the process of modification will not necessarily be a speedy one and that the NAIC will need to give serious consideration to not only our proposals, but related proposals from other groups. However, we believe that public disclosure of company practices with regard to dividend illustration and payment is essential. We hope that the NAIC can begin the process of modification as quickly as possible, and we would be happy to work with the NAIC in this process.

JHH:mw

Attachments

EXHIBIT B

POSSIBLE SCHEDULE M DISCLOSURE
Statement Year 1981

Identify the participating ordinary life business which is not subject to the actuarial principles and practices of the American Academy of Actuaries applicable to the determination of dividends paid by mutual companies. Answer the questions and state the opinion below which apply with respect to any other participating business.

Process of Dividend Determination

Describe the general methods and procedures used to determine dividends.

Description of Experience Factors

Describe the basis used in making any distinction in experience factors which underlie the determination of dividends. The description should specifically include:

- a. investment income factors;
- b. claims factors;
- c. expense factors;
- d. termination factors;
- e. any other factors which have a material effect on the dividends of any group of policies.

Also, describe in a qualitative way any material changes made in the bases used to determine those factors since this Schedule was last filed.

General Interrogatories

1. Has the Contribution Principle been followed in determining dividends?
If no, describe.
2. Since this Schedule was last filed, has any material change occurred with respect to the determination of policy factors?
If yes, describe.
3. a. Since this Schedule was last filed, have there been any changes in the scales of dividends on new or existing business authorized for illustration by the company?
If yes, describe in general the changes that were made.

- b. Since this Schedule was last filed, have there been any changes in the scales of dividends apportioned for payment?

If yes, describe in general the changes that were made.

- c. For each major block of business, indicate when the dividend scale was last changed (including changes described in b. above) and indicate the extent of such change in terms of the percentage by which dividends payable under the new scale exceeded or were less than those which would have been paid in the year of change had the scale not been changed.

4. Does the dividend scale incorporate the use of projections or forecasts of experience factors for any period in excess of two years beyond the effective date of the scale?

If yes, describe.

5. In the basis of determining investment income experience factors, state whether the company uses (a) a portfolio average approach, (b) an investment generation approach, or (c) a combination of the two approaches.

If (b) and (c), describe the general basis used, including the issue year groupings.

6. With respect to policy loan provisions,

- a. Describe how differences in such provisions affect dividends.

- b. Does the dividend scale contain any provision for varying the amount of dividend in accordance with the extent to which an individual policy's loan provision is utilized?

If yes, indicate the blocks of business where this treatment pertains, and describe the basis of variation used.

7. Does the company pay termination dividends on its policies? If yes:

- a. Are they payable on death, surrender and maturity?

- b. Are they payable or credited either upon the commencement of non-forfeiture insurance or upon termination thereof by death, surrender or maturity?

- c. Do they reflect the incidence, size and growth of amounts which may be attributed to the policies in question?

If the answer to a., b., or c. is no, describe the basis used.

8. Does the undersigned believe dividends illustrated on new or existing business can be paid if current experience continues?

If no, explain why.

9. Does the undersigned believe there is a substantial probability that because of the expected deterioration of experience, the dividends illustrated on new or existing business cannot be maintained for at least two years?

If yes, explain why.

10. Describe any aspects of the determination of the dividend scale not covered above which involve material departures from the actuarial principles and practices of the American Academy of Actuaries applicable to the determination of dividends paid by mutual companies.
11. Describe any material changes in the basis of determination of the dividend scale which were made since this Schedule was last filed and which are not covered above.

Actuarial Opinion

I, _____ (name, title) _____, am _____ (relationship to company) and a member of the American Academy of Actuaries. I have examined the actuarial assumptions and methods used in determining dividends under the dividend scale for the individual participating life insurance policies of the company issued for delivery in the United States. The dividends encompassed by this scale are both:

- i) those apportioned for payment during 1982; and
- ii) those in effect as of January 1, 1982 which are illustrated for payment on new or existing business in 1983 and later and which are authorized for illustration by the company.

My examination included such review of the actuarial assumptions and methods of the underlying basic records and such tests of the actuarial calculations as I considered necessary. In my opinion, these dividends have been determined in accordance with actuarial principles and practices of the American Academy of Actuaries applicable to the determination of dividends paid by mutual companies, except as described above.

Date

Name and Title

EXHIBIT C

POSSIBLE CHANGES IN SOME SECTIONS OF
THE LIFE INSURANCE BUYER'S GUIDE

(The Committee believes that the "What is Cost?" and "How Do I Use Cost Indexes?" sections of the Buyer's Guide could be enhanced by the following.)

What is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as cash value, your cost is smaller than the premium.

The cost of some policies is guaranteed at time of issue. These policies are called "guaranteed cost -- nonparticipating" policies. These policies do not pay dividends, but every feature is fixed at the time of purchase so that you know in advance what your future cost will be.

Listed below are some examples of policies that contain cost elements that are not guaranteed when you buy the policy. The actual cost of these policies will depend on the future actions of the company selling the policy and your actual cost can be lower or higher than that illustrated at time of purchase.

- Participating Policies

These policies have their cost reduced by dividends. Their premiums, cash values and death benefits are guaranteed, but the dividends are not. A dividend is a refund or return of part of the premiums paid. Each company pays those dividends which it believes to be appropriate, based on its current experience as to the factors affecting the cost of the insurance it provides -- primarily claims, expenses, investment earnings and taxes.

There are certain standards that have been endorsed for mutual companies as generally acceptable for use in determining dividend scales, including illustrations of dividends that may be paid in the future. Companies are required to indicate whether or not their illustrated dividends, and cost indexes reflecting them, were determined in conformance with these standards.

The future dividends illustrated by companies conforming with these standards are based on current levels of experience. The extent to which actual dividends will differ from those illustrated will depend on the extent to which actual future experience differs from that underlying the scale of illustrated dividends.

There are two main ways in which dividends may reflect investment earnings. One method involves reflection of such earnings on funds

attributable to all policies, regardless of when they were issued. The other method involves reflection of such earnings on funds attributable to policies issued in specified years. Usually, dividends based on this method are more sensitive to changes in current interest rates than are dividends based on earnings on funds attributable to all policies.

A description of the method used must accompany any figures presented which involve dividends.

- Nonparticipating Policies with Nonguaranteed Cost

While "nonparticipating" policies do not pay dividends, some of them have costs that are not guaranteed at time of purchase. Some examples are:

-- Nonguaranteed Premium Policies

Cash values and death benefits under these policies are guaranteed, but their premiums are not. These policies contain a guaranteed "maximum premium", but the company anticipates charging a lower premium. The company will illustrate the cost based on the premium it currently expects to charge. Your actual cost will be lower or higher than this, depending on the premiums you are actually charged.

-- Policies with Nonguaranteed Cash Values

Premiums and death benefits under these policies are guaranteed, but their cash values are not. These policies contain a guaranteed minimum interest rate for accumulation of cash values, but the company anticipates using a higher rate. The company will illustrate the cost based on the interest rate they currently use to accumulate cash values. Your actual cost will be higher or lower than this, depending on the interest rate actually used.

-- Policies with Nonguaranteed Death Benefits and Cash Values Under These Policies

These policies do not require a specific level of premium payments, but guarantee a minimum level of death benefit and cash value for any particular amount of premium the insured chooses. The company will also illustrate higher cash values and death benefits based on the interest rates and insurance cost it currently uses. Your actual cost under these policies, in relation to the benefits provided, will be higher or lower than that illustrated depending on the interest rate and insurance cost actually used.

-- Reunderwritten Policies

Some policies permit the insured to have lower premiums throughout the duration of the policy, if the insured can periodically meet specified health qualifications.

The actual cost of these policies will depend on whether or not the insured can meet the prescribed standards.

Cost illustrations for all policies with costs that are nonguaranteed are required to disclose the part of the cost that is not guaranteed.

POSSIBLE MODIFICATION OF EXISTING STATE
REGULATIONS WHICH DEAL WITH
DIVIDEND DISCLOSURE

The Committee has not addressed itself to each possible regulation where the following modifications might apply. However, most of the regulations involved deal with solicitation and advertising. In principle, information relevant to the comparability of dividend scales could be added to the normal dividend caveats:

- A. For those policies which are specified in Schedule M as not subject to the actuarial standards which apply to the determination of dividends paid by mutual companies, it would be appropriate to include a statement in the dividend caveat that "the dividends illustrated for this policy are determined according to standards which are different from those applicable to a mutual company."
- B. For all other policies, the method of allocation of investment earnings should be identified.

- 1) If a company is more than 10 years old, and states in Schedule M that it uses a portfolio average approach, it would be appropriate to state:

"Illustrated dividends are based upon the dividend scale applicable to currently issued policies, which reflects current investment earnings on funds attributable to all policies. Dividends are neither guarantees nor estimates and future dividends which you actually receive will differ from those illustrated to the extent that future expense, claim and investment experience differs from current experience."

- 2) For other companies it would be appropriate to state:

"Illustrated dividends are based upon the dividend scale applicable to currently issued policies, which reflects current investment earnings on funds attributable to all policies issued since 19 *. Dividends are neither guarantees nor estimates and future dividends which you actually receive will differ from those illustrated to the extent that future expense, claims and investment experience differs from current experience."

*(The earliest year of the issue year grouping used to determine the investment earnings on current issued policies.)

- C. Under the conditions defined below, with regard to the answers to the Interrogatories in Schedule M, disclosure of areas of specific concern would be appropriate.

- Interrogatory 1 - A negative answer should be disclosed.
- Interrogatory 4 - An affirmative answer would require a description of the period of projection.
- Interrogatory 6 - An affirmative answer to question 6.b. should be disclosed.
- Interrogatory 7 - A negative answer to question 7.a. or 7.b. would require disclosure of the types of transactions on which termination dividends are not paid, once they are available. A negative answer to question 7.c. should be disclosed together with a statement that termination dividends are not in conformance with the standards of practice for payment of such dividends.
- Interrogatory 8 - A negative answer should be disclosed.
- Interrogatory 9 - A positive answer should be disclosed.

STATEMENT 1981-13

REVIEW OF SEX DISTINCT PRICING IN INDIVIDUALLY MARKETED INSURANCE

In December, 1979 the NAIC Accident and Health (C1) Subcommittee Task Force on Sex Discrimination asked this (C4) Technical Subcommittee to review a statement given to the Task Force on April 9, 1979, by the Health Insurance Association of America and the American Council of Life Insurance and to review any other relevant actuarial data. The (C4) Subcommittee was asked to report to the (C1) Subcommittee on whether there would be a significant disadvantage to the public from (1) requiring that individual health insurance premium rates be the same, regardless of sex; and (2) requiring that the cost of normal pregnancy coverage be charged to a broader group of persons than those who want or need the coverage. The (C4) Subcommittee, by letter from Larry Gorski of Illinois dated May 12, 1980, requested the American Academy of Actuaries to prepare a discussion of the same questions. In August, 1980, a report was received from the Health Subcommittee of the American Academy of Actuaries Committee on Risk Classification.

The (C4) Technical Subcommittee assigned to Larry Gorski, Thomas Kelly of New York, and Spencer Hamilton of Utah, the task of reviewing the details of these reports and reporting back to the Subcommittee. They have done this in the form of Larry Gorski's letter of March 17, 1981 to Ted Becker of Texas. The (C4) Life, Accident and Health Insurance Technical Subcommittee has reached the following conclusions based on current data:

- 1) Claims costs under individually marketed and group health insurance vary significantly by sex. It is, therefore, actuarially appropriate and advantageous to the public for individually marketed health insurance premium rates to vary by sex and for group health insurance premium rates to take into account the respective distributions by sex in the various groups insured.

- 2) Spreading the cost of normal pregnancy outside the group of persons at risk would produce unfair results which are unnecessary and undesirable.

These conclusions are based on currently available evidence. The fact that the amounts of cost differentials based on sex continue to change means that investigation must continue and trends must be followed up so that we can properly respond to emerging experience.

In the course of considering these questions, we have become aware of the fact that several bills have been introduced in the U.S. Congress which would prohibit sex-based pricing differentials in all lines of insurance, even where there are statistically demonstrated cost differences. If there is to be a viable insurance system in this country, it must have a risk classification system that protects the insurance system's financial soundness; that is fair to insurance buyers; and that permits economic incentive to serve the broadest possible market.

It is generally the position of the actuarial profession that insured individuals are treated equally if they are charged prices which equitably reflect the value of the risks they transfer to the insurance pool -- not simply as a matter of theoretical preference but as a necessary condition to

the sound operation of insurance programs. Determining the value of the risks transferred necessarily involves the use of averages and classification variables; therefore, the use of averages and class groupings is fundamental to insurance. Consideration of what is fair or unfair in insurance must take place within that conceptual framework.

In testimony on H. R. 100, a bill to Prohibit Sex Discrimination in Insurance, given before the House Subcommittee on Consumer Protection and Finance on August 28, 1980, the American Academy of Actuaries Committee on Risk Classification identified the key question regarding this proposed legislation as one of whether the social benefits, if any, to be derived from the legislation, outweigh the disadvantages inherent in the elimination of cost-based pricing and the disruptions of the marketplace which it implies. Based on more recent testimony submitted to the House Subcommittee on Commerce, Transportation, and Tourism on May 20, 1981, by the American Academy of Actuaries Committee, (see Attachment A),* we believe the answer to this question is no. Cost-based pricing is critical to all commercial activities and to prohibit premium rates in insurance from reflecting the estimated cost of the risk would lead to great instability in the insurance marketplace and would actually interfere with free access to insurance by many customers.

Some of the more important possible effects identified in the American Academy of Actuaries Committee's testimony are the following:

- A. An increase in the average price of insurance in general, as insurers are forced to take on the additional risk that the sex distribution of those insured will be different from what has been assumed in pricing;
- B. Increased emphasis on selling insurance for the arbitrarily over-priced risks, along with possible steps to avoid selling insurance for risks that are known to be relatively under-priced;

* See Statement 1981-9.

- C. Increased regulatory efforts and costs to assure equal availability of coverage, especially to those for whom insurance prices are arbitrarily reduced;
- D. Adoption of new classification factors or product modifications, some of which may have the effect of differentiating risks by sex;
- E. Diversion of resources to the implementation of unisex rating, at the expense of new insurance product development efforts or investigation of other new pricing techniques.

As indicated in the testimony of the American Academy of Actuaries Committee, a significant economic impact and disruption of insurance markets would result from failing to reflect cost differences by sex in insurance pricing. Therefore, we recommend that the NAIC endorse the use of a risk classification system for individually marketed insurance, and both cost differences and distribution by sex within a group for group insurance, as being in the best interests of buyers of insurance.

STATEMENT 1981-14

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

STATEMENT TO THE SPECIAL COMMITTEE ON AGING
OF THE UNITED STATES SENATE

BY
JAMES R. SWENSON, CHAIRMAN OF THE
COMMITTEE ON SOCIAL INSURANCE
OF THE
AMERICAN ACADEMY OF ACTUARIES

June 16, 1981

Mr. Chairman and distinguished Senators of the Committee, my name is James R. Swenson. I am the Chairman of the Committee on Social Insurance of the American Academy of Actuaries. On behalf of the Academy, I wish to thank you for the opportunity to discuss financing issues affecting the Social Security program.

The American Academy of Actuaries is a professional organization 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. It includes members of three founding organizations -- the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

Requirements to become a member of the Academy can be summarized under two broad headings: (1) education and (2) experience. At the present time, the education requirements for membership can be satisfied by passing certain professional examinations given either by the Casualty Actuarial Society or the Society of Actuaries or by becoming an "enrolled actuary" under the Employee Retirement Income Security Act of 1974 (ERISA). The experience requirement consists of three years of responsible actuarial work.

As of the end of 1980, the Academy membership exceeded 6,200. The Academy is unique as the national actuarial organization for actuaries in all areas of specialization. These actuaries have a variety of types of employment, including insurance organizations, consulting firms, academic institutions, and government. A large majority of those individuals who have satisfied the education and experience requirements of the Academy have, in fact, joined the Academy.

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, liaison with other professions, and public relations.

Actuarial science involves the evaluation of the probabilities of uncertain future events, often over long periods of time, and the financial impact which these events involve. The computation of financial values for insurance and pension programs in both public and private sectors is a major application of actuarial techniques.

The actuarial nature of the financing arrangements for Social Security has been recognized since the inception of the program in 1935. In recognition of the extreme importance to society of maintaining the financial integrity of the Social Security system the Academy formed its *Committee on Social Insurance* several years ago. The Committee includes some of the most eminent actuaries in the United States with a wealth of experience in both public and private insurance and pension programs.

Since I am representing a professional organization comprised of individuals who hold diverse political views, this statement will not generally favor or oppose specific legislative proposals. Instead, the statement will discuss the actuarial projections involving the Social Security program to assist you in your important deliberations.

It is apparent that legislation needs to be enacted to resolve the predicted short term financing problems of the OASI portion of the program. The Academy believes that it is equally important that long term financing issues be addressed at the same time to help assure the financial viability of the program and to restore public confidence in the program.

While the short term financing problems of the program require immediate action, the long term financing problems pose an even greater challenge to the program. Since the Social Security program is an intergenerational transfer program, funded essentially on a pay-as-you-go basis, the demographic influences of increasing life expectancy combined with the post World War II baby boom and subsequent baby bust will require substantial increases in future payroll tax rates. Official actuarial estimates predict OASDHI benefit costs ranging from 20% to 36% of payroll by the year 2030. The cost of Medicare's Supplementary Medical Insurance program, which is financed primarily by general revenues, will require an additional intergenerational transfer equal to approximately 2½% of payroll by that year.

Since the financial viability of the program depends upon the willingness and the capability of persons who are working to pay taxes sufficient to support promised benefits, those benefit promises must be kept at levels that are

reasonable and affordable. This requires that significant long term changes to the program be enacted so that future generations will not be faced with a burden they will be unable or unwilling to support. Such changes should be enacted now so that those affected will have adequate time to plan accordingly.

In this context, it is noted that the recent Administration proposals were criticized because they produced more savings than needed to restore long term financial balance to the OASDI program. While this is true based upon the intermediate assumption projections made in the 1980 Trustees' Report, these additional long term savings would be required to help offset the even larger deficits expected to develop in the Hospital Insurance program.

Returning to the subject of this hearing, namely the short term financing problems, there are a variety of alternatives available to solve these problems.

Enactment of proposals permitting inter-fund borrowing would substantially alleviate the short term problem. However, the margins protecting the program from adverse economic conditions would be inadequate and other changes are warranted as well.

Actuarial forecasts of the degree of the short term problem largely depend upon the economic assumptions employed in those forecasts. At least three currently available forecasts have been prepared in 1981 by the Office of the Actuary and the Actuaries employed in the Health Care Financing Administration. A number of other forecasts will soon be available when the 1981 Trustees Report is released.

The three actuarial forecasts which have been released during 1981 are based upon (1) former President Carter's 1982 Budget assumptions, (2) President Reagan's 1982 Budget assumptions and (3) DRI's February, 1981 pessimistic economic assumptions.

If inter-fund borrowing were permitted among the three Trust Funds, the projections indicate that short term cash flow problems would not develop based upon President Reagan's 1982 Budget assumptions. However, cash flow problems would develop in 1985 based upon former President Carter's 1982 Budget assumptions and as early as 1983 based upon DRI's pessimistic assumptions.

My personal opinion is that former President Carter's economic assumptions are the most realistic of the three sets of assumptions. However, opinions will differ and it is impossible to accurately predict future economic conditions. In 1977 it would have been unrealistic to predict, as "best estimates", economic conditions as adverse as those that prevailed during the past two years.

Therefore, it is necessary to provide adequate margins to protect the program from the consequences of unexpected adverse economic conditions. The current margins are inadequate. Those margins should be large enough to permit adequate time for legislation to be enacted to maintain the financial viability of the program.

In addition, "safety valve" type provisions are highly desirable to protect the program from adverse economic conditions. For example, if the 1977 Social Security Amendments had provided that benefit increases be based upon the smaller of wage or price increases, the program would not now be confronted with cash flow problems. Unfortunately, tax revenues have failed to keep pace with CPI indexed benefit payments because of negative "real wage" growth. The CPI increase exceeded the average wage increase by 3.1% in 1979 and by 5.0% in 1980. This is the primary cause of the immediate cash flow problems.

If future benefit increases were limited to the smaller of the wage or price increases, this would provide the program with substantial protection from adverse economic conditions. Under favorable conditions, such as those forecast by President Reagan's 1982 Budget, benefits would continue to be fully indexed to CPI measured price increases. However, if economic conditions prove unfavorable, the benefit increases would be limited to wage increases thereby providing protection when it is needed most.

For example, using the DRI pessimistic assumptions, the Administration has indicated that \$111 billion of additional taxes or benefit reductions would be required prior to the end of 1986 to continue to make benefit payments. Limiting the benefit increases would provide \$35 billion of this total amount needed according to projections made by the Office of the Actuary.

The relative unpredictability of the economy indicates that more emphasis should be placed on actuarial projections based upon pessimistic assumptions. It should be noted that such projections indicated the potential for short term cash flow problems shortly after the 1977 Amendments were enacted. Virtually no publicity was given to that fact at the time.

It is my personal opinion that the DRI pessimistic assumptions are not unreasonably pessimistic. As a matter of fact, none of the future DRI "real wage" loss assumptions are as substantial as the actual "real wage" losses that occurred in the last two years. In addition, it should be noted that since 1972 there has been only one year during which there was more than a 1% real wage gain.

Current legislative changes should provide adequate reserve margins as well as "safety valve" provisions. Even with these margins and provisions, there is a good chance that subsequent legislative action would be required if "best estimate" forecasts are used as the basis for legislative action because of the unpredictability of the economy.

A minimum reserve of approximately 8% of annual outlays is essential to meet cash flow requirements. Additional reserves are needed to permit time for legislative action if actual economic conditions are worse than expected. Two Advisory Councils and the National Commission on Social Security have recommended reserve ratios ranging between 75% to 125% of annual outlays.

These are reasonable long range objectives for the program. They are not redundant when it is recognized that the reserve ratio was 80% in 1973 and had fallen to 24% as of the end of 1980.

It is not politically realistic to expect these reserve levels to be attained during the next five years. Therefore, a judgment must be made about a politically feasible minimum reserve level that would permit time for subsequent legislative action should it become necessary. It is my judgment that a minimum reserve level of 25% of annual outlays is essential to protect the program and its recipients. This minimum reserve recommendation is based upon the assumption of enactment of a "safety valve" provision limiting benefit increases to wage increases when "real wage" losses occur.

Based upon actuarial forecasts employing former President Carter's 1982 Budget assumptions, maintenance of this minimum reserve level would require approximately \$65 billion of additional taxes or benefit reductions to be spread throughout the period from 1982 to 1986. Again, please realize that subsequent political action may be required to protect the program, but current enactment of legislation providing a safety valve and further producing these additional revenues or savings would allow sufficient time for such action. If you wish to reduce the probability of having to take subsequent political action, then current legislation should be based on pessimistic assumptions.

The current financing problems of the program illustrate the continuing need for independent, professional actuarial analysis. The Office of the Actuary of the Social Security Administration and the actuaries employed in the Health Care Financing Administration are uniquely qualified to provide such analysis. They must be given the latitude to select a range of appropriate assumptions independent of "official" economic forecasts.

It should be noted that the Employee Retirement Income Security Act of 1974 (ERISA) requires that valuations of private pension plans be certified by qualified actuaries. A similar actuarial certification is required by P.L. 95-595 for pension plans covering federal employees. In each situation, the actuary must certify that the assumptions used are reasonable in the aggregate, representing the best estimates of anticipated experience, and the methodology is proper. The American Academy of Actuaries recommends that the Social Security Act be amended to enable the public to enjoy the same benefit of professional actuarial certification for the Social Security program. This recommendation has also been made by the National Commission on Social Security.

Consistent with this recommendation, the Board of Directors of the American Academy of Actuaries has adopted the following resolution:

"Whereas actuarial projections and cost estimates based on work of the highest professional quality and integrity have been an important force for fiscal prudence in the historical development of social insurance programs; and

"Whereas the growth of these programs and their commitments to future generations of beneficiaries makes it more important than ever that these programs be managed in a fiscally prudent manner;

"Therefore, be it resolved that this organization believes that it is in the best interests of the public that (1) the actuaries who are responsible for the projections and cost estimates be free to use their best professional judgment and expertise independent of pressures for political expediency, and (2) the actuaries ultimately responsible for their work be required to issue an opinion letter accompanying the appropriate annual report stating whether the actuarial assumptions used in the projections contained therein are (a) in the aggregate reasonable taking into account the experience and expectations of the plan and (b) represent their best estimates of anticipated experience under the plan."

Attached to this testimony is a proposed amendment to the Social Security Act.

This amendment would require a statement of opinion by the Chief Actuary of the Social Security Administration and the Chief Actuarial Officer of the Health Care Financing Administration that the techniques and methodology used in preparing the actuarial status of the Trust Funds and the cost estimates and the assumptions used with respect to such Funds are reasonable and conform with generally accepted actuarial principles.

In conclusion, the Academy hopes this testimony has been helpful, and we would welcome the opportunity to be of further assistance as you proceed with your important deliberations.

AMERICAN ACADEMY OF ACTUARIES

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PROPOSED AMENDMENT

Section 201(c) of the Social Security Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuary of the Social Security Administration expressing his or her opinion:

(1) that the techniques and methodology used in preparing the actuarial status of the Trust Funds are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and expectations of the program, including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(b) Section 1817(b) of such Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuarial Officer of the Health Care Financing Administration expressing his or her opinion: (1) that the techniques and methodology used in preparing the actuarial status of the Trust Fund are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and the expectations of the program,

including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(c) Section 1841(b) of such Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuarial Officer of the Health Care Financing Administration expressing his or her opinion: (1) that the techniques and methodology used in preparing the actuarial status of the Trust Fund are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and the expectations of the program, including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(d) The amendments made by this section shall be effective on January 1, 1982.

AMERICAN ACADEMY OF ACTUARIES

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June 30, 1981

The Honorable John Heinz
Chairman,
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Chairman Heinz:

On behalf of the American Academy of Actuaries, thank you for the opportunity to discuss short term financing issues involving Social Security.

This letter will respond to the question directed to me in your letter of June 17, 1981. Following is the question as described in that correspondence:

"Why would it be necessary, if Congress enacts your recommendation for use of wage/price indexing as a 'safety valve', for us to additionally use pessimistic assumptions and a target of a 25% reserve cushion in determining the amount of savings or revenue needed over the short term? It seems to me, even if the pessimistic assumptions were realized over the next five years, that these approaches combined would produce more savings than necessary. Would not either a 25% reserve cushion based on pessimistic assumptions or wage/price indexing by themselves produce a sufficient cushion for the near term?"

There are several issues which should be discussed before responding to this question. First, it would be highly desirable to maintain reserve levels much larger than the reserve level of 25% of annual outlays that I judged to be the minimally acceptable level for the next five years given political and economic realities. This minimally acceptable level is needed to permit time for subsequent legislative action should actual economic conditions prove worse than expected. A more desirable reserve level objective would be in the range of 75% and 125% of annual outlays as recommended by two Advisory Councils and the National Commission on Social Security.

Second, the judgment which lead to the conclusion that 25% was a minimally acceptable reserve level was based on the assumption of enactment of a "safety valve" provision limiting benefit increases to wage increases when "real wage" losses occur. Since the margins protecting the program from adverse economic conditions are very thin, this type of provision is essential to protect the program and its recipients. Even if the reserve margins were much larger, this type of provision may be warranted both to preserve intergenerational equity between taxpayers and beneficiaries and to help maintain the reserve margins.

Third, it is impossible to accurately predict future economic conditions. Because of this fact, a range of assumptions should be employed and forecasts should be made based upon this range of assumptions. History has proved that it is not prudent to rely only upon "best estimate" assumptions. Instead, there should be adequate contingency plans and provisions to protect the program from unexpected adverse economic conditions.

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Given all of this as background, it is my personal opinion that it is desirable but not essential to combine all three elements to solve the short term financing problems. That is, it is not essential to employ in combination: (1) A 25% reserve level; (2) A "safety valve" provision limiting benefit increases to the lesser of wage or price increases; and (3) Pessimistic assumptions. Instead, as minimum steps, the 25% reserve level and the "safety valve" provision should be used in conjunction with "best estimate" assumptions.

In my testimony, former President Carter's 1982 Budget assumptions were characterized as the "best estimate" assumptions. Under forecasts using those assumptions, maintenance of the 25% minimum reserve level would require approximately \$65 billion of additional taxes or benefit reductions to be spread throughout the period from 1982 to 1986. These additional taxes or benefit reductions would be in addition to any benefit reductions resulting from the "safety valve" provision. If legislation were enacted producing these additional taxes or savings and further providing the "safety valve" provision, subsequent political action might be required, but there would be sufficient time for such action.

The Academy hopes that the testimony and this response is helpful in solving the short term financing problems of this essential program.

Sincerely,



James R. Swenson, Chairman
Committee on Social Insurance
American Academy of Actuaries

JRS:vp

bcc: Messrs. Kellison
Munson
Lamb
MacKinnon
O'Hara
David
Oboz

STATEMENT 1981-15

AMERICAN ACADEMY OF ACTUARIES

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WALTER L. GRACE, M.A.A.A., President
c/o MASSACHUSETTS MUTUAL LIFE INS. CO.
1284 STATE ST.
SPRINGFIELD, MA 01111
413/788-8411

June 16, 1981

Financial Accounting Standards Board
High Ridge Park
Stamford, Connecticut 06905

Re: File Reference No. 1032-013

Gentlemen:

I am pleased to enclose a copy of comments prepared by the Pension Accounting Subcommittee of the American Academy of Actuaries concerning the FASB Discussion Memorandum "Employers Accounting for Pensions and Other Post-Employment Benefits". A concise statement of the major conclusions reached by the Subcommittee is enclosed, in addition to more lengthy discussion of the issues.

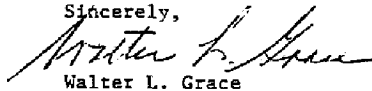
The issues raised in the Discussion Memorandum are of great interest to a significant part of the membership of the American Academy of Actuaries and to the actuarial profession in general because of the large number of actuaries working in the pension field. We believe that the staff of the Financial Accounting Standards Board has done a thorough job in attempting to present fairly all sides of this complex and controversial issue.

The comments presented are those of the Subcommittee, the composition of which represents a wide range of background and interests so as to be broadly representative of the actuarial profession.

The Academy would also like to request an opportunity to appear at the public hearing in New York City on July 13-15, in order to amplify certain points and be available for questions which the Board members may have.

We appreciate this opportunity to make this submission and trust it will be helpful to the Board in making its deliberations. In addition to the appearance at the public hearing we would be happy to consider providing other technical help or support to the Board in considering these issues.

Sincerely,



Walter L. Grace

SUMMARY OF STATEMENT OF AMERICAN ACADEMY OF ACTUARIES
(PENSION ACCOUNTING SUBCOMMITTEE) TO FINANCIAL ACCOUNTING STANDARDS BOARD

The Discussion Memorandum presents a full discussion of the issues covered in a theoretical and philosophical vein linked to the Conceptual Framework. However, we believe it contains some misconceptions or misunderstandings of the nature of the pension arrangement and its relationship to the general concept of deferred compensation. While recognizing the advantages of this theoretical approach in considering the establishment of basic accounting principles, we are concerned about the lack of attention paid to serious practical consequences that would result if certain of the proposals were adopted, particularly those proposals that depart radically from current pension accounting practice as expressed in APB Opinion #8. Linkage to Conceptual Framework may be a desirable goal, but the unique nature of the pension arrangement, in design and funding, needs to be recognized in accounting concepts.

Pension plans are adopted, and improved, by employers in exchange for future employee services. It is therefore appropriate to recognize pension expense over the future period during which such service will be rendered and during which revenues will be generated. Consequently, there should be no balance sheet liability for pensions other than the excess of accrued pension expense over contributions actually made.

Having ascertained that pension promises are in exchange for future service, it is also clear that pension expense should be recognized in some rational and systematic manner over the future period during which such service will be rendered. A range of actuarial cost methods, with suitably chosen amortization periods, fulfill this objective. For accounting purposes, the range of allowable methods should be limited to those permitted by ERISA for minimum funding purposes.

We live in rapidly changing times, and it is natural that such an economically significant subject as pensions should be the focus of intense scrutiny and even controversy.

Nonetheless, none of the factors cited by the Board for reconsidering accounting for pension plans provides justification for a significant departure from the basic principles embodied in APB Opinion No. 8. Those principles evolved over a long period of time and have worked well in practice. They still faithfully reflect the underlying economic reality of pension plans, the presence of the factors cited by the Board notwithstanding. Any attempt to deviate from time-tested, actuarially sound, accounting practices will ultimately mislead investors and management and undermine the benefit security of the plan participants.

STATEMENT TO FINANCIAL ACCOUNTING STANDARDS BOARD
BY THE SUBCOMMITTEE ON PENSION ACCOUNTING MATTERS,
AMERICAN ACADEMY OF ACTUARIES, CONCERNING THE FASB
DISCUSSION MEMORANDUM RE: EMPLOYERS ACCOUNTING FOR PENSIONS
AND OTHER POST-EMPLOYMENT BENEFITS

This statement represents the consensus of views of the Subcommittee on Pension Accounting Matters of the American Academy of Actuaries on subject Discussion Memorandum. In addition to this written statement of views, we would also like the opportunity for representatives to appear at the hearings scheduled for July 13-15.

The American Academy of Actuaries is a professional organization of actuaries which was formed in 1965 to bring into one organization all qualified actuaries in the United States, in order to seek greater consistency and uniformity of standards in the profession and draw attention to the importance of actuarial considerations in many public issues. It includes members of three founding organizations -- the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

As of the end of 1980, the Academy membership exceeded 6,200. The Academy is unique as the national actuarial organization for actuaries in all areas of specialization. These actuaries have a variety of types of employment, including insurance organizations, consulting firms, academic institutions, and government.

Membership on the Subcommittee preparing these comments has been drawn from a wide range of interests and perspectives so as to give the broadest possible range of views on the matters in the Discussion Memorandum. As with many other professional organizations, the structure of the Academy and the timing required in responding to various public issues places the responsibility of preparing

comments on such issues to its committees, on the assumption that they are representative generally of the entire membership of the Academy. However, these comments represent specifically the views of the members of this Subcommittee and do not purport to represent the views of the American Academy of Actuaries itself or its Board of Directors.

We believe the staff of the Financial Accounting Standards Board has done a thorough job in preparing the Discussion Memorandum covering such controversial and complex topics. Although the apparent preferences of the staff on certain issues are sometimes implied, in general we feel the issues are fully presented, giving an opportunity for all to comment freely before tentative decisions are made. If there is any overall criticism which might be directed to the Memorandum, it would be that the issues are presented in highly theoretical, conceptual terms, paying little attention to either current accounting practices or the practical consequences of implementing certain decisions. In areas where there is no clear-cut or well-accepted choice between alternatives, the practical consequences of the alternative decisions certainly need to be evaluated. We trust that when the Board reviews the responses and makes tentative decisions it will take into account the practical realities which must be blended with the theoretical to come up with reasonable solutions in such a complex area. While we understand and agree with the desire of the Board to tie all accounting principles to the conceptual framework, practical realities, as well as current accounting practice, must be taken into account.

Before getting into the basic issues, we might make one overall observation concerning the general thrust of the Discussion Memorandum. In this context certain statements in Appendix D, The FASB Conceptual Framework, seem particularly significant:

"The primary focus of financial reporting is information about earnings and its components." (Page 145 - emphasis added)

"Relevance and reliability are the two primary qualities that make accounting information useful for decision making." (Page 148)

"Revenues are inflows or other enhancements of assets of an entity or settlement of its liabilities (or a combination of both) during a period from delivering or producing goods, rendering services, or other activities that constitute the entity's ongoing major or central operations." (Page 150 - emphasis added)

"Expenses are outflows or other using up of assets or incurrences of liabilities (or a combination of both) during a period from delivering or producing goods, rendering services, or carrying out other activities that constitute the entity's ongoing major or central operations." (Page 151 - emphasis added)

Hopefully these are not taken out of context and suggest to us the following conclusions:

- (1) Liabilities are important -- but a focus on liabilities should not be permitted to distort the reader's perception of earnings.
- (2) Pension plans are important -- but financial operations of the pension plan should not obscure the results of the entity's primary function. The organization's need to conduct its business effectively should not be handicapped by unnecessary restrictions on its abilities to meet its pension obligations.

We hope that the Board will agree with these conclusions as it reviews and discusses these complex issues.

The Nature of Pension Arrangements

The Discussion Memorandum approaches the discussion of pension plans from the standpoint of conceptual accounting practices and attempts to classify and pinpoint various aspects of pension plans into classic and familiar accounting terms. We view the defined benefit pension plan and the structure used to derive its costs and funding levels as unique, not necessarily fitting easily into the conventional definitions employed by the accounting profession in classifying

other elements of the financial statement. The actuarial cost mechanisms, or funding methods, evolved over the years to permit an orderly planning of the necessary funding requirements for retirement benefits. APB #8, and earlier practice, accepted these approaches as being reasonable and necessary in order to account properly for the costs of pension plans.

In one sense it is unfortunate that the term "liability", perhaps borrowed from the accounting profession, became a part of pension terminology, applying to such items as the "accrued actuarial liability", "past service liability", etc. -- unfortunate because the term "liability" has such a specific connotation in the accounting sense. While the question is not entirely semantical, one cannot help wonder whether the same attention would be paid to these "actuarial liabilities" if alternative words had been used, such as actuarial obligations, actuarial deficiency, supplemental actuarial value, present value of accrued benefits, etc. However, the term "actuarial liability" has been in common use for many years, and unfortunately the word "actuarial" preceding "liability" is often overlooked or ignored as if it had no meaning.

The development of the typical defined benefit pension plan is one of the most important developments in the history of benefit plans in attempting to provide in logical fashion for an adequate level of retirement benefits from private pension plans. The development of the various actuarial funding methods, some of which define an "accrued actuarial liability," provide for a stable and orderly funding program to meet these obligations in reasonable fashion over a period of years. The acceptance of such an approach for financial reporting purposes by the accounting profession through APB #8, and by common practice before that, has been a necessary factor in the continued growth of defined benefit pension plans in this country. Without the ability to create these actuarial obligations, which have properly not been deemed to be a balance sheet liability,

it would be difficult if not impossible to provide adequate retirement benefits through a well conceived, long range plan. This basic structural feature of pension plans should be kept in mind in reviewing the comments following and in reaching decisions regarding the accounting issues.

The Discussion Memorandum raises the philosophical question as to whether pensions are a form of deferred compensation or something else, such as a gratuity. There seems to be an implication that if pensions are a form of deferred compensation, the employer has an accounting liability with respect to benefits which are, by formula, linked to a period of prior service. However, alternative benefit formulas could be devised which would not directly recognize prior service but would accomplish the same purpose as the more conventional benefit formulas which do include prior service in the calculation. Therefore, recognition of prior service in a pension benefit formula should not of itself result in classifying the obligations of a defined benefit plan as a balance sheet liability.

In short, pensions are pensions, a somewhat unique form of employee benefit. Attempts to pigeonhole them in one category or another in order to decide upon an accounting treatment is overly simplistic. This could lead to significant problems in the whole structure of employee benefit programs.

Nature of the Obligation

Paragraph 66 of the Discussion Memorandum asks certain questions concerning the nature of the employer's obligation. First, is the employer's obligation to provide all defined benefits or only to make contributions to the plan?

Again the attempt at categorizing such philosophical questions into neat little boxes is unsatisfactory. The employer's obligation is to make contributions to the plan which will provide for the defined benefits. In an ongoing plan

situation, the contributions are determined in such a way as to be sufficient to provide the benefits. If actual experience is different than anticipated, contributions will be adjusted appropriately.

Second, is the obligation to each employee, to the employee group, or to the plan? Again these issues cannot be distinctly separated. The plan itself is merely a conduit which the employer utilizes as a device for accumulating funds for later transfer to specific employees after they leave the employee group, having performed services.

The pension plan is not a form of deferred compensation in the usual sense. The employer adopts a pension plan in exchange for the future services of his employees. He then selects an actuarial cost method to meet the costs of the plan. As the employer accrues an expense or makes a contribution to fund the plan, the "compensation" paid is current, not deferred. This is particularly clear in the situation of a negotiated pension plan in which an agreement is made whereby the employees forego current compensation for the promise of future pension payments to members of the employee group who fulfill certain criteria at a later date. The primary motivation of the employer is to obtain future services of the employees. The employer does not forego any current expense since he accrues the cost of these benefits.

A pension plan can be viewed as representing a portion of the total employee benefit (or compensation) "package" provided for a group of employees. The situation may not always be so obvious or clear cut as the case of negotiated pension plans just described, but certainly employers seldom, if ever, create or improve pension plans for motives of pure generosity. Management and shareholders expect future services, and resulting future revenues, in exchange for the pension promise. Prior to ERISA, if the expected revenues were not generated (or even if they were), the employer had the right to reduce the benefits, or even terminate the plan without further obligation.

The focus was -- and is -- on the future. Even though service prior to the effective date of the plan, or the plan improvement, is used in calculating the amount of benefit payable, the pension is not granted in exchange for that prior service but primarily for future service and future employer revenues.

Consider the actions which might take place, giving rise to obligations of the employer which are measured in terms of years of past service.

- (1) The employer adopts a plan, giving credit for past service under a defined benefit pension plan formula.
- (2) The employer makes amendments to an existing plan, giving credit in some fashion for additional benefits which by formula are related to past service.
- (3) The plan experiences actuarial losses, such as the effect of pay increases greater than anticipated in a final average pay pension plan.

In the case of the adoption of a plan, the employer makes the decision to take action on the basis of ability to meet the anticipated future expenses of the plan on an orderly and rational basis, in exchange for the future services of employees. Past services of employees who terminated, retired, became disabled, etc., before the effective date of the plan are not recognized. As indicated earlier, this is very clearly the situation in the case of a collective bargaining agreement establishing a pension plan, where there is a well defined trade-off in exchange for direct future wages.

With respect to making amendments, these same arguments can be advanced as in establishing a plan with prior service credits. An employer making a decision regarding an amendment does so only after careful analysis of, (1) the annual future expense involved as part of his total compensation package, and (2) the future good will of the employees which will be realized by such changes.

With respect to actuarial losses, the best example might be those generated by pay increases under a final average pay plan. Clearly these are future events that give rise to the additional obligations, not past events.

In summary then, since we believe the transactions or events giving rise to the pension obligation is a performance of future service, no liabilities should be recorded at the effective date of a plan or amendment. The liability should be measured only with respect to pension expenses accruing on or after the effective date of the plan or amendment. This means that the only liability that would be recorded on the balance sheet of the employer would be the excess of the recorded pension expense over the actual contributions to the plan, similar to present accounting practice under APB #8.

Plan Assets

In an ongoing plan situation utilizing an acceptable actuarial cost method and reasonable actuarial assumptions, the employer discharges his liabilities by making contributions to the plan. The assets of the plan are not assets of the employer. The employer has a fiduciary responsibility to maintain the assets of the plan but does not have control of the assets.

The plan assets do not meet the definition of an asset as provided in the conceptual framework. They do not directly affect the cash inflows of the enterprise. It is possible through investment gains to lower the future cash outflows of the enterprise, but this will be reflected in the actuarial gains and losses which affect annual pension expense. In the ongoing plan situation the assets of the plan will never revert to the employer. The enterprise does not obtain any direct benefit from the assets and only controls distribution of the plan assets as required by the plan document.

Balance Sheet

Adding the assets and pension obligation to the employer's balance sheet as illustrated in Example 1 of Paragraph 143 would be inappropriate and would tend to confuse many users of the statement. Putting both plan obligations and plan assets on the balance sheets would be totally misleading and falsely portray both assets and liabilities of the plan sponsor.

Obviously if certain plan obligations were required to be on the balance sheet and exceeded plan assets by a large amount it would seriously distort the net worth of the company and substantially change all prior accounting practices in this regard. A clear example of the confusion created by including assets and pension obligations on the balance sheet would arise if the assets of the pension fund exceeded the pension obligation, however defined. This would mean that the net assets of the pension plan would be deemed to be assets of the corporation and available for other purposes, when in fact they are clearly out of the legal control of the corporation and are of little consequence in appraising the value of the corporation. It is true that prepaid pension expense (arising because actual contributions to the plan exceed the accrual pension expense) do appear on the balance sheet, even though such amounts are included in plan assets. However, such amounts are available as a reduction in future accrual pension expense, and thus are properly included on the balance sheet, whereas the excess of plan assets over obligations (except for any portion thereof which is a prepaid expense) are not available to reduce future expense.

The Discussion Memorandum discusses the possibility of including on the balance sheet an "intangible asset" which could offset, in whole or in part, the difference between an actuarial obligation to be included on the liability side of the balance sheet and the pension fund assets to be included on the asset side. Presumably this intangible asset represents future employee good will. We do not agree that either the actuarial obligations or plan assets belong on the balance

sheet, but there seems to be even less rationale for creating an intangible asset equal to some present value of future good will. For example, if plan costs are expressed as 10% of compensation, what is the rationale for putting 10% of the present value of future compensation on the balance sheet? Can the present value of future activities be deemed a current asset? This would certainly open up a Pandora's box of other types of intangible assets to include on the balance sheet.

Relationship of Funding and Accounting

Actuarial cost methods have been developed to allocate the costs of a pension plan in a rational and systematic manner to periods of time. Such methods were originally designed to provide for determining contributions in an orderly fashion in order to provide the benefits as they became due, but they serve equally well to recognize an appropriate pension expense for accounting purposes. Since the objectives of advance funding and accounting are usually the same, it is reasonable to expect that employers would generally utilize the same method for both purposes. In fact, the vast majority of employers have utilized the same method for determining contributions to pension plans and the expense recorded for the plans. Employers have overwhelmingly elected to "fund pension costs as they accrue." As will be pointed out later in our discussion of the pension expense item, we believe this is an important practical matter which should not be overlooked by the Board in reaching its decisions.

Pension Expense

The Discussion Memorandum describes various approaches for allocating units of cost to particular time periods. These approaches have many similarities to the actuarial cost methods now being used in accordance with ERISA and APB #8. Each of these approaches -- and each of the actuarial cost methods -- has a supporting rationale. Certain methods are particularly appropriate for some types of

plans. For example, a method which determines cost as a level number of dollars is normally considered appropriate for a plan whose benefits are independent of compensation. However, there is no one method which is inherently "right" for all situations. Thus, there are several methods which might be deemed applicable to any given situation based on the judgment of the actuary and the plan sponsor.

APB #8 and the Discussion Memorandum both indicate that the pension expense accrual should not necessarily be determined by the actuarial method being used to provide for funding the pension benefits. A clear distinction is drawn between the basis for the pension expense recorded on the company books and the basis for the annual contributions to the fund, as if they were totally separate elements. Acknowledging that the basis for determining the pension expense accrual does not necessarily have to be the same as the basis for funding the plan, in our view, unless there are strong reasons for doing otherwise, it would be desirable that the cost method used to determine pension expense and to determine funding levels be consistent.

We are concerned that the Discussion Memorandum implies that the Board does not acknowledge the impact which its decisions on pension expense recognition will have on establishing policy for the funding of a pension plan. In reaching decisions regarding the pension expense amount, the Board must consider that whatever it decides regarding pension expense accrual will be an extremely important factor in the decision of the corporation regarding the funding of its obligations. For example, assume the Board defines pension expense as the difference between the net present value of accumulated benefits, as defined in FASB #35, between successive plan anniversaries. For a final pay plan, this would generally be less than the ERISA minimum funding requirement. This would establish a basis for pension expense which could not be followed for funding purposes. This would result in most plans having a prepaid pension expense item as a permanent feature

on its balance sheet, leading to pressure to reduce contributions to the Plan. Therefore, it would tend to influence plan sponsors to adopt lower funding levels, leading to lesser benefit security for plan participants.

To establish a basis for the pension expense which deviates from principles of actuarial adequacy and soundness for funding purposes, or to restrict tightly the flexibility of the employer to meet its funding obligations would, in our opinion, be ignoring the practical effects of their decisions. For example, the accrued benefit cost method, deemed very suitable for career average plans by many actuaries, is not generally viewed as the most appropriate method for other types of plans. The Board probably neither presumes nor wants to have authority over the funding of pension plans; nevertheless the fact remains that their responsibility in setting the basis for pension expense is a major factor in determining pension funding levels for corporations.

The Discussion Memorandum includes as an alternative the possibility that the pension expense be the increase in pension liability during the period. This approach ignores the long range nature of the pension obligation as previously described and implies a degree of certainty in measuring the pension obligation from year to year which is misleading and not warranted. An expense determined on this basis would tend to fluctuate widely between time periods, reflecting in full the actuarial gains and losses, which may fluctuate randomly and widely. We believe the pension expense should be viewed as an allocated share of the long range obligation of the plan, to emerge in a stable and orderly fashion. It should not, for example, swing widely from year-to-year to reflect the full impact of temporary changes in the market value of assets, which will likely be corrected in subsequent years (or if it does not, the adjustment can be made gradually as the experience gains more credibility).

In summary we believe that each of the actuarial cost methods permitted under ERISA, utilizing (where applicable) a reasonable period for the amortization of unfunded prior service costs, has the effect of allocating costs in a reasonable and systematic manner over the period during which services will be provided and revenue generated. Thus, we believe that each of these methods should be acceptable for determination of annual pension expense.

We would add, however, that we believe the employer should continue to have flexibility in selection of an actuarial cost method, both for funding and expense purposes. To attempt to limit the determination of the pension expense to a single cost method would almost always force employers to adopt this same single method for funding purposes, thereby destroying the necessary flexibility an employer should have in meeting its long range pension obligations. Pension obligations are very long range in nature and the employer should have discretion in choosing the manner in which to meet such obligations which they emerge slowly and predictably over a period of time. Management is in the best position to evaluate its future needs, and in many cases the funding flexibility currently available permits the management to make the choices best for its situation. The continued viability and growth of the corporation require all the flexibility it can have in the corporation's cash flow needs. Some would argue that this is just as important as comparability of financial statements among corporations.

Actuarial Gains and Losses

The Discussion Memorandum inadvertently adds to the confusion between the actuarial and accounting professions by classifying two different items as actuarial gains and losses. The actuarial profession defines an actuarial gain or loss as the difference between the actual experience and the expected experience. The Discussion Memorandum, however, classifies as actuarial gains or losses the

financial effects of the changes in the actuarial assumptions. This classification is a holdover from APB Opinion #8. We believe that changes due to revisions in assumptions should be identified separately as such, and not be classified as actuarial gains or losses. ERISA treats the two items differently in terms of defining minimum funding requirements.

True gains and losses, which are the deviations between actual and expected experience, are inevitable. The actuarial obligation and accrual expenses of a pension plan, as determined by an actuary, are determinable with a sufficient degree of accuracy to be used in the financial statements of an employer, but they are estimates, not exact determinations.

It is not at all uncommon for an actuarial gain in one period to be offset by an actuarial loss in a subsequent period. In fact, if actuarial assumptions are reasonably accurate this is exactly what is to be expected. Actuarial gains and losses are, in effect, random fluctuations about the mean of a long term average cost.

To make a complete adjustment to the actuarial gain or loss for a particular period of time implies that the actuary and/or plan sponsor expect all future experience to be exactly in accordance with the actuarial assumptions. No actuary or plan sponsor expects this. Most actuarial cost methods, as applied either for funding or expense purposes, provide for the spreading of actuarial gains and losses over future periods, either amortized over a set number of years or spread over the future working lifetime of the employees. If the actuarial experience is reasonably close to the assumptions, then the effect on pension plan expense is relatively small. If the actuarial experience is significantly different over a period of time from the expected experience, it may indicate the need for revision of the assumptions.

As discussed in our comments concerning pension expense, gains and losses will occur year-in, year-out which, if directly reflected in the cost accrual for the year, would result in significant variations in expense from one year to the next. Those who argue that this approach should be followed so as to reflect actual experience year-by-year overlook the long range nature of pension costs and the fact that the annual pension expense is merely an estimate of such long range cost.

Disclosure

Issue 6 of the Discussion Memorandum raises a general question as to the type of disclosure which should be required in notes to the financial statement, in addition to any balance sheet or income statement recognition of pension items. As discussed earlier in response to Issue 1, we do not believe the balance sheet should include any recognition of the accrued pension obligations other than any accrued pension expense which has not been funded. Accordingly all information regarding the actuarial obligations of the plan should be included in explanatory notes to the financial statement, as is the present practice.

The problem of adequate and meaningful disclosure of pension obligations in the financial statement is indeed a very complex one, as the Board must recognize after deliberations concerning the accounting principles for the plan financial statement, as finally reflected in FASB #35. Attempting to present a measurement of either the funded position of the plan or the future obligations of the employer toward the plan through the presentation of a relatively few numbers that will be understood by users of the financial statement is a worthwhile but almost impossible objective to achieve. The confusion already in evidence arising from the presentation of the present value of accumulated benefits required by FASB #36 indicates the lack of understanding as to the meaning of these actuarial values. We endorse the statement in the Discussion Memorandum that any information presented by disclosure must pass a cost/benefit test.

As a general guideline, any information presented in the notes should be limited to information that is already derived in the regular actuarial valuation of the plan, or at least could be derived with little additional work or expense. Certain companies may wish to disclose additional information beyond a minimum standard set by the FASB statement, which might involve more complex determinations, but this should be at their discretion and not required of all companies.

There is one significant problem that affects all items of disclosure, some more significantly than others, that might appear in any proposed notes. This occurs in the case of conglomerates or any organization with a large number of plans. Some organizations have upwards of 100 different plans spread all over the country (in addition to international companies with wide-spread overseas operations), which could include a wide variety of types of plans, types of benefits, different actuarial assumptions and methods, making it difficult to summarize in brief notes the actuarial status of the employer's obligations to such plans. This is an important factor which should be kept in mind in making any final decisions concerning disclosure.

We think the following items, to be included in notes to the financial statement, might be helpful to the informed reader of the financial statements regarding pension plan obligations and costs, without, for the most part, materially increasing the amount of actuarial work required in connection with the usual valuations. An illustrative note is attached as Appendix A.

1. A general statement describing the existence of the plan or plans, including the type of plans in existence in the corporation (e.g., defined benefit, multiemployer plan, profit sharing, savings plan, money purchase, etc.), the type of benefit formulas (e.g., final average pay, career average pay, flat benefit, etc.) and a statement about the coverage of employees of the corporation under one or more plans (e.g., all eligible salaried employees are

covered by final average pay plans, hourly employees by unit benefit plans unrelated to pay, etc.). This latter description would be more difficult for the conglomerate with a wide variety of plans in existence, but a general statement to the effect that approximately X% of the employees of the company are covered by defined benefit pension plans, of which Y% are covered by final pay pension plans, Z% by Taft Hartley multiemployer plans, etc. would be appropriate.

2. The annual pension expense both in dollar amounts and as a percentage of an appropriate compensation base consistently applied for the current year and preceding two years, in order to indicate any apparent trends. Any changes or events (e.g., plan amendments, changes in actuarial assumptions, applicable changes in Social Security, etc.) which materially affect comparability of results through the three-year period should be disclosed. Projection of the future contribution levels should not be required since these could involve a considerably greater expense to produce if done properly.
3. A statement describing the basis used for determining the expense reported for the plan, expressed in terms of the actuarial cost method, and the amortization period, if applicable. If actual contributions to the plan differ significantly from the pension expense, this should be indicated and explained.
4. We have serious reservations about the capability of many users of financial statements to comprehend fully the nature of actuarial obligations associated with pension plans, be they described as present value of accumulated benefits, accrued actuarial liabilities, past service liabilities, etc. There is obviously pressure from many users to define some type of actuarial liability for the plans which gives them a measure of the future obligations of the corporation and a basis of comparison with others. The present value of accumulated benefits, as defined in FASB #35, and currently required for

reporting under FASB #36, is an amount that would seldom, if ever, emerge as an exact measure of liability of the corporation and has no intrinsic meaning in the financial statement of the employer for an ongoing plan. However, it may be viewed as representative of the value of benefits accrued to the date of the statement, and is useful as a guide in appraising the year-to-year progress in the funding of the obligation.

We believe that the concept of actuarial obligations as a balance sheet liability is misleading, and that the best measurement of the long range obligation of the plan is the annual pension expense (item 3 above). Such expense particularly measured as a percentage of payroll, combines in a single measurement the level of plan benefits, the age/service characteristics of the group, and the relative degree of funding.

Many will insist that an "actuarial liability" be shown, representing some type of measurement of the accrued benefits. If one must be shown, then we would suggest continuation of the present value of accumulated benefits required by FASB #36 (broken down between vested and non-vested benefits), provided this is accompanied by a statement describing exactly what the value represents (and does not represent). A suggested statement for this purpose is included in the enclosed illustrative footnote.

We do not believe a salary scale should be included in any such value, as it does not reflect events which have occurred prior to the date of the statement. Also, any such determination would likely lead to a wide variation in results, depending on the salary scale selected.

5. The market value of assets (or reported value of insurance contracts), as required by FASB #36.

6. The rate of interest used to calculate the pension costs and actuarial values referred to above, if applicable. Again, this poses a problem of reporting for corporations having a large number of different types of plans, which often might be using different rates of interest. Such situations would have to be handled individually to give reasonable disclosure without unduly lengthening the size of the footnote.
7. Significant changes occurring in the past year that have a significant effect on the results. This would include major amendments, a change in assumptions or funding methods, etc. and any events (perhaps happening subsequent to the valuation of the plan) which would materially effect the results presented and have not been taken into account. Any funding deficiencies or waivers thereof related to ERISA minimum funding requirements should be noted.
8. The Discussion Memorandum raises the question as to whether the professional qualifications of the plan actuary should be disclosed and whether an actuarial certification should be included. The size of the accrued actuarial liabilities and pension assets for many corporations in relation to net worth certainly makes the source of these values very pertinent, lending support to the idea of identifying the actuary in some fashion. In its presentations, both written and oral, in connection with the exposure drafts of the statement on the plan financial statement, the Academy took the position that there should be a separate actuarial statement prepared by the actuary presenting the actuarial values, attested to by the plan actuary, which should not be directly a part of the financial statement of the plan, although possibly accompanying it. The Board did not agree with the Academy position, by a 4-3 vote.

The Academy still believes in the separation of the actuarial values from the financial statement, but, given the position adopted by the Board, as well as the position in the AICPA Audit Guide on Pension Plans that auditors should not express reliance on the work of the actuary, it is difficult to make a very strong case that the company financial statement should include such material. However significant such values might be to the corporate financial statement, they are even more pertinent to the plan financial statement where such information is not disclosed. We urge the Board to reconsider its position in FASB #35 to require identification of the actuary and the inclusion of an actuarial opinion. Such action would then require reappraisal of the disclosure in the company financial statement.

9. As a follow-on to comment #8 preceeding, we believe it would be desirable that the note, including the information described above, be reviewed and approved by the Enrolled Actuary for the plan or plans. It appears to us that actuaries are in the best position to understand the significance of the various numbers and would feel free to add additional information that they felt was pertinent in the preparation of this note. In most corporate reports, the note disclosing this information is prepared by the organization or its accountants, without any review by the actuary for the plan. In many cases disclosure could be enhanced if the actuary had an opportunity to review and approve this note.

Other Post-Employment Benefits

Chapter B of the Discussion Memorandum deals with other post-employment benefits. It includes death benefits, disability benefits, health insurance plans, termination indemnities, lack of work benefits, and other miscellaneous types of benefit coverage. We would recommend that the Board postpone consideration

of these other benefit program issues until after the basic decisions are made regarding the handling of pension plans per se. The pension problems are indeed very complex and, in our view, it would be better for the Board to focus attention on the pension problems for now because: (1) while certain of the coverages listed in Chapter 8 have some characteristics similar to pension plans, many of them are totally different conceptually, (2) looking only at post-retirement benefits, pension costs and obligations are far more significant and material cost-wise than are these other benefits (except for termination indemnity plans in foreign countries which may have very material costs), and (3) to the extent that there may be some similarities it would be best to establish basic accounting principles for pension plans themselves before "muddying the waters" by bringing in other types of benefits generally of less significance.

If the Board should decide to include certain post-employment benefits in its present study, then we would strongly urge that at least those benefits where basic coverage is during the period of a typical active career of an employee be dropped from present consideration. Such coverage as group life insurance or survivor income benefits for non-retired, non-deferred disability benefits, lack of work benefits (SUB), etc., all have significantly different benefit and cost characteristics than do pension plans. Generally, the costs of these benefits are currently being provided for on what we believe is a reasonable and realistic accounting basis for the most part, since they lack the basic characteristic of the pension plans -- the long deferment of payments to beneficiaries.

If any consideration is to be given presently to such other benefits, it should be limited to only those programs which provide benefits for employees following their retirement. If there are any material costs associated with such programs these would generally be programs providing death benefits and health insurance benefits for retired employees, as well as termination indemnity benefits.

However, the termination indemnity programs, the cost of which may range from 10% to 20% of payroll in certain foreign countries, should perhaps be included with the overall subject of foreign pension plans when it is considered. The rest of our discussion will focus only on these health insurance and death benefits since we believe the other benefits listed in this DM should not be considered as part of this current study.

Post-retirement health insurance and death benefits are quite widespread in U.S. industry and these benefits are commonly expensed on a pay-as-you-go basis for current retirees only, without advance cost recognition during the period preceding retirement. For most corporations therefore, the costs of these types of post-retirement benefits for future retirees, as well as future costs for current retirees, are generally not recognized in the financial statements of corporations.

The obvious parallel for these types of post-retirement benefits is, of course, the accounting treatment given for pension plans currently under Opinion #8. The pay-as-you-go approach is not acceptable under Opinion #8 for recognizing pension costs and therefore one might argue that similar advance cost recognition should be required for these types of plans.

However the analogy between post-retirement health insurance and pension benefits is not all that clear. Both general practice and law have established pension benefits as a higher order of obligation. For example, ERISA prohibits cutbacks in accrued pension benefits while neither a legal prohibition against the cutback -- nor even the concept of an accrued benefit -- has been applied to post-retirement health insurance and death benefits. In fact most employers would probably make a major cutback in future post-retirement medical benefits if government benefits increased dramatically.

Even if one accepts the position that the commitment for post-retirement health insurance and death benefits is reasonably similar to the commitment for pension benefits, some argue that no advance cost recognition need be given to such benefits. They observe that current methods for employee health insurance and death benefit plans typically involve an averaging of costs of a large number of employees over a long period of time, and therefore, in its averaging process the total expense for the entire group of employees may be reasonable consistent over time. While this may be true of some mature employee groups, for others an advance cost recognition will produce results that are materially different from those under any averaging methods.

A major factor, of course, is the materiality of such costs or cost differences, which depends upon the type and level of benefits, the characteristics of the employee group and the size of the labor force relative to the employee's financial results. In order to obtain an opinion on materiality one must attempt to measure the potential obligation of the employer. Some doubt that post-retirement medical benefits, for example, can be adequately measured because they feel that future trends in medical inflation and social insurance are too uncertain to permit a measurement of the employer obligations. However, it can also be argued that a measure of the obligation based on reasonable assumptions as to future events is a better basis for making decisions than no measure at all.

The nature of the employer's obligation in providing post-retirement coverage for death and welfare benefits varies considerably, but would seem to be an important factor in deciding whether or not the expense of such post-retirement benefits should be recognized during the employee's active working career, similar to retirement benefits. Example of these obligations are as follows:

- A. Temporary, gratuitous, for previous retirees only - The employer undertakes by resolution of its Board of Directors a promise, to a class of previously retired employees only, to reimburse certain health insurance and death benefits that are incurred within a specific period of time.
- B. Intent to continue with right to terminate - The employer undertakes by action of its Board of Directors a program for future retired employees as well as current retirees to provide health insurance and death benefits post-retirement. The employer intends to continue the program in the future but reserves the right to terminate it at any time. This is probably one of the most common types of programs in existence now.
- C. Contractual obligation - The employer undertakes, pursuant to collective bargaining agreement, to provide post-retirement health insurance and death benefits to future retired employees and perhaps current retirees who are represented by the collective bargaining agent. This commitment is only during the period covered by the agreement.

The Discussion Memorandum requested information on the costs of these post-employment benefits. Looking only at post-retirement health insurance and death benefits, the costs on a pay-as-you-go basis for currently retired employees will vary widely from one employer to another, depending of course on the level of benefits, but primarily depending upon the relative maturity of the retired population. Thus, an average cost of a typical program will be somewhat misleading since the costs for some employers may be close to zero and for others it may be as much or more than that generated by an advance funding program. However, advance funding costs would tend to be more stable and a very broad approximation to the cost of these plans would be as follows:

- A. A typical death benefit program which is salary related, grading down with increasing age, with a maximum benefit, might cost between 1% and 2% of payroll.
- B. A moderate Medicare carve-out plan might cost between 1% and 3% of payroll.

In terms of the measurement of such costs of advance funding, the actuarial techniques to do so would be similar to those currently being used to determine pension expenses and obligations. However, additional research needs to be done in this area, particularly to establish more refined estimates of expected, age by age annual health care disbursements. While there are statistics available for this purpose, additional analysis and refinement would be desirable by the actuarial profession if advance expense accruals of these costs were required. The expense of making such actuarial determinations of course would also have to be considered.

In summary we are inclined to think that the whole matter of other post-employment benefits should be deferred until basic decisions are made regarding the retirement plan expense and obligation questions. If further consideration is given to this area at the present time, we would limit it only to those benefits such as health insurance and death benefits applicable to retired employees, since most of the other benefit programs (except termination indemnities) mentioned in Chapter 8 involve totally different considerations in terms of expense analysis. As suggested earlier, since termination indemnities in several foreign countries present a significant form of retirement income, we recommend that consideration of this type of program be considered as part of the foreign pension plan problem. Finally we feel that the question of materiality is very significant in this case, because of the potentially wide range of costs which can emerge from various programs.

Respectfully submitted,

Pension Accounting Subcommittee
American Academy of Actuaries
Edwin F. Boynton, Chairman
James Biggs
Yuan Chang
Edward H. Davis
Anthony C. Deutsch
Edward H. Friend
Donald Fuerst
Paul A. Gewirtz
Richard Q. Wendt
John H. Williams

SAMPLE ILLUSTRATIVE PENSION NOTE
IN A COMPANY'S FINANCIAL STATEMENT

The Company sponsors defined benefit pension plans which cover substantially all of its full-time employees. Pension benefits for salaried employees are determined by a formula which is based upon years of covered employment and final five-year average salary. Benefits for hourly employees, most of whom are in collective bargaining units, are generally determined by formulas based on a flat dollar benefit unit per year of covered employment.

Annual pension expense is determined in accordance with an actuarial cost method known as the "Frozen Initial Liability Cost Method", using 30-year amortization periods for costs arising from plan changes. For the fiscal years ending December 31, 19X3, 19X2, and 19X1 pension expense was \$XXX, \$XXX, and \$XXX respectively, or XX.X%, XX.X%, and XX.X% expressed as a percentage of employee payroll. An amendment to the plan covering salaried employees effective January 1, 19X3 increased pension expense by \$XXX or XX.X%, expressed as a percentage of employee payroll.

It is the policy of the Company to contribute to irrevocable trust funds an amount equal to the current pension expense of the plans as specified above. Such contributions satisfy criteria established by the Employee Retirement Income Security Act of 1974 ("ERISA"), and as of December 31, 19X3 the funding requirements of ERISA have been fully met.

Although the level of expense measured as a percentage of payroll is the best measure, both short range and long range, of the effect of the pension plan on the Company's on-going financial operations, certain other information may be of limited use. By comparing the "actuarial present value of accumulated plan

benefits" with the value of assets available to pay such benefits, a reasonable measure of the adequacy of the fund to pay currently promised benefits, if the plans then terminated, is obtained, although there is no likelihood of such termination in the foreseeable future. Such actuarial present value does not include provision for the effects of future salary increases for salaried, employees, nor the effects of potential increases in flat dollar benefit units which might be negotiated under collective bargaining agreements, both of which would increase the benefits which by formula are attributed to service prior to the statement date. The present value of accumulated plan benefits is not an accounting liability of the Company.

	<u>DECEMBER 31, 19X2</u>	<u>DECEMBER 31, 19X1</u>
Actuarial present value of accumulated plan benefits:		
Vested	SXXX	SXXX
Non-Vested	XXX	XXX
Total	SXXX	SXXX
Fair value of net assets available for plan benefits	SXXX	SXXX

The annual rates of return assumed to determine the actuarial present value of plan benefits were X.X% and Y.Y% at December 31, 19X2 and 19X1 respectively. The effect of changing the interest rate from Y.Y% to X.X% was to increase the 19X2 present values by SXXX. There were no other changes in assumptions used or changes in the plan which affect comparability between the two periods. The values shown do not reflect the plan amendment effective January 1, 19X3, which would increase the present value of accumulated plan benefits by approximately SXXX as of that date.

STATEMENT 1981-16

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

June 17, 1981

Honorable Philip R. O'Connor
Director of Insurance
Illinois Department of Insurance
Springfield, Illinois 62767

Dear Director O'Connor:

At the recent meeting of the (B3) Subcommittee in Detroit, I expressed two major concerns that the Academy's Committee on Property and Liability Insurance has with regard to the final version of the NAIC Property and Liability Model Alternative Competitive Pricing and Appropriate Support Systems Act. I agreed, at your request, to submit these in writing for the record. The concerns, their reasons and suggested technical changes follow:

Definitions

Par. (1) deals with "advisory organization." It is our fear that as written this paragraph could be construed to cover consulting actuaries whose practice includes ratemaking assistance to more than one insurer, especially if the consultant were to use similar or identical data as part of his or her deliberations. Given the rules for operation of advisory organization, the consulting actuary so classified could no longer maintain a privileged practice, if any practice at all.

We suggest deleting the last sentence of the paragraph and replacing it with the following: "The definition excludes joint underwriting or joint reinsurance organization; actuarial, legal or other consultants; or insurers under common control or management or their employers or managers."

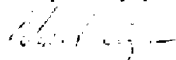
Definitions

Par. (10) The definition of "pure premium" is based on the concept of exposures. There are many important lines of insurance, notably in the property and marine areas, when exposures are simply not defined nor used in the ratemaking process. We are concerned that rate advisory organization would be unable to operate in these lines and thus that no aggregate loss data would exist for them.

Our suggestion is to delete the phrase "per unit of exposure" from the definition.

Thank you for the opportunity to share our considerations with you.

Very truly yours,



Warren P. Cooper
Chairman, The Committee on Property
and Liability Insurance

WPC:hr

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

WILLIAM D. HAGER
GENERAL COUNSEL

June 18, 1981

Honorable Philip O'Connor
Director of Insurance
State of Illinois
160 N. LaSalle Street
Chicago, Illinois 60601

Re: NAIC Open Model Competition Act

Dear Director O'Connor:

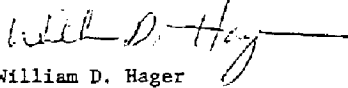
It was a pleasure to meet you at the Detroit NAIC meeting. As I indicated to you in our conversation, the Academy is concerned on behalf of its consulting actuarial constituency that the definition of "advisory organization" might be construed by a court or some future Commissioner at a later date to be applied to consulting actuaries.

As you recall, Warren Cooper made a statement to that effect at the B-3 meeting Tuesday, June 9, during floor comments on the bill. I was, of course, elated to learn through your verbal statement to me that no one ever intended that the "advisory organization" definition would be applied to consulting actuaries in their day to day work with respect to insurers.

In addition to your reassurance verbally on this matter, if you find that the language we have forwarded to you under separate cover (from Warren Cooper, Chairman of the Academy's Committee on Property and Liability Insurance) would serve to reiterate this fact, you may want to consider that language as a technical amendment.

If this letter raises any questions or you have any follow-up inquiries relating to the definition, please let me know.

Yours very truly,


William D. Hager

WDH:pjs

cc: Warren P. Cooper, Chairman
Committee on Property and Liability Insurance

STATEMENT 1981-17

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

WILLIAM D. HAGER
GENERAL COUNSEL

MEMORANDUM

TO: House Committee on Energy and Commerce
Senate Committee on Commerce, Science and Transportation

FROM: William D. Hager

RE: Amendment to H.R. 2120/S. 1096

DATE: June 25, 1981

The American Academy of Actuaries wishes to take this opportunity to convey its views on the Product Liability Risk Retention Act of 1981. First of all, we believe that this bill reflects, in its present form, a major improvement over the original proposals of the 96th Congress which granted authority to the Dept. of Commerce to certify and regulate risk retention groups. We applaud the evolution of this piece of legislation. However, we would like to propose additional language to the bill which would further protect the financial solvency of risk retention groups.

Amend § 3(a)(1)(D) of H.R. 2120/S. 1096 by inserting the phrase "including a statement of actuarial opinion of the adequacy of loss reserves" between the words "information" and "required" in the section so that it reads as follows:

"(d) submit to the appropriate authority reports and other information including a statement of actuarial opinion of adequacy of loss reserves required of licensed insurers under the law of a State relating solely to product liability or completed operation insurances losses and expenses;"

In the event there are problems with this language, we strongly recommend that the committee report, with reference to Section 3(a)(1), recognize that among information the Commissioner of the licensing or chartering state may require under this section is a statement of actuarial opinion of the adequacy of loss reserves as is required of licensed insurers under the laws of that jurisdiction.

WDH/pb

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

WILLIAM D. HAGER
GENERAL COUNSEL

June 30, 1981

Honorable James H. Scheuer
U.S. House of Representatives
Washington, D.C. 20515


Dear Mr. Scheuer:

The American Academy of Actuaries wishes to take this opportunity to convey its views on the Product Liability Risk Retention Act of 1981. First of all, we believe this bill, in its present form, reflects a major improvement over the original proposals of the 96th Congress which granted authority to the Dept. of Commerce to certify and regulate risk retention groups.

In order to further protect the financial solvency of risk retention groups, we strongly urge that the committee report, with reference to Section 3(a)(1), recognize that among information the Commissioner of the licensing or chartering state may require under this section is a statement of actuarial opinion of the adequacy of loss reserves as is required of licensed insurers under the laws of that jurisdiction.

The Academy would appreciate your consideration of this recommendation.

Sincerely,


William D. Hager

WDH/k1

STATEMENT 1981-18

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 915 • WASHINGTON, D.C. 20006 • (202) 223-8196

STATEMENT TO THE SUBCOMMITTEE ON SOCIAL SECURITY AND
INCOME MAINTENANCE PROGRAMS,
SENATE FINANCE COMMITTEE, UNITED STATES SENATE

BY
JAMES R. SWENSON, CHAIRMAN OF THE
COMMITTEE ON SOCIAL INSURANCE
OF THE
AMERICAN ACADEMY OF ACTUARIES

July 9, 1981

SUMMARY OF STATEMENT

The American Academy of Actuaries recommends that both short and long term financing issues be addressed at this time to restore financial balance and public confidence in the program.

The long term financing problems pose an even greater challenge to the program because of demographics.

Because of demographics, unless changes are made in the program, total Social Security costs are projected to increase to between 22% and 38% of payroll once the baby boom generation has fully retired.

It is important to realize that the long term deficit projected for the HI program is approximately twice as large as the deficit projected for the OASDI program.

A gradual future increase in retirement ages to age 68 would eliminate approximately two-thirds of the long term OASDI deficit.

Mandatory, universal Social Security coverage would eliminate approximately one-third of the long term OASDI deficit.

Interfund borrowing would substantially alleviate the short term cash flow problems. However, other steps are required as well to protect the program from adverse economic conditions.

- . A "safety valve" provision providing that benefit increases be based on the lesser of wage or price increases would help protect the solvency of the program from the consequences of adverse economic conditions.
- . It is impossible to accurately predict economic conditions. More emphasis should be placed on actuarial projections based on pessimistic assumptions.
- . Adequate reserve margins are necessary to protect the solvency of the program. A reasonable long term objective would be a reserve ratio of between 75% and 125% of annual outlays as recommended by two Advisory Councils and the National Commission on Social Security.
- . An economically and politically realistic minimum reserve ratio objective for the next 5 years would be 25% of annual outlays combined with enactment of a "safety valve" provision limiting benefit increases to the lesser of wage or price increases.
- . Maintenance of the 25% reserve ratio objective would require \$65 billion of additional taxes or benefit reductions to be spread throughout the next five years based upon assumptions I personally believe to be reasonable for short term planning purposes.
- . The American Academy of Actuaries strongly urges that the Social Security Act be amended to enable the public to enjoy the same benefit of professional actuarial certification as is required for private pension plans and for pension plans covering federal employees.

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

STATEMENT TO THE SUBCOMMITTEE ON SOCIAL SECURITY AND
INCOME MAINTENANCE PROGRAMS,
SENATE FINANCE COMMITTEE, UNITED STATES SENATE
BY

JAMES R. SWENSON, CHAIRMAN OF THE
COMMITTEE ON SOCIAL INSURANCE
OF THE
AMERICAN ACADEMY OF ACTUARIES

July 9, 1981

Mr. Chairman and distinguished Senators of the Subcommittee, my name is James R. Swenson. I am the Chairman of the Committee on Social Insurance of the American Academy of Actuaries. On behalf of the Academy, I wish to thank you for the opportunity to discuss financing issues affecting the Social Security program.

The American Academy of Actuaries is a professional organization 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. It includes members of three founding organizations -- the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

Requirements to become a member of the Academy can be summarized under two broad headings: (1) education and (2) experience. At the present time, the education requirements for membership can be satisfied by passing certain professional examinations given either by the Casualty Actuarial Society or the Society of Actuaries or by becoming an "enrolled actuary" under the Employee Retirement Income Security Act of 1974 (ERISA). The experience requirement consists of three years of responsible actuarial work.

As of the end of 1980, the Academy membership exceeded 6,200. The Academy is unique as the national actuarial organization for actuaries in all areas of specialization. These actuaries have a variety of types of employment, including insurance organizations, consulting firms, academic institutions, and government. A large majority of those individuals who have satisfied the education and experience requirements of the Academy have, in fact, joined the Academy.

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, liaison with other professions and public relations.

Actuarial science involves the evaluation of the probabilities of uncertain future events, often over long periods of time, and the financial impact which these events involve. The computation of financial values for insurance and pension programs in both the public and private sectors is a major application of actuarial techniques.

The actuarial nature of the financing arrangements for Social Security has been recognized since the inception of the program in 1935. In recognition of the extreme importance to society of maintaining the financial integrity of the Social Security system the Academy formed its Committee on Social Insurance several years ago. The Committee includes some of the most eminent actuaries in the United States with a wealth of experience in both the public and private insurance and pension programs.

Since I am representing a professional organization comprised of individuals who hold diverse political views, this statement will not generally favor or oppose specific legislative proposals. Instead, the statement will discuss the actuarial projections involving the Social Security program and the financial implications of various alternatives to assist you in your important deliberations.

It is apparent that legislation needs to be enacted to resolve the predicted short term financing problems of the OASI portion of the program. The Academy believes that it is equally important that long term financing issues be addressed at the same time to restore financial balance to the program and to foster public confidence in the program.

While the short term financing problems of the program require immediate action, the long term financing problems pose an even greater challenge to the program. Since the Social Security program is an intergenerational transfer program, funded essentially on a pay-as-you-go basis, the demographic influences of increasing life expectancy combined with the post World War II baby boom and subsequent baby bust will require either substantial increases in future payroll tax rates or significant benefit reductions.

Official actuarial projections prepared for the 1980 Trustees' Report predict OASDI benefit costs ranging from 20% to 36% of payroll by the year 2030. The cost of Medicare's Supplementary Medical Insurance program, which is financed primarily by general revenues, will require an additional intergenerational transfer equal to approximately 2½% of payroll by that year. In addition, long term actuarial projections based upon the 1980 intermediate assumptions indicate that OASDI benefit disbursements will exceed scheduled taxes by an average of 1½% during the next 75 years.

Since the financial viability of the program depends upon the willingness and the capability of persons who are working to pay taxes sufficient to support promised benefits, those benefit promises must be kept at levels that are reasonable and affordable. This requires that significant long term changes to the program be enacted so that future generations will not be faced with a burden they will be unable or unwilling to support. Such changes should be enacted now so that those affected will have adequate time to plan accordingly.

In this context, it is noted that the recent Administration proposals were criticized because they produced more savings than needed to restore long term financial balance to the OASDI program. While this is true based upon the 1980 intermediate assumption projections, these additional long term savings would be required to help offset the even larger deficits expected to develop in the Hospital Insurance program.

Proposals to increase the age at which full Old-Age benefits are to be paid would reduce the tax levels required to be paid by future generations of workers. For example, proposals to gradually increase the retirement age from 65 to 68 would generally eliminate approximately two-thirds of the 1½% 75 year OASDI financing deficit. To further assist you in your deliberations, it should be noted that today life expectancy at age 68 is greater than it was at age 65 in 1935 when the latter age was selected as the original retirement age under the program. Moreover, actuarial projections indicate that by the year 2000, individuals in their early 70's are expected to have the same life expectancy as individuals age 65 had in 1935.

As you are aware, Universal Social Security Coverage has been recommended by many commissions, advisory panels and study groups. Universal Coverage would help restore financial balance to the program for both the short and long term future. For example, approximately one-third of the 1 1/2% 75 year OASDI financing deficit would be eliminated if Universal Coverage were required.

If Universal Social Security Coverage is enacted, it is important that the benefit structure of existing programs be coordinated with the Social Security program. This will pose a complex problem, but the actuarial profession is prepared to offer assistance so that the coordination can be accomplished in a rational manner. If Universal Social Security Coverage is not enacted, the actuarial profession has suggested methods to remedy the unintended "windfall benefit" situation.

There are a variety of alternatives available to solve the short term financing problems. Those problems would be substantially alleviated if proposals permitting inter-fund borrowing were enacted. However, the margins protecting the program from adverse economic conditions would be inadequate and other changes are warranted as well.

Actuarial projections of the degree of the short term problem largely depend upon the economic assumptions employed in those projections. Unfortunately, it is impossible to accurately predict future economic conditions. In 1977 it would have been unrealistic to predict, as "best estimates," economic conditions as adverse as those that prevailed during the past two years. The actual economic conditions were even worse than pessimistic estimates being made at that time.

Therefore, it is necessary to provide adequate margins to protect the program from the consequences of unexpected adverse economic conditions. The current margins are inadequate. Those margins should be large enough to permit adequate time for legislation to be enacted to maintain the financial viability of the program.

In addition, "safety valve" type provisions are highly desirable to protect the program from adverse economic conditions. For example, if the 1977 Social Security Amendments had provided that benefit increases be based upon the smaller of wage or price increases, the program would not now be confronted with cash flow problems. Unfortunately, tax revenues have failed to keep pace with CPI indexed benefit payments because of negative "real wage" growth. The CPI increase exceeded the average wage increase by 3.1% in 1979 and by 5.0% in 1980. This is the primary cause of the immediate cash flow problems.

If future benefit increases were limited to the smaller of wage or price increases, this would provide the program with substantial protection from adverse economic conditions. Under favorable economic conditions, benefits would continue to be fully indexed to CPI measured price increases. However, if economic conditions prove unfavorable, the benefit increases would be limited to wage increases thereby providing protection when it is needed most.

For example, actuarial projections based upon pessimistic economic assumptions forecast earlier this year by Data Resources Incorporated would require \$111 billion of additional taxes or benefit reductions over the next five years to enable the program to make benefit payments. Limiting the benefit increases to the lesser of wage or price increases would provide \$35 billion of this total amount needed according to projections made by the Office of the Actuary.

The relative unpredictability of the economy indicates that more emphasis should be placed on actuarial projections based upon pessimistic assumptions. It should be noted that such projections indicated the potential for short term cash flow problems shortly after the 1977 Amendments were enacted. Virtually no publicity was given to that fact at the time.

It is my personal opinion that the previously mentioned DRI pessimistic assumptions are not unreasonably pessimistic. As a matter of fact, none of the future DRI "real wage" loss assumptions are as substantial as the actual "real wage" losses that occurred in the last two years. In addition, it should be noted that since 1972 there has been only one year during which there was more than a 1% "real wage" gain.

Current legislative changes should provide adequate reserve margins as well as "safety valve" provisions. Even with these margins and provisions, there is a good chance that subsequent legislative action would be required if "best estimate" forecasts are used as the basis for legislative action because of the unpredictability of the economy.

A minimum reserve of approximately 12% to 14% of annual outlays is essential to meet cash flow requirements. Additional reserves are needed to permit time for legislative action if actual economic conditions are worse than expected. Two Advisory Councils and the National Commission on Social Security have recommended reserve ratios ranging between 75% to 125% of annual outlays.

These are reasonable long range objectives for the program. They are not redundant when it is recognized that the reserve ratio was 80% in 1973 and had fallen to 24% as of the end of 1980.

It is not politically realistic to expect these reserve levels to be attained during the next five years. Therefore, a judgment must be made about an economically and politically feasible minimum reserve level that would permit time for subsequent legislative actions should it become necessary. It is my judgment that a minimum reserve level of 25% of annual outlays is essential to protect the program and its recipients. This minimum reserve level leaves very little margin of protection from adverse economic conditions and therefore, requires enactment of a "safety valve" provision limiting benefit increases to wage increases when "real wage" losses occur.

Based upon actuarial projections employing former President Carter's 1982 Budget economic assumptions, which I personally consider to be reasonable economic assumptions for short-term planning purposes, maintenance of this minimum reserve level would require approximately \$65 billion of additional taxes or benefit reductions to be spread throughout the period from 1982 to 1986. Again, please realize that subsequent political action may be required to protect the program, but current enactment of legislation providing a "safety valve" and further producing these additional revenues or savings would allow sufficient time for such action. If you wish to reduce the probability of having to take subsequent political action, then current legislation should be based on more pessimistic assumptions such as the DRI assumptions.

The current financing problems of the program illustrate the continuing need for independent, professional actuarial analysis. The Office of the Actuary of the Social Security Administration and the actuaries employed in the Health Care Financing Administration are uniquely qualified to provide such analysis. They must be given the latitude to select a range of appropriate assumptions independent of "official" economic forecasts.

It should be noted that the Employee Retirement Income Security Act of 1974 (ERISA) requires that valuations of private pension plans be certified by qualified actuaries. A similar actuarial certification is required by P.L. 95-595 for pension plans covering federal employees. In each situation, the actuary must certify that the assumptions used are reasonable in the aggregate, representing the best estimates of anticipated experience, and that methodology is proper. The American Academy of Actuaries recommends that the Social Security Act be amended to enable the public to enjoy the same benefit of professional actuarial certification for the Social Security program. This recommendation has also been made by the National Commission on Social Security.

Consistent with this recommendation, the Board of Directors of the American Academy of Actuaries has adopted the following resolution:

"Whereas actuarial projections and cost estimates based on work of the highest professional quality and integrity have been an important force for fiscal prudence in the historical development of social insurance programs; and

"Whereas the growth of these programs and their commitments to future generations of beneficiaries makes it more important than ever that these programs be managed in a fiscally prudent manner;

"Therefore, be it resolved that this organization believes that it is in the best interests of the public that (1) the actuaries who are responsible for the projections and cost estimates be free to use their best professional judgment and expertise independent of pressures for political expediency, and (2) the actuaries ultimately responsible for their work be required to issue an opinion letter accompanying the appropriate annual report stating whether the actuarial assumptions used in the projections contained therein are (a) in the aggregate reasonable taking into account the experience and expectations of the plan and (b) represent their best estimates of anticipated experience under the plan."

Attached to this testimony is a proposed amendment to the Social Security Act. This amendment would require a statement of opinion by the Chief Actuary of the Social Security Administration and the Chief Actuarial Officer of the Health Care Financing Administration that the techniques and methodology used in preparing the actuarial status of the Trust Funds and the cost estimates and the assumptions used with respect to such Funds are reasonable and conform with generally acceptable actuarial principles.

In conclusion, the Academy hopes this testimony has been helpful, and we would welcome the opportunity to be of further assistance as you proceed with your important deliberations.

AMERICAN ACADEMY OF ACTUARIES

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PROPOSED AMENDMENT

Section 201(c) of the Social Security Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuary of the Social Security Administration expressing his or her opinion:

(1) that the techniques and methodology used in preparing the actuarial status of the Trust Funds are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and expectations of the program, including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(b) Section 1817(b) of such Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuarial Officer of the Health Care Financing Administration expressing his or her opinion: (1) that the techniques and methodology used in preparing the actuarial status of the Trust Fund are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and the expectations of the program,

including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(c) Section 1841(b) of such Act is amended by adding at the end thereof the following new sentence:

"Such report shall also include a statement by the Chief Actuarial Officer of the Health Care Financing Administration expressing his or her opinion: (1) that the techniques and methodology used in preparing the actuarial status of the Trust Fund are in accordance with generally accepted actuarial principles; and (2) whether the cost estimates and the assumptions on which they are based are in the aggregate reasonable for the purpose for which they are intended taking into account the experience and the expectations of the program, including a statement of the governmental sources of the assumptions used therefor, where appropriate."

(d) The amendments made by this section shall be effective on January 1, 1982.

STATEMENT 1981-19

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

July 10, 1981

Mr. Brian Zell
American Institute of
Certified Public Accountants
1211 Avenue of the Americas
New York, New York 10036

Dear Mr. Zell:

Re: File Reference No. 3155
Draft June 2, 1981

The American Academy of Actuaries Task Force on Reinsurance Auditing and Accounting appreciates this opportunity to comment on the above captioned AICPA discussion paper.

First a few technical comments:

- . Item 3c on page 2 of the draft implies that surplus strain occurs only as a result of the statutory treatment of expenses. The statutory strain for life insurance products can also result from other factors such as deficiency reserves on life policies or maximum interest rates permissible for valuation of annuity policies.
- . Item 6 discusses the usual accounting treatment for reinsurance transactions. There are some exceptions such as the following:
 - a. In the statutory accounting blank, commissions on reinsurance ceded are treated as a revenue item rather than a deduction from the corresponding expense item.
 - b. On reinsurance assumed, reimbursement of a dividend may be posted by the assuming company, not as a dividend, but as a special type of expense allowance.

Next, a few "practical" comments:

- . The draft proposes guidelines for a ceding company to judge the financial responsibility and stability of the assuming company and in those companies lacking such procedures the auditors should extend his procedure to evaluate the collectibility of amounts recorded in the financial statements as recoverable from the assuming company. A review of this type might be appropriate when the assuming company is a newly established reinsurer. For companies which have been in the reinsurance business for an extended period of time, industry knowledge is available as to their ability to meet the terms of their agreements. Therefore, such an extensive review should not be

Mr. Brian Zell
July 10, 1981

necessary. It appears that the auditors would be taking over a part of the responsibility of the state examiners in judging the capability of the assuming company to make good on its agreements.

Item 11 discusses auditing procedures for assumed reinsurance. We see a significant cost benefit problem here. For a large reinsurer dealing with hundreds of companies, the cost of performing such a review on each and every company is prohibitive. Rather, the reinsurer will perform such a review depending upon the amount of financial risks it is undertaking in entering into the agreement.

Finally, we are concerned with the enforcement of procedures of both ceded and assumed reinsurance as they relate to "alien" companies over which the AICPA has no jurisdiction. Enactment of stringent rules would put domestic reinsurers at a competitive disadvantage as respects these alien companies.

Some members of our Task Force also take exception with the provision that would allow auditors the right to visit the ceding company's independent auditors and review his working papers. This appears to violate the confidentiality of the client-auditor relationship. It would appear that if the accounts are being rendered in accordance with contract provisions, auditing procedures should be limited to confirmation thereto.

Sincerely,



Ronald E. Ferguson
Chairman
AAA Task Force on Reinsurance
Auditing and Accounting

REF:jw

STATEMENT 1981-20

FINAL REPORT OF JOINT COMMITTEE ON PENSION TERMINOLOGY

JULY 1, 1981

Introduction and Explanatory Comments

Gives some of the reasons for recommendations made;
indicates preferred term usage

Section A - Core Terms

Defines the building blocks of the Actuarial
Cost Methods

Section B - Actuarial Cost Methods

Names the methods and descriptions, including
recommended explanations to clarify meanings

Section C - Supplemental Glossary

Identifies other terms

Section D - Terms No Longer Recommended

Provides cross-references to recommended terms

Section E - Index

Lists all recommended terms alphabetically with
locations in text

INTRODUCTION AND EXPLANATORY COMMENTS

Directive and Makeup of Committee -

The Joint Committee on Pension Terminology was formed by the American Academy of Actuaries, the Canadian Institute of Actuaries, the Conference of Actuaries in Public Practice and the Society of Actuaries to develop a consensus of actuarial terminology for pension plans that would be accepted as a standard by their members. Committee members and the organizations they represent are as follows:

<u>Committee Members</u>	<u>Representing</u>
Thomas P. Bleakney	American Academy of Actuaries
Donald L. Gowing	Canadian Institute of Actuaries
Richard C. Keating	Conference of Actuaries in Public Practice
Charles R. Keene	Conference of Actuaries in Public Practice
Owen A. Reed	Canadian Institute of Actuaries
Albert C. Simmonds, III	American Academy of Actuaries
Michael J. Tierney (Chairman)	Society of Actuaries
Gerald I. Wilson	Society of Actuaries

Why Committee Established -

The search for standard pension terminology has been frustrating the actuarial profession for some time. The meshing of common usage and a standard set of terms has not yet been successful. Some terms are poorly defined, while others are misleading, producing many misunderstandings. Previous attempts to solve the standardization problem have not been widely accepted. Therefore, the Joint Committee was appointed in 1978 to develop a consistent set of terms and definitions that would be accepted and used by a majority of pension actuaries.

Procedures

This report is the result of numerous Committee preliminary drafts and comments received after (1) publication of the Committee's Core Term Exposure Draft, (2) information hearings held in five locations throughout the United States and Canada during 1980, (3) distribution of the Final Exposure Draft to the members of the sponsoring organizations in February, 1981, and (4) consultation with members of the American Society of Pension Actuaries. Many changes were made to the report as a result of this feedback.

Endorsement

The following organizations representing actuaries have formally adopted this report of the Joint Committee and have recommended that its members use the terminology as outlined in this report:

<u>Organizations</u>	<u>Board Adoption</u>
American Academy of Actuaries	June 3, 1981
American Society of Pension Actuaries	July 19, 1981
Conference of Actuaries	July 27, 1981
Society of Actuaries	April 29, 1981

General Committee Guidelines -

The Committee has adopted the following general guidelines:

- Preserve traditional terminology where feasible.
- Emphasize proper definitions of terms and methods to promote uniformity, rather than create a new vocabulary.
- Allow some flexibility in term usage to recognize current practice.
- Avoid dictating professional standards through terminology and definitions.

General Terminology Guidelines

- Base or "core terms" have been defined in order to provide building blocks for the description of methods and procedures.
- A "multiple term" approach has been adopted, allowing the use of more than one term to describe a concept or value, as long as the term is consistently applied. Note that the preferred term is listed first in each multiple term case. This approach has been adopted to allow some flexibility in recognition of current practice. Thus, many practitioners can still use the terms they prefer, but the meaning associated with these alternate terms will now be the same. It is hoped that the preferred term will become the standard term in the course of time.
- Defined terms have been capitalized throughout the report in order to identify them as having special meanings, not necessarily those in "general usage." It is recommended that the names of the actuarial cost methods be capitalized in general use, but that capitalization of the core terms and terms contained in the supplemental glossary be left to the discretion of the practitioner.
- Definitions of terms were made as general as possible, so as to enable their application to as many methods as possible.
- The definitions of actuarial cost methods were made as general as possible to allow flexibility of use. Because of this flexibility, clarifying explanations are to be employed when any Actuarial Cost Method is identified.

"Liability" and "Cost"

Previous committees addressing terminology questions have avoided the use of the words "liability" and, to some extent, "cost". Although the present Committee accepts many of the arguments advanced for avoiding those words (including their pre-emption by accountants and possible misinterpretation by laymen), the arguments in favor of traditional and intuitively descriptive terminology were persuasive.

The following features of the recommended terminology should be noted:

- "Liability" is always method-dependent; thus "the liability for vested benefits" is not considered proper usage, and should be replaced by "the actuarial present value of vested benefits".
- To emphasize method-dependency, the note following the definition of Actuarial Accrued Liability calls for reference to the name of the method as a hyphenated item when an Actuarial Accrued Liability is presented.
- "Cost" is never used as a synonym for "liability" or "actuarial present value". Thus, one meaning sometimes attached to the phrase "past service cost" is replaced by "actuarial accrued liability", while another meaning is replaced by "amortization payments".

Explanatory Comments

The following general remarks are intended to assist in the understanding of how the terms and definitions were developed:

- The standard pension terminology was developed primarily for use by actuaries. Although some clarification items were added or expanded in order to allow understanding by the general public, the general public was not considered the primary user.
- Some comments received requested descriptions of specific applications of methods. It is to be emphasized that the terminology report's purpose is to define terms, and is not meant to be a text on specific application of methods. Hopefully, future groups will consider specific applications of the terminology.
- Some comments requested specific duplication of terms in ERISA and IRC Bulletin 23P while others wished to eliminate terms no matter what their history. The Committee chose a middle path, adopting historic terms when possible and modifying or changing those terms only when reasons to change appeared more important. For example, while the term "Attained Age Normal" has much history, it was often used to define two distinct kinds of Actuarial Cost Methods. Therefore, the terms "Attained Age" and "Frozen Attained Age" were proposed to eliminate this duplication.
- The Committee did not address which terms or methods are acceptable under ERISA, as it was thought beyond the scope of the Committee's assignment. Other committees or texts can address how the lexicon should be used in context.
- Some comments asked why terms never before in common usage were adopted either as recommended or alternate terms. One of the reasons for this approach was to coordinate with the work of the Canadian terminology committee. In this manner, terms in common use in other areas could still have the blessing of either report. For example, the term "Normal Actuarial Cost" is not used in the United States, but it is to be the recommended term in Canada.

- The Committee decided not to try to go out of its way to attempt to increase the meaning of any term by adding additional words. Rather, additional words were added only if the present term was considered misleading. For example, the Committee proposed the term "Actuarial Accrued Liability" to be preferred over "Accrued Liability" in order to emphasize the actuarial nature of the term.

The following comments relate to the Core Terms of Section A:

- Term A-1 defines Actuarial Present Value in terms of life contingencies. This allows the use of the term "Present Value" with relation to other financial values, but not for values involving life contingencies.
- A definition suggested for Normal Cost (A-3) was "cost if plan was in existence since each individual's date of hire and funding followed the Actuarial Cost Method without Actuarial Gains (Losses)". The Committee prefers the recommended definition in order to allow the use of the term A-3 for all Actuarial Cost Methods.
- The terms A-4 and A-6 have several alternate expressions in addition to the preferred expressions, "Actuarial Accrued Liability" and "Unfunded Actuarial Accrued Liability." "Accrued Liability" was chosen to provide a link to current usage in practice and in the law. "Actuarial Liability" was chosen to coordinate with Canadian terminology (their preferred term) as well as current practice in the United States. "Actuarial Reserve" was chosen to provide an expression for those who do not wish to use the word "liability" as part of this term.
- The definition of Actuarial Gain (Loss) (A-8) is broad in order to allow flexibility. For example, a definition such as "the difference between actual and expected Actuarial Accrued Liability" would have to address what actually was paid toward the Unfunded Actuarial Accrued Liability the previous year. In addition, the definition leaves open whether to treat changes in employee group as Actuarial Gains (Losses) or separate Actuarial Accrued Liability increases (decreases), to allow discretion on the part of the practitioner.

The following comment relates to the Actuarial Cost Methods in general:

- The Committee is aware that Actuarial Cost Methods exist other than those defined in the report. It is anticipated that a future terminology committee might address an "exhaustive list" Actuarial Cost Method project. The Actuarial Cost Methods have been defined in a manner general enough to encompass some variations from the "primary method." However, when a method is used which has not been defined, it should be described in sufficient detail so that the method will be clearly understood. Where the method used is similar to one which has been defined, but involves significant variations which do not permit it to be labeled as the defined method, a separate term should be used as a label for that method.

The following comment relates to the Actuarial Cost Method B-1:

- The phrase "Unit Credit" has been chosen rather than "Accrued Benefit" to be used in the term "Unit Credit Actuarial Cost Method" to avoid possible confusion with the term "Accrued Benefit" which has a more narrow definition than the benefit which the Actuarial Cost Method usually addresses. This choice is consistent with the Committee objective to permit multiple terms but to avoid multiple meanings of the same term.

The following comment relates to the Actuarial Cost Method B-2:

- With regard to Method B-2, the word "normal" is omitted from the Entry Age Actuarial Cost Method name in order to help generalize the term "Normal Cost" as well as to shorten the term.

The following comments relate to Actuarial Cost Methods B-3, B-5 and B-6:

- The word "initial" was not added to the Frozen Entry Age Actuarial Cost Method and the Frozen Attained Age Actuarial Cost Method in order to avoid duplication as well as to keep the term as short as possible.
- It was thought important to clarify the use of "frozen" vs. "unfrozen" methods; therefore, separate terms were proposed and the word "frozen" added to all "frozen methods" in order to assist in the separation of these methods. In addition, the word "normal" was removed from Attained Age Actuarial Cost Method so as not to confuse it with the former frozen method.

The following comment relates to the Actuarial Cost Method B-9:

- "Annual cost allocation" is used to denote the portion of the Actuarial Present Value allocated to a particular year under the Projection Actuarial Cost Method. The "annual cost allocation" under this method has elements of a conventional Normal Cost and Amortization Payment in a mix that is essentially inseparable. Accordingly, the use of the familiar term "Normal Cost" for this purpose introduces a misleading concept for an Actuarial Cost Method.

Section A

CORE TERMS

A-1. Actuarial Present Value

The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of Actuarial Assumptions.

A-2. Actuarial Cost Method or Funding Method

A procedure for determining the Actuarial Present Value of pension plan benefits and expenses and for developing an actuarially equivalent allocation of such value to time periods, usually in the form of a Normal Cost and an Actuarial Accrued Liability.

Note: An Actuarial Cost Method is understood to be a Closed Group Actuarial Cost Method unless otherwise stated.

A-3. Normal Cost or Normal Actuarial Cost

That portion of the Actuarial Present Value of pension plan benefits and expenses which is allocated to a valuation year by the Actuarial Cost Method.

Note 1: The presentation of Normal Cost should be accompanied by reference to the Actuarial Cost Method used.

Note 2: Any payment in respect of an Unfunded Actuarial Accrued Liability is not part of Normal Cost (see Amortization Payment).

Note 3: For pension plan benefits which are provided in part by employee contributions, Normal Cost refers to the total of employee contributions and employer Normal Cost unless otherwise specifically stated.

A-4. Actuarial Accrued Liability, Actuarial Liability, Accrued Liability, or Actuarial Reserve

That portion, as determined by a particular Actuarial Cost Method, of the Actuarial Present Value of pension plan benefits and expenses which is not provided for by future Normal Costs.

Note: The presentation of an Actuarial Accrued Liability should be accompanied by reference to the Actuarial Cost Method used; for example, by hyphenation ("Actuarial Accrued Liability - XYZ", where "XYZ" denotes the Actuarial Cost Method) or by a footnote.

A-5. Actuarial Value of Assets or Valuation Assets

The value of cash, investments and other property belonging to a pension plan, as used by the actuary for the purpose of an Actuarial Valuation.

Note: The statement of Actuarial Assumptions should set forth the particular procedures used to determine this value.

A-6. Unfunded Actuarial Accrued Liability, Unfunded Actuarial Liability, Unfunded Accrued Liability, or Unfunded Actuarial Reserve

The excess of the Actuarial Accrued Liability over the Actuarial Value of Assets.

Note: This value may be negative in which case it may be expressed as a negative Unfunded Actuarial Accrued Liability, the excess of the Actuarial Value of Assets over the Actuarial Accrued Liability, or the Funding Excess.

A-7. Frozen Actuarial Accrued Liability or Frozen Actuarial Liability

That portion of the Actuarial Present Value of Projected Benefits which is separated as of a valuation date and frozen under certain Actuarial Cost Methods. Generally this separated portion is the sum of an initial Unfunded Actuarial Accrued Liability and any increments or decrements in the Actuarial Accrued Liability established subsequently as a result of changes in pension plan benefits or Actuarial Assumptions.

A-8. Unfunded Frozen Actuarial Accrued Liability or Unfunded Frozen Actuarial Liability

The portion of the Frozen Actuarial Accrued Liability remaining after the addition of interest and the deduction of Amortization Payments.

A-9. Actuarial Gain (Loss) or Experience Gain (Loss)

A measure of the difference between actual experience and that expected based upon a set of Actuarial Assumptions, during the period between two Actuarial Valuation dates, as determined in accordance with a particular Actuarial Cost Method.

Note 1: The effect on the Actuarial Accrued Liability and/or the Normal Cost resulting from changes in the Actuarial Assumptions, the Actuarial Cost Method or pension plan provisions should be described as such, not as an Actuarial Gain (Loss).

Note 2: The manner in which the Actuarial Gain (Loss) affects future Normal Cost and Actuarial Accrued Liability allocations depends upon the particular Actuarial Cost Method used.

Section B

ACTUARIAL COST METHODS

B-1. Unit Credit Actuarial Cost Method

A method under which the benefits (projected or unprojected) of each individual included in an Actuarial Valuation are allocated by a consistent formula to valuation years. The Actuarial Present Value of benefits allocated to a valuation year is called the Normal Cost. The Actuarial Present Value of benefits allocated to all periods prior to a valuation year is called the Actuarial Accrued Liability.

Note 1: The description of this method should state the procedures used, including:

- (a) how benefits are allocated to specific time periods;
- (b) the procedures used to project benefits, if applicable; and
- (c) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, the Actuarial Gains (Losses), as they occur, generally reduce (increase) the Unfunded Actuarial Accrued Liability.

B-2. Entry Age Actuarial Cost Method or Entry Age Normal Actuarial Cost Method

A method under which the Actuarial Present Value of the Projected Benefits of each individual included in an Actuarial Valuation is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit age(s). The portion of this Actuarial Present Value allocated to a valuation year is called the Normal Cost. The portion of this Actuarial Present Value not provided for at a valuation date by the Actuarial Present Value of future Normal Costs is called the Actuarial Accrued Liability.

Note 1: The description of this method should state the procedures used, including:

- (a) whether the allocation is based on earnings or service;
- (b) where aggregation is used in the calculation process;
- (c) how entry age is established;
- (d) what procedures are used when different benefit formulas apply to various periods of service; and
- (e) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, the Actuarial Gains (Losses), as they occur, reduce (increase) the Unfunded Actuarial Accrued Liability.

B-3. Attained Age Actuarial Cost Method

A method under which the excess of the Actuarial Present Value of Projected Benefits over the Actuarial Accrued Liability in respect of each individual included in an Actuarial Valuation is allocated on a level basis over the earnings or service of the individual between the valuation date and assumed exit. The portion of this Actuarial Present Value which is allocated to a valuation year is called the Normal Cost. The Actuarial Accrued Liability is determined using the Unit Credit Actuarial Cost Method.

Note 1: The description of this method should state the procedures used, including:

- (a) whether the allocation is based on earnings or service;
- (b) where aggregation is used in the calculation process; and
- (c) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, the Actuarial Gains (Losses), as they occur, reduce (increase) the Unfunded Actuarial Accrued Liability.

Note 3: The differences which regularly arise between the Normal Cost under this method and the Normal Cost under the Unit Credit Actuarial Cost Method will affect the determination of future Actuarial Gains (Losses).

B-4. Aggregate Actuarial Cost Method

A method under which the excess of the Actuarial Present Value of Projected Benefits of the group included in an Actuarial Valuation over the Actuarial Value of Assets is allocated on a level basis over the earnings or service of the group between the valuation date and assumed exit. This allocation is performed for the group as a whole, not as a sum of individual allocations. That portion of the Actuarial Present Value allocated to a valuation year is called the Normal Cost. The Actuarial Accrued Liability is equal to the Actuarial Value of Assets.

Note 1: The description of this method should state the procedures used, including:

- (a) whether the allocation is based on earnings or service;
- (b) how aggregation is used in the calculation process; and
- (c) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, the Actuarial Gains (Losses), as they occur, reduce (increase) future Normal Costs.

B-5. Frozen Entry Age Actuarial Cost Method

A method under which the excess of the Actuarial Present Value of Projected Benefits of the group included in an Actuarial Valuation, over the sum of the Actuarial Value of Assets plus the Unfunded Frozen Actuarial Accrued Liability, is allocated on a level basis over the earnings or service of the group between the valuation date and assumed exit. This allocation is performed for the group as a whole, not as a sum of individual allocations. The Frozen Actuarial Accrued Liability is determined using the Entry Age Actuarial Cost Method. The portion of this Actuarial Present Value allocated to a valuation year is called the Normal Cost.

Note 1: The description of this method should state the procedures used, including:

- (a) whether the allocation is based on earnings or service;
- (b) how aggregation is used in the calculation process; and
- (c) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, the Actuarial Gains (Losses), as they occur, reduce (increase) future Normal Costs.

B-6. Frozen Attained Age Actuarial Cost Method

A method under which the excess of the Actuarial Present Value of Projected Benefits of the group included in an Actuarial Valuation, over the sum of the Actuarial Value of Assets plus the Unfunded Frozen Actuarial Accrued Liability, is allocated on a level basis over the earnings or service of the group between the valuation date and assumed exit. This allocation is performed for the group as a whole, not as a sum of individual allocations. The Frozen Actuarial Accrued Liability is determined using the Unit Credit Actuarial Cost Method. The portion of this Actuarial Present Value allocated to a valuation year is called the Normal Cost.

Note 1: The description of this method should state the procedures used, including:

- (a) whether the allocation is based on earnings or service;
- (b) how aggregation is used in the calculation process; and
- (c) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, the Actuarial Gains (Losses), as they occur, reduce (increase) future Normal Costs.

B-7. Individual Level Actuarial Cost Method or Individual Level Premium Actuarial Cost Method

A method under which the Actuarial Present Value of each increment of an individual's Projected Benefits is allocated on a level basis over the future earnings or service of the individual between the age at which such increment is first recognized and the exit age(s). The portion of this Actuarial Present Value allocated to a valuation year is called the Normal Cost. Each individual's portion of the Actuarial Accrued Liability should be determined on a consistent basis, usually as the retrospective accumulation of the individual's prior Actuarial Accrued Liability and prior Normal Cost, using the valuation Actuarial Assumptions.

Note 1: The description of this method should state the procedures used, including:

- (a) whether the allocation is based on earnings or service; and
- (b) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, Actuarial Gains (Losses), as they occur, result in amortization credits (debits) which offset (supplement) Normal Cost. Increases (decreases) in Projected Benefits from one valuation date to the next usually produce Normal Cost increments (decrements) rather than Actuarial Losses (Gains).

B-8. Individual Spread Gain Actuarial Cost Method or Individual Aggregate Actuarial Cost Method

A method under which the Actuarial Present Value of each increment of an individual's Projected Benefits is allocated on a level basis over the future earnings or service of the individual between the age at which such increment is first recognized and the exit age(s). The portion of this Actuarial Present Value allocated to a valuation year is called the Normal Cost. The Actuarial Value of Assets is deemed to be assigned to individuals on a reasonable and consistent basis; for example, each individual's share may be the accumulation of his (her) prior Normal Costs and any prior Actuarial Gains (Losses) allocated to the individual. Actuarial Gains (Losses) are allocated to individuals in proportion to the assigned Actuarial Value of Assets, or on any other reasonable and consistent basis. The Actuarial Accrued Liability for an individual equals the assigned portion of the Actuarial Value of Assets.

Note 1: The description of this method should state the procedures used, including:

- (a) whether the allocation is based on earnings or service; and
- (b) a description of any other method used to value a portion of the pension plan's benefits.

Note 2: Under this method, the Actuarial Gains (Losses), as they occur, reduce (increase) future Normal Costs.

Note 3: This method has the effect of applying the Aggregate Actuarial Cost Method separately for each individual.

B-9. Projection Actuarial Cost Method or Forecast Actuarial Cost Method

A method under which the excess of the Actuarial Present Value of the sum of Projected Benefit payments for a specified period plus a funding objective as of the end of the period over the Actuarial Value of Assets is allocated on a level basis over the earnings or service of the group during the specified period, including earnings or service for any future entrants assumed. The allocation is performed for the group as a whole, not as a sum of individual allocations. The portion of this Actuarial Present Value allocated to a valuation year is called the "annual cost allocation".

Note 1: The description of this method should:

- (a) explain the funding objective, and describe any anticipated benefit increases which have been taken into account;
- (b) specify the period involved, and any scheduled changes to that period for future valuations;
- (c) state the procedure used to allocate the excess and whether the allocation is based on earnings or service; and
- (d) state the Actuarial Cost Method to be used to determine future allocations when the end of the specified period is reached.

Note 2: The funding objective will usually be expressed as the Actuarial Accrued Liability as projected to exist under another Actuarial Cost Method at the end of the specified period.

Note 3: Under this method, Actuarial Gains (Losses), as they occur, reduce (increase) the annual cost allocation.

Note 4: Only a Projection Actuarial Cost Method with an Open Group assumption should be so labeled; if an Open Group assumption is used with any other Actuarial Cost Method, the method should be named and the Open Group assumption described.

Section C

SUPPLEMENTAL GLOSSARY

C-1. Accrued Benefit or Accumulated Plan Benefit

The amount of an individual's benefit (whether or not vested) as of a specified date, determined in accordance with the terms of a pension plan and based on compensation (if applicable) and service to that date.

C-2. Actuarial Assumptions

Assumptions as to the occurrence of future events affecting pension costs, such as: mortality, withdrawal, disablement and retirement; changes in compensation and national pension benefits; rates of investment earnings and asset appreciation or depreciation; procedures used to determine the Actuarial Value of Assets; characteristics of future entrants for Open Group Actuarial Cost Methods; and other relevant items.

C-3. Actuarial Valuation

The determination, as of a valuation date, of the Normal Cost, Actuarial Accrued Liability, Actuarial Value of Assets, and related Actuarial Present Values for a pension plan.

C-4. Actuarially Equivalent

Of equal Actuarial Present Value, determined as of a given date with each value based on the same set of Actuarial Assumptions.

C-5. Amortization Payment

That portion of the pension plan contribution which is designed to pay interest on and to amortize the Unfunded Actuarial Accrued Liability or the Unfunded Frozen Actuarial Accrued Liability.

C-6. One-Year Term Cost

The Actuarial Present Value, as of a valuation date, of all benefits expected to become payable in the future as a result of an event or events expected to occur during a valuation year.

C-7. Open Group/Closed Group

Terms used to distinguish between two classes of Actuarial Cost Methods. Under an Open Group Actuarial Cost Method, Actuarial Present Values associated with expected future entrants are considered; under a Closed Group Actuarial Cost Method, Actuarial Present Values associated with future entrants are not considered.

C-8. Pay-as-You-Go

A method of financing a pension plan under which the contributions to the plan are generally made at about the same time and in about the same amount as benefit payments and expenses becoming due.

C-9. Projected Benefits

Those pension plan benefit amounts which are expected to be paid at various future times under a particular set of Actuarial Assumptions, taking into account such items as the effect of advancement in age and past and anticipated future compensation and service credits. That portion of an individual's Projected Benefit allocated to service to date, determined in accordance with the terms of a pension plan and based on future compensation as projected to retirement, is called the Credited Projected Benefit.

C-10. Terminal Funding

A method of funding a pension plan under which the entire Actuarial Present Value of benefits for each individual is contributed to the plan's fund at the time of withdrawal, retirement or benefit commencement.

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Section D

TERMS NO LONGER RECOMMENDED

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STATEMENT OF WALTER L. GRACE

PRESIDENT OF THE AMERICAN ACADEMY OF ACTUARIES

FINANCIAL ACCOUNTING STANDARDS BOARD
PUBLIC HEARING JULY 14, 1981
NEW YORK, NEW YORK

The American Academy of Actuaries is pleased to be able to make comments and attend this hearing on the subject of Accounting for Pension Costs. In recent years, there has been an increasing interface between the two professions, accounting and actuarial, as they have had to confront issues of common interest. This interface has been broad-based throughout the actuarial profession covering life insurance, health insurance, casualty insurance and pensions. The Academy and its members have been enthusiastic of and supportive of this interface, as we are absolutely convinced that cooperation between the two professions is essential for the well-being of the publics we serve.

Academy members are vitally interested in the outcome of the issues in this discussion memorandum. Over 40% of our roughly 6500 members specialize in the area of pensions.

The subject of pensions is so complex, even for professionals like accountants and actuaries and almost impossibly complex for the layman. I believe most actuaries view the current accounting procedures in this complex area as having produced reasonably stable results over the years. We urge, as changes to the current accounting system are considered, that accounting professionals probe very carefully with actuarial professionals as to the consequences of any change. Not only the technical consequences of any change should be clearly understood, but also more general questions might be asked like the following:

1. Will the change tend to inhibit the growth of private pension plans?
2. Will the change tend to have any adverse effect on the employer's freedom in selecting funding policy?
3. Is the change justified from a cost benefit standpoint?
4. Have the consequences of the change been fully evaluated over the whole wide range of possible pension arrangements?

Adding to the confusion in this complex area has been the fact that different pension terminology has been used by different people. The actuarial profession has been concerned about this confusion and has been working on developing a new consistent set of terminology. We now have it. Yesterday, the new terminology was brought to this Board. The terminology has been endorsed by the Board of Directors of the Academy. The actuarial profession commends consideration of this terminology to the accounting profession.

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AMERICAN ACADEMY OF ACTUARIES

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July 23, 1981

Dr. Judith R. Lave, Ph.D.
Director-Office of Research
Health Care Financing Administration
Room 423B, North Building
300 Independence Avenue, SW
Washington, DC 20201

RE: ORDS, HCFA MEDIGAP RESERACH PLAN

Dear Dr. Lave:

We have followed with great interest the RFP concerning a study of the effectiveness of state regulation of Medigap insurance policies. Obtaining factual information about distribution and characteristics of insurance coverage such as required for this study is never easy. We commend you for what appears to be an effort to obtain objective information.

We are concerned, however, that the actuarial analysis required in this research effort has been underestimated.

As you know, the focus of actuarial science is on the evaluation of risk. Actuaries are uniquely trained in the area of measuring the present and future impact of various contingent events. The proposed study centers on the ways in which insurance carriers cover the health care risk of Medicare eligibles. This will involve such concepts as loss ratios, economic value, analysis of reserve and loss data, etc. Analysis of these items requires the quantification of contingent events which may take place over the term of the insurance contract.

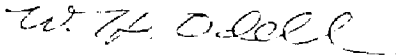
We fear that without expert actuarial analysis the data gathered in this research may be misinterpreted as has occurred in other studies of this subject. If the actuarial areas are improperly addressed then subsequent application of the study may produce unintended adverse consequences to the consumer or to the insurance industry or both. Especially at this time when the Administration is seeking new directions and is exploring private industry alternatives to large federal health programs it seems extremely desirable to all concerned that such consequences be avoided. Hence, we believe it is of utmost importance that the study be technically beyond reproach.

Dr. Judith Lave, Ph.D.
Health Care Financing Admin.
July 23, 1981

In view of this we submit that competent actuarial expertise should be sought in connection with the study so that it will have meaningful results which will lead to meaningful conclusions, and hence be useful in attaining broader objectives. Obviously even preparing the outline of study has involved a great deal of work and the study itself will be a tremendous undertaking. We are sure that with such a commitment of resources you want to rely on any conclusions as being representative of a complete analysis. This is the basis for our suggestion that the study be conducted with the advantage of professionals uniquely qualified in this area.

Dr. Lave, we will be glad to answer any questions you may have and to meet with you to talk about this some more.

Sincerely,



Committee on Health Insurance

W. H. Odell, Chairman
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cc: Dr. James M. Kaple, Ph.D., Acting Director, Office of Research

STATEMENT 1981-23

AMERICAN ACADEMY OF ACTUARIES

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July 29, 1981

The Honorable James Florio
Chairman
Subcommittee on Commerce, Transportation and Tourism
U. S. House of Representatives
Washington, D. C. 20515

Dear Congressman Florio:

This letter responds to your request for more information about the Academy of Actuaries' report on the economic impact of H.R. 100. It describes in detail the methodology and data used. The results reported represent our best estimates, based on available information and data. This approach involved analysis of comprehensive broad data, rather than the development of any statistical model. Hence, some of the questions you posed are not directly applicable. We believe that what we present here answers fully the applicable questions. Because of differences between the various types of insurance, we used different methods for assessing the impact of H.R. 100. Therefore, we have organized our response by type of insurance coverage.

I. Life Insurance

A. Percentage Changes in Price to Individual Insurance Buyers

The numbers shown in our report were as follows:

	<u>Male</u> <u>Age 20</u>	<u>Male</u> <u>Age 40</u>	<u>Male</u> <u>Age 65</u>	<u>Female</u> <u>Age 20</u>	<u>Female</u> <u>Age 40</u>	<u>Female</u> <u>Age 65</u>
Life Insurance	- 2%	- 3%	N/A	+ 6%	+ 11%	N/A

The numbers were derived from two sources — the 1980 Consumers' Shopping Guide for Life Insurance, published by the State of New York; and the 1980 Life Insurance Fact Book, published by the American Council of Life Insurance.

They represent the probable effect of mandated unisex premiums, using average premiums from the Shopping Guide, weighted by type of insurance and by sex distributions taken from the Fact Book. The calculation of the numbers for age 40 illustrates our methodology.

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From the Consumers' Shopping Guide:

	AVERAGE GROSS PREMIUMS PER \$1000 OVER 20 POLICY YEARS							
	Males				Females			
	Non-Par Term	Par Term	Non-Par Whole Life	Par Whole Life	Non-Par Term	Par Term	Non-Par Whole Life	Par Whole Life
Issue Age 35	\$ 7.47	\$ 8.44	\$16.08	\$20.27	\$ 6.31	\$ 7.21	\$14.40	\$18.79
Issue Age 45	15.98	17.79	24.61	29.90	12.89	14.60	21.46	27.10

From the Life Insurance Fact Book

1. Mutual companies, which issue par insurance, account for about 50% of life insurance in force (p. 90).
2. Ordinary insurance purchases were approximately equally divided between permanent and term forms, with a significant percentage of the coverage consisting of combinations of permanent and term (p. 14).
3. During 1978, 79% of the total individual coverage was purchased by males and 21% by females.

Calculations

Average Male

$$\text{Premium at Age 35} = .25 \times (7.47 + 8.44 + 16.08 + 20.27) = 13.065$$

Average Male

$$\text{Premium at Age 45} = .25 \times (15.98 + 17.79 + 24.61 + 29.90) = 22.070$$

Average Male

$$\text{Premium at Age 40} = .5 \times (13.065 + 22.070) = 17.568$$

Average Female

$$\text{Premium at Age 35} = .25 \times (6.31 + 7.21 + 14.40 + 18.79) = 11.678$$

Average Female

$$\text{Premium at Age 45} = .25 \times (12.89 + 14.60 + 21.46 + 27.10) = 19.013$$

Average Female

$$\text{Premium at Age 40} = .5 \times (11.678 + 19.013) = 15.346$$

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Hypothetical Unisex

Premium at Age 40 = $.79 \times 17.568 + .21 \times 15.346 = 17.101$

% Change for Males (17.568 \rightarrow 17.101) = -3%

% Change for Females (15.346 \rightarrow 17.101) = +11%

B. Aggregate Annual Cost Impact on Men and Women

The numbers shown in our report were as follows:

	<u>Aggregate Annual Cost Impact</u>	
	<u>On Men</u>	<u>On Women</u>
Life Insurance	\$- 360 million	+\$360 million

These numbers were also derived primarily from the same sources on the effects on individual insurance costs — namely, the New York Consumers Shopping Guide for Life Insurance and the Life Insurance Fact Book. The previous calculations dealt with new purchases; these calculations must relate to total insurance in force, since H.R. 100 would affect all insurance — both new and in force. (For insurance now in force, the average original issue age is approximately age 33.)

From the Consumers' Shopping Guide:

	<u>Average Premiums</u> (Calculated as in A above)	
	<u>Male</u>	<u>Female</u>
Age 25	\$ 8.79	\$ 8.16
Age 35	13.07	11.68
Age 33 (by interpolation)	12.21	10.98
% Average Female Discount (12.21 \rightarrow 10.98) = 10%		

From the Life Insurance Fact Book

Total Insurance In Force as of 12/31/79 — \$1,586 billion (p. 7)

Total 1979 Annual Premiums for Ordinary
Insurance (excluding Single Premiums) — \$26.1 billion (p. 59)

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From previous Fact Books and lapse studies, we have inferred that approximately 91% of the insurance in force (weighted by premium) uses sex-distinct premiums, and approximately 18% of the individual insurance in force is on women.

Calculations

Let Y = Average Male Premium per \$1000

Z = Average Female Premium per \$1000

Then

$$.82 Y + .18 Z = 26.1 \div 1,586 \times 1000 = 16.456$$

And, since the average female discount is 10%, $Z = .9 Y$

Solving these equations, we find

$$Y = 16.758$$

$$Z = 15.080$$

Therefore, under H.R. 100, the average premium per \$1000 of insurance for men would decrease by \$.302 (\$16.758 — \$16.456) and for women would increase by \$1.376 (\$16.456 — \$15.080)

Aggregate decrease for males

$$= \$1,586 \text{ billion} \times .91 \times .82 \times .302 \div 1000 = \$357 \text{ million}$$

Aggregate increase for females

$$= \$1,586 \text{ million} \times .91 \times .18 \times 1.376 \div 1000 = \$357 \text{ million}$$

Because these numbers excluded industrial insurance, we rounded them up slightly to the \$360 million figure shown in our report.

C. Administrative Implementation Costs

1. For New Insurance Policies

H.R. 100 would require the development of new insurance policies using unisex premiums.

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To illustrate the time and expense required for such a change, let us consider the steps now under way to change just one segment (non-tax qualified individual insurance products) of one company (Massachusetts Mutual Life Insurance Company). The primary element of this change is to develop products which charge different prices for smokers and nonsmokers. Much of the work involved is, therefore, similar to that required to develop products which would end the practice of charging separate rates for men and women. Product design and pricing work began on August 1, 1980 and ended with the production of rates and values (including testing for compliance with state laws), in December 1980. Drafting, printing, and legal review of the policies themselves required $4\frac{1}{2}$ months (8/15 — 12/17). Six months (1/29/81 — 7/31/81) is the estimated time for obtaining legally required state insurance department approvals. Producing computer files and revising computer systems for producing sales illustrations, issuing policies and maintaining policies (including legally required financial information) will require ten months (10/1/80 — 7/31/81). Formal announcement and availability of the new products is scheduled for August 5, 1981. In total, the project required one year of elapsed time and incurred roughly \$620,000 in development costs.

Extrapolating from this experience, we estimate that the total cost of developing a complete line of unisex products would cost Massachusetts Mutual at least \$1,250,000. As of the end of 1979, there were approximately 1900 legal reserve life insurance companies in business in the United States. Other insurers who would have to revise their products would include fraternal associations, banks and government agencies. It is unreasonable to assume that all 2,000 or so insurers would have to spend as much as \$1,250,000 to develop unisex life insurance products. A conservative estimate of the total cost for all insurers can be developed by assuming that, because Massachusetts Mutual accounted for approximately 1.75% of all life insurance sold during 1979, \$1,250,000 would represent about 1.75% of the cost for all insurers. This gives us a total cost of approximately \$71 million for the development of new products to comply with H.R. 100. This estimate is probably an understatement, as it amounts to less than \$38,000 per insurer, but it does provide some insight into the general level of such costs.

2. For Insurance Currently In Force

The retroactive aspect of H.R. 100 would create substantial administrative costs. Most premium paying life insurance coverages would have to be revised. In the case of individual

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insurance, each insurer would have to notify its customers of the impact of the law on each policy. The notification would include revised schedules of premium and/or benefits (if applicable). Recently, the Pan American Life Insurance Company changed the reserve basis on a large number of policies, resulting in cost savings to all affected customers. No policyholder approval or special action was required to accomplish the change. This change involved approximately 200,000 policies at an administrative cost of approximately \$5 or \$6 per policy.³ The cost of retroactively changing in force policies to comply with H.R. 100 would probably be more, because of the need to deal with policyholders whose costs have been increased by the change. At the end of 1979, there were approximately 145.6⁴ million ordinary life policies in force, of which approximately 81% (weighted by number of policies) were priced using sex based mortality tables. If insurers must spend an average of \$6 per policy to comply with H.R. 100, the administrative cost for retroactivity to these individual policies would be \$708 million.

At the end of 1979, there were 559,000⁵ insured group life insurance policies in force in the United States covering approximately 115⁵ million people. Because the administrators of these plans are generally familiar with insurance concepts and accustomed to frequent rate changes, the cost of restructuring group rates to a unisex basis would be less difficult and costly. If we assume that the job can be done for \$100 per master contract (or 43 cents per insured) the cost will be approximately \$56 million, bringing the total administrative cost for retroactivity, as applied to legal reserve life insurers to almost \$764 million. When the costs for government insurance plans and miscellaneous expenses are considered, it is reasonable to conclude that the direct administrative costs of the retroactive feature of H.R. 100 will be approximately \$800 million.

3. Total Administrative Costs

For New Insurance Policies	\$ 71 million
For Insurance In Force	800 million
TOTAL	<u>\$871 million</u>

(Rounded to \$870 million
in our report.)

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II. Health Insurance

A. Percentage Changes in Price to Individual Insurance Buyers

The numbers shown in our report were as follows:

	<u>Male</u> <u>Age 20</u>	<u>Male</u> <u>Age 40</u>	<u>Male</u> <u>Age 65</u>	<u>Female</u> <u>Age 20</u>	<u>Female</u> <u>Age 40</u>	<u>Female</u> <u>Age 65</u>
Health Insurance						
- Medical Expense						
Unisex Rating	+18%	+13%	0	-12%	-7%	0
Full Maternity	+38%	+ 1%	0	+26%	+1%	0
Total	<u>+56%</u>	<u>+14%</u>	<u>0</u>	<u>+14%</u>	<u>-6%</u>	<u>0</u>
- Disability						
Unisex Rating	+ 4%	+ 2%	0	-26%	-21%	0
Full Maternity	+20%	--	0	+20%	--	0
Total	<u>+24%</u>	<u>+ 2%</u>	<u>0</u>	<u>- 6%</u>	<u>-21%</u>	<u>0</u>

These numbers were derived primarily from Society of Actuaries studies, supplemented by other sources, as shown in Exhibits 1, 2, and A-F. In addition, the percentages have been reduced to reflect the fact that some individual health insurance coverage is currently on a unisex basis. (Of approximately \$3.3 billion of annual premium for medical expense policies issued to people under age 65, \$2.5 billion are estimated to be on a sex-distinct basis; for disability coverage, about \$2.07 billion out of \$2.3 billion is on a sex distinct basis.)

For example, the 56% increase in medical expense premiums for a male age 20 was derived as follows from Exhibit 1:

1. Unisex Rating

(a) Estimated sex-distinct premiums for Males Age 20-29	\$121.5 million
(b) Re-distribution of those premiums on unisex basis for Males Age 20-29	\$149.9 million
(c) Amount of premiums already on unisex basis (.085 ÷ 1.749 X \$800 million)	\$ 38.9 million
(d) Estimated total current premiums for Males Age 20-29 = (a) + (c)	\$160.4 million
(e) Estimated total premiums for Males Age 20-29 on unisex basis = (b) + (c)	\$188.8 million
(f) Effect of unisex mandate (160.4 → 188.8)	17.7%

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2. Full Maternity

(a) Added premiums to Males Age 20-29 for maternity coverage on unisex basis	\$ 61.8 million
(b) Estimated total current premiums for Males Age 20-29 (Item 1(d) above)	\$160.4 million
(c) Effect of unisex mandate (61.8 ÷ 160.4)	38.5%

3. Total Effect on Males 20-29 = 17.7% + 38.5% 56.3%

Our report showed a rounded figure of +56% in total. To make the component parts add, 17.7% was rounded to 18%; 38.5% was rounded to 38%.

B. Aggregate Annual Cost Impact on Men and Women

The numbers shown in our report were as follows:

	<u>Aggregate Annual Cost Impact</u>	
	<u>on Men</u>	<u>on Women</u>
- Medical Expense		
Unisex Rating	\$ +69 million	\$ -69 million
Full Maternity	+82 million	+85 million
Total	<u>\$+151 million</u>	<u>\$ +16 million</u>
- Disability		
Unisex Rating	\$ +37 million	\$ -37 million
Full Maternity	+57 million	+ 7 million
Total	<u>\$ +94 million</u>	<u>\$ -30 million</u>

These numbers were derived primarily from Society of Actuaries' studies supplemented by other sources, as shown in Exhibits 1, 2, and A-F. The basic methodology in Exhibit 1 was to spread the estimated premiums for males and females in a specific age group over that age group on a unisex basis, in proportion to their relative exposures. For example, the \$69 million increase in cost to men for medical expense insurance is derived from Exhibit 1 as follows:

Estimated current sex-distinct premiums
paid by males in total = \$713.2 million

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Estimated premiums for these policies on a unisex basis	=	\$782.5 million
Effect of mandated unisex rating = \$782.5 - \$713.2	=	\$ 69.3 million
		(Rounded to \$69 million in our report)

C. Administrative Implementation Costs

1. For New Insurance Policies

For future sales, new rates would have to be calculated, new rate book pages would have to be printed and distributed, policy issue computer systems adjusted, etc. Also, policy forms, outlines of coverage, advertising and brochures would have to be changed to incorporate full maternity benefits. The cost here is magnified by the variations in coverage required by state laws and regulations. For some forms, this cost will exceed \$200,000. The cost of implementing such changes was estimated from cost studies conducted by Mutual of Omaha. Based on the number of forms currently marketed by Mutual of Omaha affected by H.R. 100 and the costs involved, their implementation cost for future sales would be at least \$2,000,000. Extrapolating this cost to an industry-wide basis, the cost for all companies combined is estimated to be at least \$120,000,000³.

These costs for future sales would be ameliorated if companies were given several years to implement these changes. This is because new products/premiums are usually adopted every 3-5 years in any event and thus, implementation delays would bring about substitution of normal costs for additional cost.

The cost of implementing unisex and full maternity prices under private group insurance would be considerably less significant, since group premiums are usually recalculated each year in any event, and most group policies already provide full maternity benefits.

2. For Insurance Currently In Force

Implementation of H.R. 100 for health insurance policies in force is complicated by the large number of different policy forms currently in force. This situation has arisen for many reasons. First, insurers have historically issued

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individual policies which are renewable (i.e., continuable indefinitely or to age 65 with timely payment of premiums). Thus, policies issued decades ago are still in force. Second, changes in medical care practices and costs have led to changes in the coverage marketed every 3 to 5 years. Third, variations in benefit requirements by state have multiplied the number of different forms used nationally. This means that each insurer will have to calculate and implement unisex-full maternity premiums on a large number of different policy forms that have been sold over the last 50 years.

In order to gain insight as to the magnitude and cost of this work, the number of individual policy and benefit endorsement forms currently in force for Mutual of Omaha, the largest writer of individual health insurance policies, was tabulated. This tabulation showed that this company would have to calculate, file and implement new unisex premium schedules on over 400 different policy forms and on approximately 1,200 additional benefit endorsement forms. In addition, expanded maternity costs would have to be assessed against as many as 1,000 policy and 1,500 endorsement forms. Since the majority of these forms were sold throughout the country, state approval filings would be 40-50 times as large. This process would be further complicated if some of the state insurance departments insist that unisex premiums or maternity premiums be calculated on a different basis or method than that which is acceptable in other states.

Based on rough cost estimates that indicate that the average cost of calculating, filing and implementing revised premium structures is at least \$600.00 per form plus \$.30 per policy, the cost for Mutual of Omaha for in-force policies would be approximately \$2,000,000. This \$2,000,000 relates to 1,700,000 Mutual of Omaha policies needing rate/benefit adjustment. These figures indicate an implementation cost of \$1.18 per policy. This \$1.18 estimate is low for the industry as a whole since it is based on the cost of the largest insurer which already has a computerized system for installing premium schedule changes. It is reasonable to assume that many companies would have to adjust premiums on each policy on a manual basis either because they don't have a computerized system available or their computerized policy information is inadequate to allow computerization of revised premium calculations. In these instances, the implementation process would be more costly and physically impossible unless companies were given several years for implementation. For example, in those cases where Mutual

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of Omaha must utilize a manual basis, the cost would exceed \$3.00 per policy. Since many insurers will have to implement the revised premiums on the manual basis, the industry-wide implementation cost is estimated at \$2.00 per policy.

Based on an estimated 40,000,000 industry-wide policies that would be affected, the industry-wide implementation cost would be \$80,000,000.¹⁰

3. Total Administrative Costs

For New Insurance Policies	\$120 million
For Insurance In Force	<u>80 million</u>
TOTAL	\$200 million

III. Casualty and Property Insurance

H.R. 100 would have little or no economic effect on property/casualty insurance, except for private passenger automobile insurance. Therefore, our analysis is confined to that line of coverage.

A. Percentage Changes in Price to Individual Insurance Buyers

The numbers shown in our report were as follows:

	Male <u>Age 20</u>	Male <u>Age 40</u>	Male <u>Age 65</u>	Female <u>Age 20</u>	Female <u>Age 40</u>	Female <u>Age 65</u>
Automobile Insurance ¹¹	-20%	0 ¹²	0	+37%	0 ¹²	0

These numbers were derived from two separate estimates of the effect of eliminating sex-distinct rates from the pricing structure of two major automobile insurers (Allstate and State Farm), which write over 25% of the private passenger automobile insurance market. A sample calculation for one of the companies is shown in the following table:

<u>COMPANY 1</u>				
	<u>1979 Exposure</u>	<u>Rating Relativity</u>	<u>"Unisex" Relativity</u>	<u>% Change</u>
Unmarried Male, Principal Operator, under 21	436,900	340	279	- 18%
Unmarried Female, Principal Operator, under 21	349,200	203	279	+ 37%

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Calculations

$$\begin{aligned} \text{"Unisex" relativity} &= (436,900 \times 340 + 349,200 \times 203) \div (436,900 + 349,200) \\ &= (148,546,000 + 70,887,600) \div 786,100 \\ &= 279 \text{ (rounded to nearest whole number)} \end{aligned}$$

$$\% \text{ Change for Male } (340 \rightarrow 279) = -18\%$$

$$\% \text{ Change for Female } (203 \rightarrow 279) = +37\%$$

Similar calculations for the second company yielded the following results:

COMPANY 2

	<u>% Change</u>
Unmarried Male, Principal Operator, under 21	- 22%
Unmarried Female, Principal Operator, under 21	+ 38%

The numbers appearing in our report reflect the average result.

B. Aggregate Annual Cost Impact on Men and Women

The numbers shown in our report were as follows:

<u>Aggregate Annual Cost Impact</u>	
<u>on Men</u>	<u>on Women</u>
\$ - 700 million	\$ +700 million

These numbers were derived from the same two major automobile insurers, by applying percentage changes, derived as above, to each of the classes with sex-distinct rates.

These calculations yielded the following results:

	<u>Aggregate Cost Shift from Men to Women</u>	<u>Approximate Share of Market</u>	<u>Extrapolation to Total Market, Before Adjustment</u>
Company 1	\$104.1 million	17%	\$612 million
Company 2	\$ 58.5 million	10%	\$585 million

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These figures do not include states where an atypical class plan is used, nor do they include assigned risks. To adjust for the omissions an additional 18% was added, yielding in both instances an estimate of just over \$700 million annually, which we show as a conservative approximation in our report. This represents a shift of approximately 2.2% of the total \$31.9 billion of estimated private passenger automobile insurance premiums (sources: Best's Insurance Management Reports; Property/Casualty, January 1981).

C. Administrative Implementation Costs

Enactment of H.R. 100 would require insurers to alter their private passenger auto classification plans and rates for each of the coverages involved (Bodily Injury Liability, Property Damage Liability, Personal Injury Protection, Comprehensive, Collision and several Minor coverages) to eliminate separate classes for male and female drivers. We assume that the experience of the separate classes would be combined and a new unisex rate determined for each of the coverages. These rates would then be incorporated into each insurer's marketing and distributive systems so that

- (i) revised rating manuals can be published and distributed to the agency force,
- (ii) proper premiums for each individual policy can be computed upon policy issuance,
- (iii) subsequent rate level reviews will reflect the revised rate structure.

It is difficult to accurately assess the cost of the above measures, although it is not expected to be significant, particularly if there is sufficient lead time to implement the changes. An informal consensus of several major auto writers puts this estimate at approximately \$1.00 per policy. This translates into an industry-wide cost of about \$75,000,000. The costs by company would, of course, vary considerably.

IV. Pensions and Annuities

A. Percentage Change in Price to Individual Insurance Buyers

Our report indicated that individual annuity prices would increase by 6% for males and decrease by 6% for females. There are a large number of different types of annuities, with varying differences in premium rates by sex. We chose to analyze the effect on a representative individual annuity form — i.e., annuity payments beginning at age 65, with return of premium with interest if death occurs before age 65, and a guarantee of at least 120 monthly payments after age 65, regardless of time of death.

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We had several sources of information:

	Difference Between Male and Female Rates
	<hr/>
1. Survey of 12 companies' Single Premium Immediate Annuity Rates	6.9%
2. TIAA/CREF "Guaranteed" Purchase Rates	12.9%

The spread between these sources is due primarily to the rate of interest assumed; the higher the rate of interest used, in general, the less the effect of different mortality assumptions by sex. Depending on the particular type of annuity and the specifics of its contractual terms, different rates of interest are appropriate. The male-female differences shown above bracket the usual range.

We further assumed that new purchases of individual annuities are now split fairly evenly between males and females. This was the indication from the records of two major insurance companies — Massachusetts Mutual and Etna Life & Casualty. Accordingly, the approximate effect of mandated unisex rates would be about 1/2 of the current differences between male and female purchase rates — i.e., male rates would increase by 3½–6½%; female rates would decrease by a similar amount. Since the effect on annuities without refund features is somewhat greater, we chose to show a number at the upper end of the range — 6%.

B. Increase in Pension Benefits and Costs

Our report indicated an additional annual cost to pension plans in the aggregate of \$5.5 billion.

The basis of that figure is a 1976 report prepared by a task force of actuaries for the U. S. Department of Labor, in connection with a proposal by the Federal Equal Employment Opportunity Coordinating Council to require that equal pension benefits be paid to similarly situated males and females in all instances. The method of equalization assumed, as in H.R. 100, was that no benefits would be reduced; that is, where there were differences between males and females, the higher benefit would prevail for all. That report showed an illustrative average cost increase of 5.9% for defined benefit plans and 7% for defined contributions (the latter being an estimate for the TIAA plan).

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To translate that percentage into a dollar amount, we assumed that roughly 3/4 of pension plan assets are defined benefit and 1/4 defined contribution.¹³ Therefore, the weighted percentage effect on pension costs was derived as

$$.75 \times .059 + .25 \times .07 = .06175$$

Deposits to pension plans in 1980 were estimated at \$90 billion — excluding OASDI and the Civil Service Retirement System, neither of which would be significantly affected by H.R. 100.¹⁴ Therefore, the total cost impact was estimated as

$$\$90 \text{ billion} \times .06175 = \$5.5575 \text{ billion}$$

Our report showed \$5.5 billion, rounded down slightly.

C. Administrative Implementation Costs

The administrative costs to implement H.R. 100 vary significantly by type of plan, extent of amendments required, and the amendment process (e.g. collective bargaining, legislation, board of trustees' action, etc.). We estimate an average cost of roughly \$1000 per plan. Approximately 200,000 plans¹⁵ would be significantly affected by H.R. 100, yielding a total estimated implementation cost of \$200 million.

V. Congressman Scheuer's Questions

Your letter relayed three questions from Congressman Scheuer, which we answer below, as succinctly as we can:

1. "How do actuaries justify making rates on the basis of group data when they know there are some members of the group who will not fit the averages of the group?"

Insurance deals with uncertainty — with risk. That is its essence. In order to set insurance prices, actuaries must rely on mathematical expectations. These expectations are based upon statistical methods using the experience of large groups. The group average can be used as a valid predictor for individual members of the group; generally, the larger the group or volume of experience data used, the more reliable is the prediction. Although actual individual results will be distributed in some fashion around the average result for the group, where the actual results for an individual will fall cannot be known in advance.

In short, rates are made on the basis of group data because group data is essential for statistically reliable predictions.

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2. "Based on your report, is it fair to say women as a group would gain financially under H.R. 100?"

It's hard to answer that question with absolute assurance, because of the uncertainty regarding the effect on pensions. Aside from pensions, it appears from our analysis that women as a group would lose financially under H.R. 100.

H.R. 100 appears to mandate only increases in pension benefits — no decreases. Both men and women would receive greater benefits, but, of course, these increased benefits involve increased costs. Whether men or women would gain more pension benefits is hard to say. In general, men gain more under defined benefit plans; women gain more under defined contribution plans. We observe that there is more defined benefit type pension coverage than defined contribution coverage in this country at present. We have not been able to quantify the relative increases in benefits by sex, however.


In summary, our investigations do not support the statement that women as a group would gain under H.R. 100; on the contrary, they suggest that women as a group would lose financially on balance.

3. "Your report concludes that H.R. 100 will result in additional pension benefits to the tune of \$5.5 billion annually. Can you explain how you arrive at this figure?"

Our report indicates an aggregate additional annual cost for pension benefits of \$5.5 billion. This is different from an increase in benefits of \$5.5 billion. Section IV of this letter explains our derivation of the estimated \$5.5 billion annual cost.

We trust that this letter contains the additional information that you require for your further consideration of H.R. 100 in general and our report in particular. Please let us know if we can be of further assistance to you.

Very truly yours,


Jay C. Ripps, FSA, MAAA, EA
Chairman
Committee on Risk Classification

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FOOTNOTES

¹ Fact Book, page 89

² Massachusetts Mutual Production Reports and Fact Book, page 7

³ Society of Actuaries Record, Volume 6, Number 4, page 1002

⁴ Fact Book, page 20

⁵ Fact Book, page 29

⁶ Fact Book, page 29

⁷ Health Insurance Institute, Source Book of Health Insurance Data. Premium income in 1980 was approximately \$4.3 billion for medical expense policies and \$2.3 billion for disability income policies. (p. 30) Approximately \$1.0 billion of the medical expense premium is for persons over 65. (The \$1.0 billion estimate is based on the fact that approximately 7 million persons over 65 have purchased medical insurance from private companies (p. 13). The average annual premium for these policies is about \$150; in total, the premiums for those over 65 is estimated at just over \$1 billion.)

Of the coverage on those under 65, we estimate that 75% of the medical expense and 90% of the disability insurance is on a sex-distinct premium basis.

The estimate of 75% of the medical business being on a sex differentiated price basis was based on judgment and the information shown in Exhibits B2 and G. Exhibit B2 shows an industry-wide sample of hospital daily room and board policies and their rates. Almost half (45.83%) of these policies are on a unisex basis. Exhibit G shows an industry-wide sample of more comprehensive policies and their rates. Only 1 of the 19 companies shown here utilizes unisex rating. Much greater weighting was placed on this latter type of business in estimating the overall portions of the total business on a unisex basis. The reason for this is that relatively comprehensive benefit policies involve much greater premiums than limited coverage and probably the majority of the premiums currently in force.

The estimate that 90% of the disability business is on a sex differentiated price basis was based on the fact that almost all disability coverage is priced on that basis but there is some franchise business written on a unisex basis.

⁸ The studies by Mutual of Omaha indicate that average costs may easily exceed \$50,000 per form. Since there are approximately 1,200 companies writing individual health insurance and assuming each company is currently selling at least two different forms, an industry-wide cost of \$120,000,000 is derived (1,200 X \$50,000 X 2 = \$120,000,000).

Footnotes (continued)

⁹It was assumed that the 2,500 forms (1,000 policy forms plus 1,500 rider forms) affected by expanded maternity benefits would include the 1,600 forms affected by unisex rating. Since these forms involve at least 1,700,000 separate policies, the implementation cost would be approximately:

$$2,500 \times \$600 \text{ plus } 1,700,000 \times \$.30 = \$2,010,000$$

¹⁰For the 36,000,000 citizens covered by individual medical insurance, it is estimated that there would be 18,000,000 policies covering persons affected by unisex or maternity rating. This is a rough estimate which takes into account the fact that out of the 36,000,000 citizens, approximately 7,000,000 are persons over age 65 which would be unaffected by maternity or unisex rating. Of the remaining 29,000,000, many are dependents covered under policies held by their spouse or parent. On the other hand, many citizens are covered by more than one policy.

For the 24,000,000 citizens covered by individual disability income insurance, it is estimated that there would be at least 22,000,000 policies affected by unisex or maternity rating. While some policies would be unaffected because they are already written on a unisex basis to citizens beyond maternity ages, many citizens are covered by more than one policy.

¹¹Effects shown are for unmarried men and women who are principal drivers of the insured car.

¹²Some insurers now charge women between the ages of 30 and 64 who are the sole operators of their car approximately 10% less than similarly situated men. The price of auto insurance for these women would increase slightly, and the price for men would decrease slightly, but the impact is difficult to predict and would be small in any event.

¹³This assumption was drawn from table of a 1980 paper, "Economic Determinants and Implications of the size and Allocation of Pension Fund Capital," by

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Table 6 related to a distribution of pension assets in 1975; since that time, we believe the percentage of defined contribution plans is higher, but the 75-25 assumption is conservative.

Footnotes (continued)

- ¹⁴ This estimate is based on an internal planning document compiled by Aetna Life & Casualty from several sources — "Pension Facts" (published by American Council of Life Insurance), Social Security Bulletins, and "Security Expenditures in the U.S.: A Market Study" (published by the Life Insurance Marketing and Research Association). That document estimates 1980 deposits to private plans of roughly \$64 billion, and deposits to government plans (excluding CSRS and OASDI and, therefore, largely state and local government plans) of roughly \$26 billion.
- ¹⁵ There are approximately 500,000 pension plans in the U. S. (sources: President's Commission on Pension Policy, confirmed by Department of Labor statistics). However, most of these plans are defined contribution plans, many of which do not have sex-based elements of any significance.

Exhibit I
Impact of Unisex Rating and Maternity Benefits on Individual
Medical Expense Policies

Sex	Age	Relative ¹ Exposures	Relative Premiums Per Exposure ²	Relative Exposures Weighted by Relative Premiums	Estimated Distribution of \$2,500,000,000 ³ Premiums (in millions)	Estimated Distribution of \$2,500,000,000 Premiums on a Unisex Basis (in millions)	Estimated Additional Cost for Full Maternity Benefits ⁴ (in millions)	Estimated Additional Cost for Full Maternity Benefits on a Unisex Basis (in millions)
Adult Males	Thru 29	8.52	1.090	.083	\$121.5	\$149.9		\$ 61.8
	30 - 39	5.9	1.240	.073	104.3	134.8		19.4
	40 - 49	5.0	1.700	.085	121.5	143.5		.9
	50 - 59	5.7	2.620	.149	213.0	299.7		
	60 - 64	3.2	3.350	.107	152.9	166.6		
				<u>\$713.2</u>	<u>\$782.5</u>			<u>\$ 82.1</u>
Adult Females	Thru 29	8.2	1.480	.121	\$173.0	\$144.6	\$121.5	\$ 59.7
	30 - 39	7.3	1.890	.138	197.3	166.8	42.5	24.1
	40 - 49	8.1	2.200	.178	254.4	232.4	2.4	1.5
	50 - 59	14.5	2.560	.371	530.3	533.6		
	60 - 64	9.8	3.100	.304	436.5	442.8		
				<u>\$1,569.5</u>	<u>\$1,520.2</u>			<u>\$ 85.3</u>
Children		<u>23.8</u>	.580	<u>.138</u>	<u>192.3</u>	<u>192.3</u>	<u>12.2</u>	<u>12.2</u>
		100.02		1.749	\$2,500.0	\$2,500.0	\$179.6	\$179.6

Impact of Unisex Rating: Male Premiums increase by \$69,300,000, Female Premiums decrease by \$69,300,000.

Impact of Full Maternity benefits (including such benefits on policies below 65 already on unisex basis): Male Premiums increase by \$86,600,000, Female Premiums increase by \$89,600,000, Children Premiums increase by \$12,400,000.

¹Based on Society of Actuaries study of 1975-6 intercompany room and board morbidity experience. See Exhibit A.

²Based on study of hospital indemnity premiums used by several companies, Prudential's major medical premiums, and judgment. See Exhibit B.

³Excludes \$1,000,000,000 in average 65 premiums and \$800,000,000 in unisex premiums under age 65 (\$728,200,000 for males, \$568,700,000 for females,

⁴Includes impact on \$800,000,000 in unisex premiums under age 65. See Exhibits D and E for derivation. and \$63,100,000 for children). See Exhibit C.

Exhibit 2
Impact of Unisex Rating and Maternity Benefits on Individual
Disability Income Policies

Sex	Age	Occ. Class ¹	Relative Exposures ²	Relative Premiums Per Exposure ³	Relative Exposures Weighted by Relative Premiums	Estimated Distribution of \$2,070,000,000 ⁴ Premiums (in millions)	Estimated Distribution of \$2,070,000,000 Premiums on a Unisex Basis (in millions)	Estimated Additional Cost for Full Maternity Benefits (in millions) ⁵	Estimated Additional Cost for Full Maternity Benefits on a Unisex Basis (in millions)
Males	Thru 29	I	9.67%	1.00	.0967	\$ 95.6	\$ 101.8		\$ 36.7
	Thru 29	II	4.82	1.75	.0844	83.5	84.5		3.5
	30 - 39	I	22.58	1.36	.3071	303.7	314.2		14.2
	30 - 39	II	7.67	2.31	.1772	175.3	177.3		1.6
	40 - 49	I	20.20	2.00	.4040	399.6	408.0		.6
	40 - 49	II	6.01	3.26	.1959	193.7	199.5		.1
	50 - 59	I	13.28	2.60	.3453	341.5	346.4		
	50 - 59	II	4.62	4.03	.1862	184.2	185.0		
	60 - 64	I	3.31	2.60	.0861	85.2	86.1		
60 - 64	II	1.27	4.03	.0512	50.6	51.0			
Male Total			93.43		1,934.1	\$1,912.9	\$1,949.7		\$ 56.7
Females	Thru 29	I	1.42	1.50	.0213	\$ 21.1	\$ 14.9	\$ 42.1	\$ 5.4
	Thru 29	II	.13	2.49	.0032	3.2	2.3	3.6	.1
	30 - 39	I	1.82	2.00	.0364	36.0	25.5	15.3	1.1
	30 - 39	II	.21	3.33	.0070	6.9	4.9	1.7	.1
	40 - 49	I	1.38	2.66	.0367	36.3	27.9	.6	.0
	40 - 49	II	.17	4.30	.0073	7.2	5.4	.1	.0
	50 - 59	I	1.12	3.09	.0346	34.2	29.3		
	50 - 59	II	.12	4.87	.0058	5.7	4.9		
	60 - 64	I	.18	3.09	.0056	5.5	4.6		
	60 - 64	II	.02	4.87	.0010	1.0	0.6		
Female Total			6.57		.1589	\$ 157.1	\$ 120.3	\$ 63.4	\$ 6.7
TOTAL			100.00		2.0930	\$2,070.0	\$2,070.0	\$ 63.4	\$ 63.4

¹ I - White Collar; II - Blue Collar

² Based on Society of Actuaries study of 1976-7 intercompany experience (not published).

³ Based on a study of disability premiums charged by almost every insurer of any importance. See Exhibit E for more information.

⁴ Excludes \$212,500,000 Male and \$17,500,000 Female premiums already on a unisex basis. See Exhibit C.

⁵ See Exhibit F.

Exhibit A

	<u>AGE</u>	<u>DAILY HOSPITAL BENEFITS EXPOSED*</u>	<u>% OF TOTAL</u>
<u>MALE</u>	20 - 29	\$2,331,615	8.5%
	30 - 39	1,618,595	5.9
	40 - 49	1,367,682	5.0
	50 - 59	1,547,778	5.7
	60 - 64	873,350	3.2
<u>FEMALE</u>	20 - 29	2,248,286	8.2
	30 - 39	1,990,788	7.3
	40 - 49	2,198,313	8.1
	50 - 59	3,946,108	14.5
	60 - 64	2,680,233	9.8
<u>CHILD</u>		<u>6,474,098</u>	<u>23.8</u>
<u>TOTAL</u>		\$27,276,846	100.0%

*Obtained from the Society of Actuaries' study of intercompany morbidity experience for years 1975 and 1976 (unpublished data)

Exhibit B

The relative premiums were based on a study of relative premiums by sex and age charged under Prudential's \$100 deductible CHIP plan (see Exhibit B1), a sample of premiums for daily hospital benefits charged by 13 companies (see the non-unisex portion of Exhibit B2), and judgment. The weighted average ratios for the 13 companies were as follows (using the age 50-59 ratio for ages 60-64):

<u>Age</u>	<u>Ratio to Male, Age: Thru 29</u>	
	<u>Male</u>	<u>Female</u>
Thru 29	1.000	1.689
30-39	1.209	1.537
40-49	1.350	1.655
50-59	1.819	1.780
60-64	1.819	1.780
Child	.463	

Exhibit B2 shows the individual companies and their rates and Exhibit B3 shows the companies and their 1979 premiums that were used for weighting purposes. These premiums reflect these companies' total book of individual hospital-medical business and not just the premiums for the utilized form. Because of the large volume of business under the Prudential plan and the recent industry trend toward the sale of the benefits and rating system involved therein, the majority of the weighting was given that plan vs. the 13 company plans (which represent more limited benefits and sales volume). For example, from the total Prudential premium shown in Exhibit B3, 822 is represented by the CHIP plan and less than 1% by the Prudential policy shown in Exhibit B2.

Prudential Rates
\$100 Deductible CHIP Plan

	<u>AGE</u>	<u>MONTHLY PREMIUM</u>	<u>RATIO TO MALE AGE 25</u>
<u>MALE</u>	25	\$ 36.15	1.000
	35	46.35	1.282
	45	66.86	1.850
	55	107.23	2.966
	64	138.57	3.833
<u>FEMALE</u>	25	\$ 54.68	1.513
	35	75.15	2.079
	45	89.03	2.463
	55	104.99	2.904
	64	129.62	3.586
<u>CHILDREN</u>		\$ 58.60	.648 (per child)*

*This assumes 2.5 children per policy.

Exhibit B2

(page 1)

ANNUAL PREMIUMS PER ONE DOLLAR
OF DAILY HOSPITAL BENEFITSFirst Day Coverage - Principal
Insured (Male Rates)

COMPANY	POLICY	UNISEX	CHILD	AGE	AGE	AGE	AGE
				27	37	47	57
Mutual Of Omaha	280H	No	.72	1.08	1.80	1.52	3.12
American National	GHC	No	1.13	2.47	2.73	3.30	4.20
Bankers L & C	GR-74K	No	.82	2.16	2.28	2.52	2.88
Bankers Multiple Line	D-77E	Yes	.43	2.72	2.84	3.68	4.40
Beneficial Standard	1-842-2	No	1.69	2.44	2.44	2.44	2.44
Central States	235	No	.80	1.70	2.00	2.80	3.70
Continental Casualty	P1-67515A	Yes	1.02	2.65	3.35	3.35	4.42
Continental Casualty	P1-67500A	Yes	1.02	2.67	3.35	3.35	4.14
Federal Life & Casualty	NAC9620	Yes	1.05	1.05	1.61	2.38	3.01
Globe Life & Accident	G-5	Yes	1.01	4.68	4.68	4.68	5.21
Interocean	0563 Econ.	No	1.43	2.08	2.41	3.41	5.53
J. C. Penney Life	7-841	Yes	1.02	2.10	2.10	2.10	2.10
J. C. Penney Life	7-866A	Yes	1.02	1.74	1.74	2.34	2.64
John Hancock	PH-05-77	No	1.58	2.46	2.94	4.01	4.97
Metropolitan	FAH43-71	No	1.00	2.05	2.40	2.93	3.67
National Casualty	8206U	No	.75	2.60	3.15	3.70	5.15
National Home Life	NH48-380	Yes	.69	2.72	2.72	3.38	3.90
Pennsylvania Life	350	Yes	2.30	4.20	4.20	4.20	6.70
Physicians Mutual	P370/380	Yes	.51	3.98	3.98	3.98	3.98
Prudential	SA1H-73	No	.54	1.70	1.94	2.32	2.71
Pyramid Life	H-64 Rev.	No	1.05	2.71	2.71	3.59	4.92
Reserve Life	G762T	No	1.52	1.93	2.54	3.09	3.75
Travelers	GLH	No	.80	2.35	2.82	3.66	4.15
Union Fidelity	1-2490	Yes	.50	3.24	3.24	3.24	3.24
Non-Unisex Weighted Average			.82	1.77	2.14	2.39	3.22

ANNUAL PREMIUMS PER ONE DOLLAR
OF DAILY HOSPITAL BENEFITS

First Day Coverage - Principal
Insured (Female Rates)

COMPANY	POLICY	UNISEX	CHILD	AGE 27	AGE 37	AGE 47	AGE 57
Mutual Of Omaha	280H	No	.72	4.08	2.52	2.76	2.76
American National	GHC	No	1.13	3.30	3.60	3.77	3.93
Bankers L & C	GR-74K	No	.82	2.88	2.88	2.88	2.88
Bankers Multiple Line	D-77E	Yes	.43	2.72	2.84	3.68	4.40
Beneficial Standard	1-842-2	No	1.69	2.84	2.84	2.84	2.84
Central States	235	No	.80	2.20	2.60	3.10	3.40
Continental Casualty	PI-67515A	Yes	1.02	2.65	3.35	3.35	4.42
Continental Casualty	PI-67500A	Yes	1.02	2.67	3.35	3.35	4.14
Federal Life & Casualty	NAC9620	Yes	1.05	1.05	1.61	2.38	3.01
Globe Life & Accident	G-5	Yes	1.01	4.68	4.68	4.68	5.21
Interocean	Q563 Econ.	No	1.43	3.19	3.64	4.23	6.18
J. C. Penney Life	7-841	Yes	1.02	2.10	2.10	2.10	2.10
J. C. Penney Life	7-866A	Yes	1.02	1.74	1.74	2.34	2.64
John Hancock	PH-05-77	No	1.58	3.16	3.72	4.25	4.97
Metropolitan	FAH43-71	No	1.00	2.84	2.99	3.17	3.43
National Casualty	8206U	No	.75	3.30	3.75	4.00	4.80
National Home Life	NH48-380	Yes	.69	2.72	2.72	3.38	3.90
Pennsylvania Life	350	Yes	2.30	4.20	4.20	4.20	6.70
Physicians Mutual	P370/380	Yes	.51	3.98	3.98	3.98	3.98
Prudential	SA1H-73	No	.54	2.05	2.24	2.48	2.74
Pyramid Life	H-64 Rev	No	1.05	3.42	3.42	4.03	4.92
Reserve Life	G762T	No	1.52	2.21	2.87	3.48	4.14
Travelers	GLH	No	.80	3.05	3.39	3.92	4.15
Union Fidelity	1-2490	Yes	.50	3.24	3.24	3.24	3.24
Non-Unisex	Weighted Average		.82	2.99	2.72	2.93	3.15

Exhibit B3

<u>COMPANY</u>	<u>1979 PREMIUM</u>	<u>WEIGHTING FOR NON-UNISEX COMPANIES</u>
Mutual of Omaha	\$284,609,440	.2587
American National	20,648,866	.0188
Bankers L & C	271,795,975	.2471
Beneficial Standard	13,966,476	.0127
Central States	12,922,677	.0118
Interocean	34,897,099	.0317
John Hancock	14,094,262	.0128
Metropolitan	85,338,658	.0776
National Casualty	14,682,305	.0133
Prudential	262,383,467	.2385
Pyramid Life	12,213,280	.0111
Reserve Life	47,697,562	.0434
Travelers	<u>24,770,918</u>	<u>.0225</u>
TOTAL	\$1,100,020,985	1.0000

Exhibit C

The distribution of the \$800,000,000 unisex medical expense premium among males, females, and children by age grouping assumes the same relative distribution as was used to split the \$2,500,000,000 sex differentiated premiums.

Similarly, the distribution of the \$230,000,000 unisex disability premium assumes the same relativities as for the sex differentiated premiums.

Exhibit D

(page 1)

MATERNITY PREMIUM -- HOSPITAL-MEDICAL
DERIVATION

The general approach was to determine the relative cost of expanded maternity benefits vs. current benefits by comparing maternity frequencies with hospital frequencies as follows:

<u>Age</u>	<u>Maternity Frequencies for 1977 from the 1979 Statistical Abstract</u>	<u>Hospital Frequencies from the Society of Actuaries' Studies*</u>
Female: 22	.1152	.1152
27	.1142	.1313
32	.0575	.1562
37	.0192	.1761
42	.0042	.1857
47	.0000	.1873

Relative Factor for Expanded Maternity Benefits
Assuming that 25% Maternity Benefits already
Included in Current Premiums

<u>Age</u>		
Female: 22	$\frac{.75(.1152)}{.1152 + .25(.1152 \times 1.34^{**})}$	= .5618
27	$\frac{.75(.1142)}{.1313 + .25(.1142 \times 1.35^{**})}$	= .5043
32	$\frac{.75(.0575)}{.1562 + .25(.0575 \times 1.30^{**})}$	= .2466
37	$\frac{.75(.1092)}{.1761 + .25(.0192 \times 1.30^{**})}$	= .0790
42	$\frac{.75(.0042)}{.1857 + .25(.0042 \times 1.30^{**})}$	= .0168
47	$\frac{.75(0)}{.1873 + .25(0)}$	= 0

*Transactions, Society of Actuaries, 1977 Reports Number, page 108.

**Population maternity frequencies are assumed to apply to the additional coverage extended to policies already in force since anti-selection should be minimal. For currently in-force maternity benefits, insurers experience worse than population frequencies and current premiums reflect this anti-selection. Therefore, the anti-selection level developed on page 6 was assumed to apply.

Exhibit D

(page 2)

Since relative additional cost factors were developed on a quinquennial age basis, it was necessary to combine them into decennial age factors.

	<u>Age</u>	<u>Quinquennial Factors</u>	<u>Relative Weights (See Exhibit A)</u>	<u>Decennial Factors</u>
Female:	22	.5618	.4874	>
	27	.5043	.5126	
	32	.2466	.5238	>
	37	.0790	.4762	
	42	.0168	.4293	>
	47	.0000	.5707	

The additional cost for full maternity benefits was derived using these factors. For example, for female ages "Thru 29," the cost would be:

$$\$173.0 \text{ Million} \times \frac{\$3.3 \text{ Billion}}{\$2.5 \text{ Billion}} \text{ (to include unisex rated policies)} \times .532$$

$$= \$121.5 \text{ Billion}$$

Exhibit D1

MATERNITY DERIVATION FOR CHILD

Data from 1979 Statistical Abstract, pages 29, 42, 66

	<u>Age</u>	<u>% Single</u>	<u>Population</u>
Male:	0-17	100% (Assumed)	32,344,000
	18-19	94.4%	4,251,000 (est.)
Female:	0-17	100% (Assumed)	41,033,000
	18-19	81.3%	4,211,500 (est.)
	TOTAL 0-19		71,839,500
	TOTAL SINGLE 0-19		70,813,894

TOTAL BIRTHS TO SINGLE WOMEN

Age 0-15	10,100
Age 16-19	<u>234,700</u>
	244,800

MATERNITY FREQUENCY FOR DEPENDENT CHILD =

$$\frac{244,800}{70,813,899} = .003457$$

TOTAL CHILD HOSPITALIZATION FREQUENCY
FROM SOCIETY OF ACTUARIES* = .0736

$$\text{RATIO**} = \frac{.003457}{.0736} = .047$$

*From Transactions, Society of Actuaries, 1977 Reports Number, page 108.

**The 25% current maternity benefit assumption was not applied to children since many of the maternity benefits in force are limited to spouses under family policies.

Exhibit E

In order to determine the relative premiums by age, sex and occupation, the premiums for nearly 70 insurers were recorded and compared for ages 27, 37, 47, and 57 and 23 occupations. For each age, sex and occupation, average premiums for all companies were first calculated. From these averages, ratios of male premiums to the male age 27 premium were calculated for each occupation. In addition, the ratio of female to male premiums for each age and occupation were calculated.

Based on judgment, overall ratios to the male age 27 premiums by age and sex were derived separately for white-collar and blue-collar occupations. Since the relativities are fairly consistent for each occupation within the white- and blue-collar groupings, these overall ratios should be fairly accurate.

Finally, ratios of blue-collar premiums to white-collar male age 27 premiums were calculated by assuming blue-collar premiums average 175% of white-collar premiums for males age 27.

Exhibit FMATERNITY PREMIUM - L.O.T.DERIVATION

The general approach to estimating maternity costs was to examine the relative claim costs of maternity vs. non-maternity coverage. Population maternity frequencies were used assuming there would be no anti-selection under policies already in force. An average disability of 11 weeks was used which was reduced by the 2-week deductible period utilized in the claim cost comparison.

Age	Quinquennial Maternity Frequencies for 1977 from the 1979 Statistical Abstract	Relative Weights (See Exhibit A)	Decennial Maternity Frequencies
male: 22	.1152	.4874	.1147
27	.1142	.5126	
32	.0575	.5238	.0393
37	.0192	.4762	
42	.0042	.4293	.0018
47	.0000	.5707	

Age	Occ.	Maternity Frequencies	Assumed Average Claim	Claim Cost (for \$1/Mo. Benefit)
male: 20-29	I (White Collar)	.1147	2.08 months	\$.2386
20-29	II (Blue Collar)	.1147	2.08 months	.2386
30-39	I	.0393	2.08 months	.0817
30-39	II	.0393	2.08 months	.0817
40-49	I	.0018	2.08 months	.0037
40-49	II	.0018	2.08 months	.0037

Age	Occ.	Maternity Claim Cost	Non-Maternity Claim Cost	Ratio*
male: 20-29	I	\$.2386	\$.133	1.793
20-29	II	.2386	.233	1.024
30-39	I	.0817	.214	.382
30-39	II	.0817	.375	.218
40-49	I	.0037	.251	.015
40-49	II	.0037	.439	.008

*The Occ. I claim costs were taken from Transactions, Society of Actuaries, 1977 Reports Number, page 156. The Occ. II claim costs were assumed to be 175% of the Occ. I claim costs (since the Transactions do not report Occ. II female experience).

The additional cost for full maternity benefits was derived using these ratios. For example, for Occ. I, Ages 30-39, the cost would be:

\$36.0 Million x $\frac{\$2.30 \text{ Billion}}{\$2.07 \text{ Billion}}$ (to include unisex rated policies) x .382

= \$15.3 Million

Exhibit CSAMPLE OF BROAD MEDICAL INSURANCE PLANS

<u>Company</u>	<u>Policy</u>	<u>Type of Plan</u>	<u>Normal Maternity</u>	<u>Unise</u>
Aetna	23392 Med.	Compre. Med. Exp.	Optional	No
Aetna	23393 Med.	Maj. Med.	No	No
American Family Mutual	H28B-1	Maj. Med.	Yes	No
American National	GMMC	Maj. Med. (Comp.)	No	No
American Republic	A-2484	Maj. Med.	No	No
American Republic	A-2434	Maj. Med.	No	No
American Republic	A-2288	Maj. Med.	No	No
American Republic	A-2284-5-6	Hosp-Surg-Medical	Yes	No
Bankers Life & Cas.	VIP 81,82,83,84	Maj. Med.	Optional	No
The Equitable Life Assurance Society	CBM122	Maj. Med.	Yes	No
The Equitable Life Assurance Society	AS-102MM	Maj. Med.	No	Yes
Illinois Mutual	760	Maj. Med.	Optional	No
Metropolitan Life	FAH47-71, 1CIH-71	Compre. In-Hosp. Med. Exp.	No	No
Metropolitan Life	FAH47-71 w/rider 1CME-71	Compre. Med. Exp.	Yes (Family Policy only)	No
Metropolitan Life	FAH47-71 w/rider 1TOW-71	Hosp. & Surg. Exp.	Yes (Family Policy only)	No
MFA	H-627	Maj. Med.	Optional	No
Mutual of Omaha	80CM	Maj. Med.	Optional	No
Mutual of Omaha	81CM	Maj. Med.	No	No
Mutual of Omaha	280H	Hosp-Surg-Med.	Yes	No
New York Life	7744	Hosp-Surg-Med.	Optional	No
Prudential	CHIP	Maj. Med.	Optional	No
Reserve Life	M79	Maj. Med.	Optional	No
State Farm	97032	Hosp-Surg-Med.	Optional	No
State Farm	97023	Hosp-Surg-Med.	Optional	No
Time Insurance Co.	G47	Hosp-Med-Surg	Optional	No
Time Insurance Co.	644	Maj. Med.	Optional	No
Time Insurance Co.	645	Maj. Med.	Optional	No
Time Insurance Co.	625 & 626	Maj. Med.	Optional	No
Travelers	GR(6)	Hosp-Med.	Yes	No
Union Bankers	UB-81,82	Maj. Med.	Optional	No
Vulcan Life	350	Maj. Med.	No	No
Washington National	CC3146	Maj. Med.	No	No

STATEMENT 1981-24

August 5, 1981

Mr. Loren B. Kramer
AICPA Medical Malpractice
Self-Insurance Task Force
Kramer Consulting Services
222 N. Michigan Avenue
Chicago, Illinois 60601

Dear Loren:

Thank you for the opportunity to review and comment on your Task Force's revised issues paper. With a few exceptions, we believe your Task Force has done an excellent job. The following describes those items in your revised issues paper that we believe are either inconsistent with other issue items or published procedures, or redundant.

Item 5

It appears that the definitions of "Reported incident" and "Unasserted claim" (page 4) are redundant. Also, this definition of unasserted claim is more restricted than that used in the 1978 SOP reference and the Hospital Audit Guide (p. 66), which clearly disagrees with this definition.

Item 15

The last sentence of this item is incorrect. To the best of our knowledge, the "contribution" is not intended to cover expected costs to be incurred beyond the current year nor is it intended to level the cost of malpractice over a period of years. We suggest the following to replace the last sentence of this item.

"The current year's "contribution" to a malpractice trust fund generally represents the present values of expected malpractice claims for the current year plus or minus the effect of changes in the current estimated costs of prior years' malpractice claims, if any."

Item 19

We continue to have problems with your issues paper stating that - "They point out that actuaries rarely, if ever, indicate that funding requirements are in accordance with FASA 5". Firstly, we do not recall ever being asked the question by an auditor and have not heard of any other actuaries being asked the question. Secondly, we are not sure that language of this type should be expected to be a normal part of an actuarial report. Finally, it has a negative connotation; that is, it indicates a possible omission by the actuary. The term "is (are) generally" used throughout this item is not correct.

Mr. Loren B. Kramer
August 5, 1981

Section 1 of this item states that - "A funding program is generally aimed at leveling the cost of malpractice claims over a period of years." While this may occur with some regularity with some practitioners, we do not believe that it generally occurs. Generally implies most of the time, more than half. Thus, we do not feel that this is a true statement. You could change "is generally" to "may be" and probably be correct. Also, a \$1 million claim, when discovered, would require adjustment!

Section 2 of this item is probably true; however, only rarely are actuaries requested to provide this information. Timing of reports is typically controlled by the client and the client's audit requirements! We don't believe that this is an actuarial problem. In fact, the auditors are in a position to control the timing of actuarial reports. Also, retrospectively rated policy premiums are determined at the beginning of the period, and adjustments to trust funds are made if large claims (\$ 1 million) occur during the period.

Section 4 of this item contains the statement, "Sometimes actuarial computations contain substantial explicit provisions for adverse deviation which would not be in accordance with FAS 5." While this is undoubtedly true, we believe that it may be true primarily in those instances when an actuary is not involved. That is, we believe that it is more likely to occur when brokers, etc., are involved. We would appreciate your removing the word "actuarial," and just referring to computations and determination. Also, provisions for adverse deviation are permitted in the Life Audit Guide; is the Life Audit Guide inconsistent with FAS 5?

Item 23

We suggest the following wording for the first sentence.

"If a health care provider does not have sufficient experience on which to estimate claims incurred, it is appropriate to use actuarial methods to incorporate industry experience into estimates of such claims if:"

Also, the word measurement in Section 2 should be estimation.

Items 24 & 25

These items, as you may have anticipated, present a problem. The following specific comments highlight our technical problems followed by our suggested changes.

- These items are vague and will result in inconsistencies.
- These items are inconsistent, in fact, with items 22 and 23.
- These items do not recognize the fact that exposures exist and create an expectation of loss, not the reverse.

Mr. Loren B. Kramer
August 5, 1981

- The decision required in Item 25 might be made without loss data; to require loss data contradicts Item 23.
- Item 25 implies that a new hospital bears no resemblance to other hospitals, i.e., no correlation. This is certainly not so, and suggests that standard insurance principles are not applicable.
- These items appear to be more restrictive than and possibly contradictory to the 1978 SOP (page 66).

"It would be appropriate ... to unasserted claims before the date of the financial statement. Although the experience ... similar institutions may be a useful guide."

As the issues paper points out (see Items 30, 31 and 38), the estimating process is very difficult. It seems more appropriate to recognize that the judgments of many experts will have to be considered in assessing the reasonableness of the overall accrual and such issues as materiality will also have to be considered. Note that the auditor will have to consider all of these items when assessing retro policies and captives.

- It is not clear why malpractice liabilities should be considered differently from the treatment of product warranties liabilities since both are often based on the same legal doctrines. (See specifically Item 25 of FAS 5.)

As a solution, we suggest that Item 24 be replaced with the following language.

"If a health care provider is unable to meet the requirements of the preceding paragraph, no accrual should be made in the financial statements but the existing contingency should be disclosed in the footnotes."

This will eliminate the inconsistencies between sources and eliminates the need for Item 25; that is we suggest that Item 25 be deleted.

Item 32

The statement is made that - "It is difficult to determine if health care providers are presently considering the time value of money... If the estimates have been determined by actuaries, it is more likely ...". It would seem that determining if discounting of liabilities was applied could be easily verified by the auditor.

Mr. Loren B. Kramer
August 5, 1981

Item 37

This item states - "as malpractice insurance premiums take into consideration the time value of money". All casualty insurance premiums directly or indirectly take into consideration the time value of money. With some exceptions, it is likely that the major national malpractice carriers do not explicitly reflect the time value of money. This statement could be made for most liability insurers for most lines of business; thus, if the intent here is to indicate an exceptional case, it may be incorrect.

Item 100

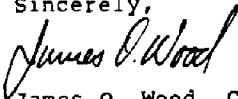
See comments on Items 24 and 25 regarding Section 1 of this item.

Due to the scope of our task force's assignment we have limited our comments to those items we believe impact our own work. We have forwarded a copy of your issues paper to The American Academy of Actuaries so that they can determine if comments from other AAA committees are appropriate.

It is our understanding that Mr. McRae of the AICPA staff has also prepared a re-draft of the issues paper. For this reason, we are supplying Mr. McRae a direct copy of our comments.

If you should have any questions, please call.

Sincerely,



James O. Wood, Chairman
American Academy of Actuaries
Task Force on Self-Insured Trusts

JOW/bjw

cc: AAA Task Force on Self-Insured Trusts
Mr. Steve Kellison, AAA
Mr. Thomas W. McRae, AICPA
Mr. Warren Cooper

STATEMENT 1981-25

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

August 21, 1981

WALTER L. GRACE, M.A.A.A., President
c/o MASSACHUSETTS MUTUAL LIFE INS. CO.
1285 STATE ST.
SPRINGFIELD, MA 01111
413/786-8411

Mr. John S. R. Shad
Chairman, Securities and Exchange Commission
500 North Capitol Street
Washington, DC 20549

Dear Mr. Shad:

At yesterday's open meeting, the Commission indicated that it would soon issue a release withdrawing Accounting Series Release No. 264 and soliciting comments on rescinding Release No. 250 (which is the basis for Item 8(g) of the proxy rules). The American Academy of Actuaries believes that the withdrawal of ASR 264 is an exceedingly significant step which should be taken (if at all) only after careful consideration of the views of all interested parties. Accordingly, the Academy urges the Commission to modify its proposed release so as to solicit comments not only on rescission of ASR 250 but also on withdrawal of ASR 264, and to defer any decision on withdrawal of ASR 264 until the Commission has had an opportunity to review those comments.

I am writing to you in my capacity as President of the American Academy of Actuaries. The Academy and its three sponsoring organizations function as a professional association for the actuarial profession within the United States. Its over 6,500 members represent the vast majority of the practicing actuaries in this nation. While most of its members are employed by insurance companies, independent actuarial consulting organizations, and government agencies, a significant number are employed by accounting firms.

The Academy has been an active participant in the Commission's effort, culminating in ASR 264, to define how the independence of an accountant is affected by the provision of management advisory services to its audit clients. The Academy has a keen interest in this issue because actuarial services are one of the principal nonaudit services offered by accounting firms. When these services are rendered to audit clients, a question as to the independence of the auditor is raised that affects not only the accounting firm itself but also those actuaries that are employed by it -- actuaries who are, in many instances, Academy members.

The Academy and many other groups other than accountants actively participated in the development of ASR 264. Securities Act Release No. 5869, issued on September 26, 1977, requested information and comment from all interested persons as well as accountants concerning the nature and extent of the nonaudit services provided to audit clients, their effect on independence, and what services should and should not be provided to audit clients. The Academy, as well as other interested organizations, responded.

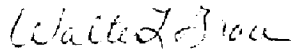
But having been intimately involved in fashioning ASR 264, these same parties are now not even to be consulted before ASR 264 is summarily withdrawn. The Commission's proposed disposition of this release without any opportunity for public comment is wholly inconsistent with the Commission's own past handling of this issue, which recognized that many diverse groups have a significant stake in the matter.

In the view of the Academy, it would be a serious mistake to withdraw ASR 264 in the manner proposed. ASR 264 represented to a great extent an extension of Rule 2-01 of Regulation S-X. For this reason, it may be that it cannot properly be withdrawn without public comment. In any event, it would be ill-advised to do so given the significance of the release. ASR 264 is not just another in a series of case by case releases on independence issues. Rather, it is a broad policy statement that is the Commission's single most significant statement on the issue of nonaudit services. Its withdrawal would raise a real question as to just what is left of the Commission's guidance in this area. Is withdrawal a statement that in the Commission's view the provision of nonaudit services to audit clients never presents an independence issue? If not, when does it do so? Unless the Commission has abdicated altogether its role in overseeing the independence of accountants, which we do not understand it to have done, these questions require an answer. A comment process will assist in providing the needed clarification.

The Academy believes that the forthcoming release should be modified before it is issued so as to solicit public comment on withdrawal of ASR 264 as well as ASR 250, and that no action to withdraw ASR 264 should be taken until that comment procedure is completed. Our request is not an extreme one. Its purpose is simply to provide the Commission with the benefit of the views of all the various parties who will be significantly affected by the Commission's action.

Finally, although we readily admit to having no specific knowledge, we are persuaded that the Commission's decision may have followed rather extensive consultations between members of the accounting profession and the Commission's accounting staff, if not the Commission members themselves. Even if such contacts were not improper, we think that at least these contacts, if they did occur, warrant according other interested groups an opportunity to express perhaps contrary views. This is what the comment process would provide.

Yours very truly,



Walter L. Grace

WLG:pjs

cc: Commissioner John R. Evans
 Commissioner Philip A. Loomis, Jr.
 Commissioner Barbara S. Thomas
 Commissioner Bevis Longstreth
 Chief Accountant A. Clarence Sampson
 Honorable Alphonse d'Amato
 Honorable Timothy Wirth

STATEMENT 1981-26

September 29, 1981

Director of Research and Technical Activities
File Reference 1057-019
Financial Accounting Standards Board
High Ridge Park
Stamford, Connecticut 06905

Dear Sir:

The Academy of Actuaries is responding to your invitation for comments on the Exposure Draft, Foreign Currency Translation.

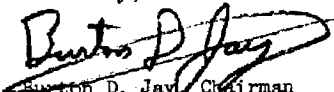
Our understanding of the proposed Statement is that the basic measurement of all of the elements of a foreign entity's financial statements would be made in conformity with U. S. generally accepted accounting principles in terms of its functional currency. All of the foreign entity's assets and liabilities would then be translated from that functional currency into the reporting currency using the current exchange rate. All revenues, expenses, gains and losses would be translated to approximate the effect of using the exchange rates on the dates they are recognized.

In the "remeasurement" and the "translation" processes, both benefit reserves and deferred acquisition costs are translated using current exchange rates. As stated in our position papers, dated October 31, 1977, and August 14, 1978, and in our letter dated November 7, 1980, it is important that benefit reserves and deferred acquisition costs be remeasured and translated at the same rate of exchange.

We believe that in most cases the proposed FASB Statement would produce results consistent with the Industry Audit Guide and sound actuarial principles, and that adoption of this Statement would eliminate inconsistencies which currently exist under Statement No. 8 and Interpretation No. 15.

We thank you for the opportunity to provide our comments, and hope these comments will be helpful to you.

Sincerely,



Burton D. Jay, Chairman

American Academy of Actuaries
Committee on Life Insurance Financial Reporting Principles

BDJ:lw

STATEMENT 1981-27

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

STATEMENT TO THE SUBCOMMITTEE ON HEALTH
OF THE HOUSE COMMITTEE ON WAYS & MEANS
BY W.H. ODELL, CHAIRMAN OF THE
COMMITTEE ON HEALTH INSURANCE OF THE
AMERICAN ACADEMY OF ACTUARIES

October 2, 1981

Mr. Chairman and distinguished members of the Subcommittee, my name is W. H. Odell. I am the Chairman of the Committee on Health Insurance of the American Academy of Actuaries. On behalf of the Academy, I wish to thank you for the opportunity to appear before you today to discuss some of the issues involved in the "pro-competition" health care bills.

The American Academy of Actuaries is a professional organization composed of actuaries practicing in a variety of fields, including the area of health insurance. Since I am representing an organization composed of individuals who hold diverse political views, this statement will not generally favor or oppose specific legislative proposals. Instead, I will discuss the financial implications of some of the proposals to assist you in your deliberations. Attached to this statement is additional background information about the American Academy of Actuaries.

* * * * *

As this hearing is likely to be the first of many in Congress' search for a way to achieve a marketplace environment for health care prepayment programs, we would like to offer our assistance in studying the probable effects of specific sections of some of the "pro-competition" bills -- especially those that might produce unwanted and unexpected results.

The "pro-competition" bills have raised a number of technical issues which are of interest to health actuaries. The most important technical issues are:

- The impact of greater cost-sharing on the cost of health care
- Possible variations in the financial impact of a uniform limit on tax-free employer contributions to health plans
- The effect of mandating multiple choices
- Who pays for those in poor health in a multiple choice system
- The effect of requiring a choice of three insurers on the cost of employer health plans

1. The impact of greater cost-sharing on the cost of health care.

Actuaries have generally found that cost-sharing, i.e., deductibles, copayments, or other patient payments, will reduce the use of most types of health services significantly. By making patients more aware of the cost, fewer services will be demanded and more attention will be paid to price increases by providers. These in turn would reduce inflationary pressures.

2. Possible variations in the financial impact of a uniform limit on tax-free employer contributions to health plans.

One possible measure to discourage growth in first-dollar coverages is to place what is commonly called a "tax cap" on the employer contribution. A similar cap already exists on employer paid group life insurance over \$50,000. Such a cap would have to be carefully constructed or it will have a widely different financial impact on employees in different situations. For example, a flat cap in all cases would have relatively heavier financial consequences for employees of:

- Firms in high cost areas (\$125 a month buys much more coverage in South Carolina than it does in New York leaving relatively more for the New York employee to pay).
- Small firms, who pay more for the same coverage as a result of higher administrative expenses.
- Firms with an older work force.

Therefore, any cap considered should include variation by geographic location, size of firm, and actuarial category (e.g., age, sex) if such variations in financial impact are to be avoided. Some of the proposed legislation does vary a cap by certain of these factors, while other proposals do not provide for such variance.

3. The effect of mandating multiple choices.

Some proposals would require an employer to offer two (or more) plans, providing a choice of "high" option coverage and "low" option coverage. Employers would be required to pay the same contribution per employee to each plan. Payment would be in the form of rebates to those choosing the "low" option.

Multiple option requirements create numerous problems. First, there are complex technical problems with defining "equal" contributions. The premium paid monthly by the employer may differ from the actual cost of insurance for enrollees in each option for several reasons. Insurers may pay dividends, make more profit or loss on one option than the other, or vary rates for many other factors.

Further, as with the employer contribution cap, the rates, and therefore the rebates, may have to be allowed to vary by geographic location and actuarial category. Some of the proposed legislation provides for such variance while other proposals do not.

The most serious problem, however, is "adverse selection." Adverse selection refers to the tendency for younger and healthier employees to choose the "low" option, and for older or less healthy employees to choose the "high" option. The premium rates of the options depend more on the age and health of those choosing them than on the difference in cost-sharing. Thus, the savings when younger and healthier employees change from the "high" to "low" option plan is less than the difference in premium rates. Employer outlays will thereby be increased if the full difference in premium rates is paid as a rebate. The principal beneficiaries will be the young and healthy employees.

Our major concern with many of the "pro-competition" bills as they now appear has to do with adverse selection. We are concerned that providing "high" vs. "low" option coverages to employees could result in a significant increase in adverse selection. If this should happen, then instead of achieving the desired result of competitive forces, that is selection of the most efficient health care delivery systems, the more probable result could be higher employer payments.

It is not our intent to imply that competition in a private enterprise system cannot be applicable to the health care sector. Our concern is that the competition will occur in attempting to enroll the healthiest employees rather than the hoped-for competition between health care delivery systems.

For competition to occur between providers of health care services, i.e., the physicians and hospitals, they must feel the financial effects of the competition between health care delivery systems. Under the proposed legislation, this will not be the case, and providers of

health care services will have little or no incentive to achieve greater efficiency in the delivery of health care services.

The concept of adverse selection is discussed more fully in a booklet published by the American Academy of Actuaries entitled "Risk Classification: Statement of Principles." This booklet is attached to our testimony.

4. Who pays for those in poor health in a multiple choice system.

In the current health care financing system, the employer pays a relatively greater share of the cost of the less healthy than of healthier employees. This occurs because a group premium rate is actually a composite of the different rates applicable to each family in the group, both healthier and less healthy. The employer customarily contributes a larger portion of the premium and the employee makes a flat contribution for just the remaining portion of the premium. This is therefore an attractive purchase for all members of the group.

Proposals which mandate multiple choice for employment-based insurance would, in their current form, prevent this cross-subsidization. It is likely that if two options were required, the healthier employees would be more likely to choose the low option, anticipating lower utilization of health services, thereby leaving the less healthy employees in the high option, and driving up its cost.

The situation is like the experience of the so-called assessment societies which for a time flourished in the early 1900s. These assessment societies offered life insurance benefits to members without making price distinctions for different age groups. Many younger

members were gradually attracted to other lower price plans that offered reduced rates for younger enrollees. This opting-out resulted in higher prices for the remaining older insured members. Some of those remaining members then opted out because of the higher prices. An upward spiral of higher prices resulted for the fewer and fewer remaining older lives. Consequently, these assessment plans became economically unsound and were unable to survive in the competitive market place.

Pro-competition health legislation might create a situation similar to that of the assessment societies of 75 years ago. Further aggravating this danger would be the rebate of the full difference in cost of a multiple choice plan. It over-compensates the younger, healthier, or lower utilizers for electing the low cost option plan. The result will be to drive up the cost of the high option plan, producing the same spiral effect as did the aforementioned life insurance assessment plans.

5. The effect of requiring a choice of three insurers on the cost of employer health plans.

Requiring more than one insurer is intended to introduce competition among insurance providers and thereby hold down costs of coverage. However, the results may be just the opposite. If several insurers are covering one group of employees, there will be fixed administrative costs and sales associated with each. These will in the aggregate be greater than if there were only one insurer.

Under a three carrier rule, there are two competitions, one to be one of the carriers and another to enroll employees. Competitive forces will encourage insurers to enroll the healthiest employees. Since the

main financial rewards will go to the carrier than enrolls the healthiest employees, insurers will design their plans to appeal to them. This may reduce the variety of coverages available as each insurer attempts to appeal most to the young and healthy. This effect is far afield from the original intent of the three carrier rule.

Since the insurer cannot be certain that other carriers will not enroll the healthiest employees leaving only the less healthy enrolled in its plan, the insurer may tend to raise rates to cover this additional uncertainty about the composition of its segment of employees. This would further increase the cost of insurance.

* * * * *

Finally, on a somewhat different issue, many actuaries are concerned about the basis of the financial reporting of the liabilities of uninsured plans. State insurance regulatory authorities are presently considering making the financial reporting requirements of such plans more exacting. But definitive guidance is presently lacking. Also, we believe that insufficient attention has been given to the question of whether the contribution levels of these plans are sufficient to provide the benefits anticipated by the plan members. Some of the proposed legislation provides for preparation or review of financial statements by experts and also for a review of the sufficiency of contribution levels. The actuarial profession commends such proposals and stands willing to assist you in this regard.

* * * * *

We hope these observations will be of use to you in your deliberations on these important bills. We will be glad to assist you with the actuarial considerations inherent in the "pro-competition" proposals. Thank you for this opportunity to testify.

APPENDIX A

The American Academy of Actuaries is a professional organization 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. It includes members of three founding organizations -- the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

Requirements to become a member of the Academy can be summarized under two broad headings: (1) education and (2) experience. At the present time, the education requirements for membership can be satisfied by passing certain professional examinations given either by the Casualty Actuarial Society or the Society of Actuaries or by becoming an "enrolled actuary" under the Employee Retirement Income Security Act of 1974 (ERISA). The experience requirement consists of three years of responsible actuarial work.

As of the end of 1980, the Academy membership exceeded 6,200. The Academy is unique as the national actuarial organization for actuaries in all areas of specialization. These actuaries have a variety of types of employment, including insurance organizations, consulting firms, academic institutions, and government. A large majority of those individuals who have satisfied the education and experience requirements of the Academy have, in fact, joined the Academy.

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, liaison with other professions and public relations.

STATEMENT 1981-28

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

October 5, 1981

Dr. Judith R. Lave, Ph.D.
Director, Office of Research
Department of Health & Human Services
Health Care Financing Administration
Washington, DC 20201

RE: BPP-91-P

Dear Dr. Lave:

We are glad to help you with the questions you have raised in your letter of September 11 and comment on the areas touched on in that letter. We have tried to reply as soon as it was possible to give considered thought to your letter. We trust this letter is still timely.

This letter is organized along the following lines:

- A. The use of actuarial expertise in each of the three segments of the study of individual health policies.
 - B. The specific questions raised on page 2 of your letter.
 - C. The survey material.
- A. The three areas of the research project:
- There are three areas mentioned: development of a regulation typology; a consumer survey; and industry survey. The following comments relate to the second and third segments.

We think the requirement in the RFP that bidders have actuarial expertise goes a long way toward providing you assurance that the successful bidder will complete the job in a meaningful manner so that it meets your objectives. We do have two observations. First, not all people mean the same thing by "actuarial expertise". In this connection membership in the American Academy of Actuaries is generally considered to indicate actuarial competence. Members of the Academy are subject to guides to professional conduct which are intended to provide assurance to employers and clients of actuaries that each actuarial undertaking performed by a Member of the Academy has brought to it the proper breadth and level of actuarial training and expertise. Our second observation is that the degree of involvement of the actuary in the undertaking is extremely important. To have meaningful results from the project we believe it is important that actuarial expertise be extensively involved in the design, implementation and analysis of this very important study segment. If the role of the actuary is

Dr. Judith R. Lave
October 5, 1981

limited to closely defined specific areas, the conclusions of the actuarial staff are not reflected in the final product and hence you will not receive the type of results you desire.

Turning to the third part of the study, the industry survey, we again suggest extensive involvement of one or more actuaries in this part of the undertaking. Some of the comments in items B and C below are reflections of this need. We suggest that a portion of the budget for this project be used to obtain the needed actuarial help. We would like to think that the budgeted amount is sufficient enough so that this would not pose any difficulty. In any event the need for such help is, we believe, a priority claim on the budget dollars since without it we are concerned that the objectives of the study will not be met.

B. Specific questions raised on page 2 of your letter:

Most of these questions relate to insurance practice. We will write to you separately about such questions, namely numbers 2, 3, 5 and 6.

We would like to offer some very preliminary thoughts on items #1 and #4.

Item #1 asked if the choice of the timing of the two years of data is appropriate to detect changes in the state insurance market. This depends on the type of policy, among other things. It also depends on the other forces at work. This is not a simple question and selection of two years can be done in a much more meaningful way by an actuary who obtains the facts and circumstances as they relate to each particular state and policy form.

With respect to item #4 the question arises whether \$100,000 of premium volume is appropriate or too high or too low. Again, the answer depends on the circumstances. This question might well be best addressed by the application of credibility theory, a subject which is understood in depth by many actuaries and takes up a significant portion of one of their examinations. Again, an actuary working with the facts of the particular situation being studied could provide considerable insight into the best approach.

C. The insurance survey material:

The survey material really requires in-depth actuarial analysis. We believe that a different or at least an additional approach is required for some policies. Generally speaking the reason for our concern is the limitation on calendar year loss ratio data. This is not a simple subject. In fact the Academy's Committee on Health Insurance is currently endeavoring to digest the available information on loss ratios. This undertaking is frankly not very far along because of the complexity of the subject and the tremendous variation in the quality of the materials available.

Dr. Judith R. Lave
October 5, 1981

Just by way of indicating the extent of the difficulties of relying on annual statement calendar year loss ratios as is done in the present draft of the questionnaire, actuaries have found these numbers to be so misleading that there is material included in the actuarial examination reading requirements which points out how misleading these numbers can be and aspiring actuaries are required to study this material.

This topic was the subject of a session at a recent meeting of the Society of Actuaries. The discussion of that meeting is recorded in the "Record". A copy of this is enclosed for your use. The discussion by Charles Habeck beginning on page 210 may be particularly helpful because it lists the major writings on this subject as well as containing some helpful observations.

In any event we believe the present survey questionnaire will not develop meaningful data for certain policies and again suggest utilization of actuarial help on this segment of the project.

Dr. Lave, we hope you find the above comments helpful. If we can be of assistance in some further way please do not hesitate to get in touch with the Washington office of the Academy or me.

Sincerely,



W. H. Odell, FSA, MAAA
Chairman, Committee on Health Insurance

WHO/dw

Enclosure

STATEMENT 1981-29

ACCOUNTING FOR THE COST

OF POST-RETIREMENT

WELFARE BENEFITS

Submitted to the Financial Accounting Standards Board on October 16, 1981

American Academy of Actuaries
Task Force on Post-Retirement
Life and Health Benefits

Executive Summary

The findings of our Task Force are as follows:

- I. There is a failure to recognize the future costs of post-retirement welfare benefits in the financial statements of many corporations.
- II. The nature of the corporate obligations for these benefits varies --but some obligations are permanent enough to warrant advance cost recognition.
- III. The common types of post-retirement welfare benefits vary widely.
- IV. A preliminary review of data available to our Task Force shows that the total expense on an advance cost recognition basis can range between 2% and 5% of payroll. If the expense is materially greater than pay-as-you-go costs, the financial statement should reflect it.
- V. Techniques and procedures for measuring the liabilities are generally available.
- VI. Assumptions appropriate for measuring the liabilities can be unique to these benefits, but are generally available.
- VII. Cost methods for allocating the expense over the working lifetime of all employees are generally those used for pension expense purposes. Pay-as-you-go is not an appropriate accounting method.
- VIII. Cash funding of these plans is a separate issue from proper cost accounting. Cash funding is not legally required currently as for pension plans.

Recommendation:

The Academy's Subcommittee on Accounting Matters should now advance this project to the point of developing an opinion on principles and practices.

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- III. TYPES OF POST-RETIREMENT WELFARE BENEFITS
- IV. RELATIVE COSTS
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- VI. ASSUMPTIONS
- VII. COST METHODS
- VIII. FUNDING

I. Statement of the Problem

Post-retirement welfare benefits (death and medical) are widespread in U.S. industry. These benefits are commonly expensed on a pay-as-you-go basis for current retirees only, without advance cost recognition for active employees of their eventual post-retirement benefits. There is, therefore, a failure to recognize the future costs of these welfare benefits in the financial statements of many corporations.

Generally accepted accounting principles require a matching of revenues and expenses. Specifically for pension plans, Opinion No. 8 requires a matching of pension costs with the revenues generated during the active working lifetimes of employees. A pay-as-you-go accounting approach is not acceptable under Opinion 8 for recognizing pension costs. Conceptually, where an employer undertakes and communicates a long-term commitment to provide post-retirement welfare benefits, accounting for the costs for these benefits may parallel the accounting for pension costs.

However, the analogy between post-retirement welfare and pension benefits is not all that clear-cut. Both general practice and law have established pension benefits as a higher order obligation. For example, ERISA prohibits cutbacks in accrued pension benefits (except to offset Social Security increases), while neither a legal prohibition against a cutback --nor even the concept of an accrued benefit--has been applied to post-retirement welfare benefits. In fact, some employers would expect a major cutback in future post-retirement medical benefits if government benefits increase dramatically.

Even if it is conceded that the commitment for post-retirement welfare benefits is reasonably similar to the commitment for pension benefits, some still argue that no advance cost recognition need be done for welfare benefits. Their argument is that current methods for employee welfare benefit plans typically involve an averaging of costs over a large number of employees and over long periods of time. In this averaging process, the incidence of costs for individual employees can safely be ignored--they say--so long as the total amount of expense for the entire group is reasonably consistent over time.

For some mature employee groups, this consistency of cost under current averaging approaches may actually be the case. For many others, an advance cost recognition will produce results that are materially different from those under any averaging approach. Accounting principles call for the recognition of these costs to the extent they are measurable. Of course, materiality governs in all cases.

Materiality depends on the type and level of benefits, the characteristics of the employee group, and the size of the labor force relative to the employer's financial results. In general, an opinion on materiality is not possible without an attempt to measure the liability. Doubts as to the measurability of post-retirement medical benefits are raised by those who feel that future trends in medical inflation and social insurance are too uncertain to permit a measurement of employer liabilities. In our opinion, a measure of liability based on reasonable assumptions as to future events is a better basis for management and investment decisions than no measure at all.

II. Nature of The Obligation

The nature of employer obligations to provide post-retirement welfare benefits varies widely. Examples are as follows:

- A. Temporary, Gratuitous, Previous Retirees Only - the employer undertakes, by resolution of its Board of Directors, a promise to a class of previously retired employees only, to reimburse certain welfare benefits that are incurred within a specific period of time. This type of obligation normally includes a letter or similar announcement to the covered class of retirees who are currently entitled to receive benefits, describing the benefits and the temporary and gratuitous nature of the promise.
- B. Intent to Continue with Right to Terminate - the employer undertakes, by action of its Board of Directors, a program for active employees as well as current retirees to provide welfare benefits post-retirement. The employer intends to continue the program in the future, but reserves the right to terminate it at any time. This type of obligation normally includes communication of the program to the class of retired employees currently eligible for benefits as well as those active employees who may become eligible in the future.
- C. Contractual Obligation - the employer undertakes, pursuant to a collective bargaining agreement, to provide post-retirement welfare benefits to active employees (and perhaps current retirees) who are represented by the collective bargaining agent. The employer commits itself to continue the program only during the period covered by the agreement.

Clearly, the degree of permanence associated with the employer's obligation must first be assessed. Where there is either an expressed intent to continue, or a contractual obligation to continue, an appropriate provision should be made for the cost of the plan.

III. Common Types of Post-Retirement Welfare Benefits

General categories of benefits provided can be summarized as follows:

A. Death Benefits:

1. Flat dollar amount (such as \$5,000).
2. Schedule of dollar amounts related to pre-retirement position (such as \$20,000 for officers, \$10,000 for other employees).
3. Salary related benefits with maximum amount (such as 50% of final salary but not more than \$20,000).
4. A reducing percentage of salary (such as 100% of salary in the first year of retirement, 75% in the second year and 50% thereafter).
5. A level percentage of final salary (such as 50% of final salary).

B. Medical Benefits

1. Reimbursement of charges not eligible under Medicare (such as private nursing and prescription drugs).
2. Reimbursement of amounts excluded by Medicare deductible, copayment and coinsurance provisions.
3. Continuation of active plan benefits, but reduced by the amount of Medicare reimbursement. This is generally referred to as a Medicare carve-out.

IV. Relative Costs

In order to provide some perspective on the materiality of costs for post-retirement welfare benefits, approximate observed cost relationships, using cost methods discussed in Section VII, are as follows:

1. Death benefit which is salary related, but with a maximum salary, might cost between 1% and 2% of payroll.
2. A moderate Medicare carve-out plan might cost between 1% and 3% of payroll.

V. Measuring the Liability

Before calculating the annual expense for these benefits under an appropriate actuarial cost method, it is first necessary to calculate the present value of the anticipated benefits. The following briefly describes some procedures used for this purpose:

Death Benefits

The first step is to project the amount of death benefit payable at any point in time after retirement occurs. The present value of these projected death benefits may then be calculated using the fundamentals of life contingencies with appropriate discounts for mortality and interest and other factors appropriate for this calculation. An insurance company's term premiums may be used in some circumstances.

Medical

The first step is to project annual disbursements per covered participant. Projected annual disbursements should reflect the absence or presence of Medicare benefits at age 65. Early retirement medical benefits are usually quite costly. It may also be appropriate to distinguish between healthy and disabled participants, if material.

If benefits are provided through an insurance contract, the premium rates may be used to determine annual disbursements. It should first be determined, however, that the premium rates accurately reflect the retiree costs. There is often an internal subsidy within the medical plan between active employee and retiree costs, and one must be careful in deriving the appropriate amount. Alternatively, if the plan is sufficiently large, statistics for the plan could be utilized to estimate annual disbursements.

If medical coverage is continued to the spouse after the retiree's death, the continuing benefits must also be recognized. These costs are especially sensitive to the spouse's age when the retiree dies, since the spouse could be younger than the Medicare eligibility age and require a substantial increase in benefits.

If the medical plan includes specified dollar amounts which limit benefits, a reduction in the medical care inflation rate assumption may be a satisfactory approach to reflect the plan limitations. Other types of limits may also be satisfactory, such as a dollar maximum on projected annual disbursements. The type of limit will depend on the plan provisions.

In anticipation of future FASB disclosure requirements, the accumulated liability--in FAS #36 parlance--might also be calculated, since it provides a reasonable funding or discussion target. Benefits before eligibility to early retire could be pro-rated, as is done with pension benefits in FAS #35 and #36, although new concepts in pro-rating medical benefits would need to be developed.

Generally, post-retirement welfare benefits do not vest in the pension sense, since many companies reserve the right to discontinue them for everyone at any time. But some employers recognize that under plan termination it would be unthinkable to discontinue these promises to already retired employees, or those now eligible to early retire. Accordingly, as a surrogate for vested liabilities, it may be appropriate to calculate the present value of anticipated benefits for those who could retire unilaterally and qualify for post-retirement benefits, plus those already retired and eligible for benefits.

VI. Assumptions

In calculating the liability for post-retirement welfare benefits, the actuary should choose assumptions that reflect a reasonable estimate of future events. In some situations, assumptions that are consistent with those used to calculate pension liabilities may be appropriate. In other situations, unique assumptions might apply.

In either case, additional assumptions may be necessary. Some of the additional assumptions are as follows:

1. Medical Care Inflation - it may be appropriate to assume that inflation in medical care will outpace general inflation for some period of time.
2. Age-Specific Disbursement Scale - it may be appropriate to adjust the pre-age 65 and post-age 65 annual disbursement amount by applying an age-specific scale to obtain an expected disbursement for each attained age. This is particularly true where plan statistics are used to develop the average annual disbursement.
3. Percentage married, and Age of Spouse
4. Early Retirement Probabilities

Assumptions should be explicitly realistic, but simplifying assumptions are satisfactory if the difference in results is not material. The medical care inflation assumption must reflect an assumption, implicitly or explicitly, concerning the future scope of Medicare.

For current expensing purposes, it is appropriate to reflect the current plan provisions only, without anticipation of future benefit improvements. However, it is useful in a forecast to anticipate that benefit improvements may be required to maintain the current value of benefits in light of future inflation.

The medical care inflation assumption should recognize both convenience in calculation and reliability of results. It should be consistent with the inflation rate inherent in other assumptions and particularly consistent with the overall general inflation inherent in the interest assumption. The impact of medical inflation on future employee contributions should also be considered.

The choice of assumptions is crucial, because of the long-term nature of these benefits and their sensitivity to a large number of future events. The actuary should carefully discuss with the employer the chosen assumptions and their implications.

VII. Cost Methods

After calculating the present value of future benefits, a cost method should be selected which fairly allocates the total expense by year. The available cost methods encompass those currently used for pension plans, although others may be appropriate. The selection of a cost method should reflect the nature of the particular benefit. Generally, the method used should spread the expense for employees over their active years of service in an orderly manner.

A method which is reasonably simple to use, but not theoretically accurate, may still be considered appropriate for these benefits, provided the difference in results is immaterial.

However, pay-as-you-go is not an appropriate accounting method because it fails to recognize the cost of post-retirement benefits during the working lifetimes of employees. Similarly, terminal funding is not generally appropriate.

VIII. Funding

Selection of the cost method and vehicle used to fund the benefits are distinct from the accounting issues. The funding method need not be identical to the cost recognition method for accounting purposes. Except for utilities and government contractors who want to pass these costs on to the consumer or government agency, cash funding of these plans is not currently required. Of course, a company who wants a current tax deduction must cash fund currently.

Each employer will have to decide whether it makes economic sense for money to be put aside currently when various corporate projects are competing for the use of capital. Of course, neither accruing nor pre-funding these costs imply a vested right of employees in their benefits, nor a legal obligation of employers to provide them.

Possible funding vehicles include individual policies, insurance deposit funds and trusts (including pension trusts). It is not necessary to use a single vehicle for all benefits. The choice of vehicle (insurance company or trust) should not decree the appropriate accounting for the cost of post-retirement death or medical benefits.

STATEMENT 1981-30

AMERICAN ACADEMY OF ACTUARIES

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STEPHEN G. KELLISON, M.A.A.A.
EXECUTIVE DIRECTOR

October 30, 1981

Treva McCall
Executive Officer
Equal Employment Opportunity
Commission
2401 E Street, N.W.
Washington, D.C. 20506

RE: Comments on Proposed Equal Pay Act Interpretations/29 CFR 1620

Dear Ms. McCall:

The Committee on Risk Classification of the American Academy of Actuaries has prepared the attached commentary on the proposed interpretations published in the Federal Register by the EEOC on September 1, 1981 regarding the Equal Pay Act.

We do not agree with the finding that the proposed interpretation has been "determined not to be a major rule." We estimate an approximate total annual cost impact of the proposed rules of \$5.5 billion, exclusive of implementation costs. In addition, there are other long-term implications on retirement plans such as the possible reduction in the availability of certain optional forms of retirement benefits, and a possible increase in terminations of small plans.

We believe it is important to consider the economic effects of the proposed rules, as well as their intended social purposes. The attached comments are a more extensive explanation of our concern about the proposal. If any of our comments raise questions or if you would like further explanation, please feel free to get in touch with us. Finally, we ask that this cover letter itself also be considered part of our comments.

Yours very truly,



Stephen G. Kellison

SGK:bjn
attachment

The following comments are submitted by the Committee on Risk Classification of the American Academy of Actuaries to the Equal Employment Opportunity Commission with respect to the proposed interpretations* of the Equal Pay Act.

The American Academy of Actuaries is the national professional organization representing actuaries in all areas of practice. Its membership currently totals 6,500 individuals, including approximately 90% of the enrolled actuaries** in the United States.

The actuarial profession, as one of its major functions, plays a central role in the design and administration of employee retirement plans. As a result, we believe we have a unique expertise to offer as to the proposed interpretations. The proposed interpretations provide that an employer may not have a retirement plan which differentiates in benefits on the basis of sex. The Academy's Committee on Risk Classification has concluded that, if adopted, these interpretations would have a major economic impact on the sponsors, participants and beneficiaries of retirement plans. Specifically, the impact will far exceed the \$100 million criterion for a major rule under Executive Order 12291. As a result of our analysis and conclusions, we believe the economic consequences of the proposed interpretations should be carefully considered before a decision is reached.

* As published on September 1, 1981 at 46 FR 43848

** Enrolled actuaries are individuals authorized by the federal Joint Board for Enrollment of Actuaries to provide actuarial services for qualified plans under the Employee Retirement Income Security Act of 1974 (ERISA).

The following consequences would result if the interpretation were implemented:

- I. Mandated increases in plan benefits, with women generally benefiting in defined contribution plans and men generally benefiting in defined benefit plans.

- II. Substantial increases in the cost of retirement plans.

- III. Changes in retirement plan design.

- IV. Potential increase in plan terminations, particularly among small plans, resulting in lost benefits and an additional burden on the Pension Benefit Guaranty Corporation.

I. Mandated Increases in Plan Benefits

There are two types of retirement plans - defined contribution and defined benefit plans - each of which must meet appropriate standards of nondiscriminatory treatment. The standard of nondiscriminatory treatment in a defined contribution pension plan is equality of contributions for similarly situated men and women. The standard of nondiscriminatory treatment in a defined benefit plan is equal benefits under the normal benefit form.

Under defined contribution plans, equal amounts are set aside for similarly situated men and women and are accumulated on their behalf. When a participant retires, his/her accumulated contributions are used to provide his/her benefit. If the participant elects (or the plan dictates) a life income

benefit of some kind, the amount of the income payments will vary by sex, because it costs more to provide life income benefits to women than to men. As an example, consider a male and female participant, each of whom retires at age 65 with accumulated contributions of \$100,000. The amounts payable under various options might be*:

<u>FORM OF BENEFIT</u>	<u>MALE EMPLOYEE</u>	<u>FEMALE EMPLOYEE</u>	<u>REQUIRED % INCREASE TO RAISE FEMALES TO MALES</u>
Lump sum	\$100,000	\$100,000	
Life income with no period certain	897/month	786/month	14%
Life income with 10 years certain	819/month	747/month	10
Joint and 50% survivor (spouse) income	760/month	721/month	6

The effect of the proposed interpretations on defined contribution plans would be to require increases in life income benefits for women, relative

* These figures are actuarially equivalent values contained in the 1976 report of a task force of actuaries whom the Equal Employment Opportunity Coordinating Council had asked to estimate the cost impact of an equal-benefits requirement. That report states that the figures are based on the 1971 Group Annuity Mortality Table and 6% interest.

to men. Fewer than one-third of participants in pension plans are covered under defined contribution plans.*

Under defined benefit plans, a normal benefit form is established. Examples of such normal forms are a monthly life income, a monthly income guaranteed for 10 years and life thereafter and a joint and survivor annuity. Similarly situated men and women are entitled to the equal normal form benefit at normal retirement age. For example, a plan might provide all employees with a monthly life income of 50% of final pay, upon retirement at 60 with 20 years of service. Most defined benefit plans offer various optional benefit forms as well as the normal form. The amounts payable under these optional forms are often determined on a basis that results in their having the same actuarial value as the normal form benefit. Therefore, the factor for converting normal form benefits to an optional form are often sex distinct.

<u>FORM OF BENEFIT**</u>	<u>MALE EMPLOYEE</u>	<u>FEMALE EMPLOYEE</u>	<u>REQUIRED % INCREASE TO RAISE MALES TO FEMALES</u>
Life income	\$1,000/month	\$1,000/month	
Life income with 10 years certain	912/month	950/month	4%
Joint and 50% survivor (spouse) income	849/month	918/month	8
Lump sum	111,405	127,160	14

* Preliminary Estimates of Participant and Financial Characteristics of Private Pension Plans, 1977. U.S. Department of Labor, Labor-Management Service, Administration Pension and Welfare Benefit Programs. 1981.

** This table is representative for plans with normal benefits in the form of a life annuity. Many plans have normal benefits in other forms. For those plans, the effect of the proposed rules on males and females would be different. We believe that the life annuity normal form is most common.

Also, defined benefit plans often impose less severe benefit reductions for women than for men when early retirement is elected. This is because beginning payments at a younger age has a proportionately less significant impact on the value of a life income payable to a woman than on the value of a life income payable to a man.

The overall effect of the proposed interpretations on defined benefit plans would be to require increases in optional form benefits for men, relative to women. Over two-thirds of participants in pension plans are covered under defined benefit plans.*

II. Impact on the Cost of Retirement Plans

The proposed interpretations provide that an employer "can come into compliance only by raising the wage rate of the lower paid sex" when a prohibited sex-based wage or benefit differential has been proved. Generally, sponsors of defined contribution plans would be required to increase life income benefits to women, while sponsors of defined benefit plans would generally be required to increase optional benefit and early retirement factors for men. In our May 20, 1981 statement to the House Subcommittee on Commerce, Transportation and Tourism on HR 100, we estimated that the annual cost of achieving a unisex pension system in this way would be \$5.5 billion. An additional \$200 million would be needed to cover the administrative cost

* Preliminary Estimates of Participant and Financial Characteristics of Private Pension Plans, 1977. U. S. Department of Labor, Labor-Management Service, Administration Pension and Welfare Benefit Programs. 1981.

of amending the affected plans. These interpretations cover a wide variety of private and governmental plans. Therefore, the increased costs will be reflected in various combinations of higher prices, higher taxes and curtailment of future benefit increases.

III. Changes in Retirement Plan Designs

The \$5.5 billion estimate of annual increases in plan costs anticipates no changes in the behavior of plan sponsors or participants. In fact, each participant with the opportunity to choose among various benefit forms is likely to choose a form which is clearly advantageous to him/her. Also, sponsors may revise plans to minimize the adverse cost impact of the proposed interpretation and the tendency of participants to choose advantageous options.

Consider a plan which offers an optional lump sum benefit form in addition to a normal life income form. If the lump sum available is determined on a unisex basis, there may be considerable incentive for men to elect the lump sum and purchase a male annuity on the open market. Women, of course, might be wise to elect the life income.

The sponsor of a defined contribution plan can enable male participants to continue to realize higher monthly income benefits than female participants by offering a lump sum option, which can be used to buy an annuity on the open market. Such an arrangement is specifically recognized under Manhart.*

* See Los Angeles Department of Water and Power v. Manhart 435 U.S. 703 (1978) at 718: "Nothing in our holding implies that it would be unlawful for an employer to set aside equal retirement contributions for each employee and let each retiree purchase the largest benefit which his or her accumulated contribution could command in the open market."

The sponsors of a defined benefit plan can avoid or minimize the cost impact of the proposed interpretations by eliminating or curtailing the availability of optional benefit forms and early retirement. The sponsor of either a defined contribution or a defined benefit plan can avoid the costs of unisex benefit factors by offering only lump sums and/or installment payments for a fixed number of months. If these lump sums are used to purchase annuities, the monthly benefit will vary by sex. If annuities are not purchased, the primary purpose of a retirement plan, providing an income for life, will be defeated.

IV. Plan Terminations

The increased costs of the proposed interpretations will add a new financial burden to many existing plans. During the 5 years following enactment of ERISA, over 30,000 plans terminated. Government studies indicate that ERISA's increased paperwork and cost burdens contributed to this level of terminating plans. The combination of these added costs and the availability of new retirement incentives under the Economic Recovery Tax Act of 1981 could encourage the termination of some small plans. A new surge of termination of small plans would reduce benefits paid to participants and might place an additional burden on the Pension Benefit Guaranty Corporation.

STATEMENT 1981-31

STATEMENT OF THE
SUBCOMMITTEE ON ERISA - PENSION COMMITTEE
AMERICAN ACADEMY OF ACTUARIES
RETIREMENT INCOME INCENTIVES AND ADMINISTRATIVE
SIMPLIFICATION ACT OF 1981 (S. 1541)
November 9, 1981
Stephen G. Kellison, Executive Director

I. INTRODUCTION

The Subcommittee on ERISA of the Pension Committee of the American Academy of Actuaries appreciates the opportunity to present this statement on the Retirement Income Incentives and Administrative Simplification Act of 1981 (S. 1541). The Academy is a professional organization of actuaries and consists of members who work daily with ERISA and the private pension system in general. Over 80% of enrolled actuaries under ERISA are members of the Academy. Appendix A provides some background information on the Academy.

The membership of the Academy includes actuaries with a wide range of views on current pension issues. Certain of the more controversial of these issues are not primarily actuarial in nature. Accordingly, this statement is limited to commentary on items which have actuarial implications. The views expressed in this statement are a consensus of the subcommittee that prepared it, and not necessarily the views of all the members of the Academy.

Although this statement will not specifically address itself to several of the proposals contained in this bill, we are supportive of the general thrust of the bill. ERISA was a most complex piece of

legislation which produced implementation problems. In the seven years that have elapsed since its passage, a number of amendments to ERISA that would help achieve its original purposes have been discussed. We believe that this bill, in general, is a highly constructive piece of legislation designed with this worthwhile intent in mind.

We are particularly pleased to see the declaration of policy contained in Section 3(c) of S. 1541 which would add the following to Section 2 of ERISA:

It is hereby further declared to be the policy of this Act to enhance employee retirement income security by establishing a national policy (1) to encourage the establishment and growth of employee benefit plans, and (2) to encourage savings to meet the needs of employees and their families in the event of death, disability, or retirement.

This statement of public policy is vital, and is a most important addition to ERISA.

One of the lessons ERISA has taught us is that efforts to close perceived loopholes and prevent potential abuses also create complexity and extra costs. At some point such efforts, worthy as they may be, become counterproductive if they result in increased plan terminations and decreased new plan formation. Thus, certain complex requirements which do not have major significance for most plans may create more negative than positive results, even though conceptually the requirements appear desirable. In considering simplifications to ERISA Congress should thus evaluate proposals with the balance between benefits and costs clearly in focus.

In accordance with the groundrules for this hearing we are confining our comments to the first five Titles of S. 1541. We do have a special

Subcommittee on PBGC of our Pension Committee which is reviewing Title VI and this Subcommittee may wish to submit additional material on Title VI at a later date.

II. COMMENTARY ON S. 1541

We would like to comment on the following Sections of S. 1541 which we believe touch on areas of significance to the actuarial profession:

- Sec. 1002. Transfers to the Board of Directors of the Employee Benefit Administration.
- Sec. 3101. Exemption for severance pay and supplemental retirement income arrangements.
- Sec. 3202. Opinions of actuaries and accountants; scope of accountant's opinion.
- Sec. 3204. Conformance with current reporting requirements.
- Sec. 3306. Changes in actuarial assumptions.
- Sec. 3309. Clarification and improvement of joint and survivor annuity requirements.
- Sec. 3401. Clarification of funding standard account; improvement of alternative method.
- Sec. 3402. Approval of changes in funding methods or plan years.
- Sec. 3403. Funding to take account of plan provisions providing for future benefit changes.
- Sec. 4306. Changes in actuarial assumptions.
- Sec. 4807. Clarification of benefit limitation for defined benefit plans where retirement income benefit begins after normal retirement age.
- Sec. 4808. Reduction of amortization period to five years in determining amount of past service or other supplementary pension or annuity credits on which deduction for contributions by employers to pension trusts may be based.
- Sec. 4811. Amendment of integration requirements for plan qualification.

Sec. 1002. Transfers to the Board of Directors of the Employee Benefit Administration.

We should like to limit our comment to the redesignation of the Joint Board for the Enrollment of Actuaries as the "Actuary Enrollment Board."

We recommend that the new name be "Pension Actuary Enrollment Board" and that enrolled actuaries be redesignated as "enrolled pension actuaries."

Sections 3041 and 3042 of ERISA created the Joint Board for the Enrollment of Actuaries to enroll actuaries to perform services required of actuaries under the Act. We would like to comment on two unintended developments which have occurred involving "enrolled actuaries" since the passage of ERISA.

The first is the very name "enrolled actuary" itself. Enrollment under ERISA involves rather narrow credentials to perform certain specific functions, such as providing the actuarial statement required by Section 103(d) of ERISA (contained in IRS/DOL Form 5500 Schedule B). The regulations promulgated by the Joint Board to implement Sections 3041 and 3042 have required satisfaction of certain examination and experience standards involving basic actuarial mathematics and pension actuarial topics related to ERISA. However, the Joint Board has not required evidence of education and/or experience in a variety of other areas of actuarial practice not directly related to ERISA.

Unfortunately, since enrollment essentially involves licensing of actuaries by the federal government (albeit licensing in a narrow area to perform only a small number of well-defined functions), "enrolled actuary" status has understandably but mistakenly been interpreted by many non-actuaries as evidence of broader qualifications. This is not to say that many enrolled actuaries do not possess broader credentials as an actuary, since most do. However, nothing involved

in becoming an enrolled actuary is evidence of such broader training and experience per se.

Accordingly, the Academy proposes that the term "enrolled actuary" be changed to "enrolled pension actuary" throughout ERISA. This revised term is much more descriptive of the training and experience inherent in the enrollment process and should lessen the confusion and ambiguity which has occurred.

The second involves the performance of actuarial services for welfare plans (see Section 3(1) of ERISA for a definition of "welfare plan"). Although ERISA affects both welfare plans and pension plans (the latter to a much greater extent), no actuarial statements or reports for welfare plans are required by the Act or subsequent regulations.

The Joint Board requires evidence of both education and experience in pension actuarial matters in order to meet the standards for enrollment. The Joint Board does not require any evidence of either education or experience on welfare plans in order to meet these standards. The Joint Board does not require such evidence in its enrollment regulations, understandably because nothing is required by the government of an actuary on a welfare plan.

This situation involves potential problems of both inclusion and exclusion. On the one hand, the designation "enrolled actuary" does not provide any assurance that the individual in question has competence to perform actuarial services on welfare plans. On the other hand, a number of actuaries that are not enrolled because of lack of education

or experience in pension matters may be highly qualified to perform services on welfare plans. Certain problems may arise from this anomaly, since the users of actuarial services are often not aware of these subtleties. For example, cases have been called to the attention of the Academy in which auditors do not rely on the work of an actuary on a welfare plan unless the actuary is enrolled.

The confusion in this area has arisen from the language in Section 3042(a):

"The Joint Board shall, by regulations, establish reasonable standards and qualifications for persons performing actuarial services with respect to plans to which this Act applies . . ."

(emphasis added)

We wish to propose an amendment to clarify that enrollment involves only pension plans and not welfare plans. This proposal is quite compatible with the first proposal to change the term "enrolled actuary" to "enrolled pension actuary."

Appendix B contains proposed amendments to implement these two clarifications.

Sec. 3101. Exemption for severance pay and supplemental retirement income arrangements.

We would like to comment on the exemption from the funding standards of pension plans of cost-of-living supplements paid out of the general assets of an employer.

The purpose of the proposed exemption is to permit employers to pay pension supplements to offset inflation without also evading the funding standards of ERISA applicable to pension plans. We would like to point out that pay-as-you-go funding under a welfare plan may

represent a stronger funding program than is required under ERISA for a pension plan. A plan may be amended to provide an "ad hoc" pension supplement payable for life, e.g., \$100 monthly. The present value for a participant aged 65 using PBGC annuity rates at 10% interest is \$8,557. ERISA permits funding this over 10 to 30 years. The annual amortization payments (payable in monthly installments) are \$1,322 for 10 years and \$862 for 30 years. The pay-as-you-go welfare contribution of \$1,200 (12 months x \$100) is stronger than the 30-year amortization and only marginally lower than the 10-year amortization. Further, ERISA permits adopting an "ad hoc" supplement promised for only one year. Assuming that the tax deduction is to be taken under Section 404(a), then the \$1,200 one-year supplement must be amortized over no fewer than 10 years at the rate of only \$177 per year. Consequently, ERISA permits a much weaker funding program for a pension plan than for a welfare plan which pays the entire supplement (\$1,200) each year.

Both ERISA's present requirements and the proposed exemption permit plan sponsors to systematically make ad hoc increases each year, in effect providing automatic cost-of-living increases while avoiding prefunding these increases over the active working lifetime of employees. Further, no protection of these supplements is provided at plan termination since assets, if available, are allocated only to promised future benefits. Further, PBGC guarantees do not apply to welfare plan supplements.

Consequently, the desirability of the proposed exemption depends on the relative value placed upon the desirability of prefunding promised benefits as generally required under ERISA versus encouraging

increased participation of the private pension sector in providing cost-of-living supplements. An important consideration in this regard is that only a very small percentage of private plans presently provide automatic cost-of-living supplementation, although many plans, especially the larger ones, do provide "ad hoc" supplements.

Sec. 3202. Opinions of actuaries and accountants; scope of accountant's opinion.

Section 3202 of S. 1541 would make some fundamental changes in the relative roles of actuaries and accountants in connection with annual reports for plans and we strongly endorse this section of the bill. ERISA currently provides that the accountant may (emphasis added) rely on the work of the actuary, and conversely. S. 1541 would change "may" to "shall," which would provide for compulsory reliance (in both directions, i.e., reliance on actuaries by accountants, and conversely).

Section 103 of ERISA appears to create a division of responsibility between actuaries and accountants. The actuarial statement required by Section 103(d) is concerned with such items as the determination of plan liabilities for future benefit payments and the various computations required to determine whether the plan complies with minimum funding requirements. The financial statement prepared by the accountant pursuant to Section 103(b) is concerned with a proper presentation of the financial status of the pension fund itself.

A problem may arise if the actuarial liabilities are included within the scope of the auditor's opinion. This creates a potential for friction between the auditor and the enrolled actuary. If the auditor chooses to challenge the work of the enrolled actuary, an impasse may

result. The enrolled actuary cannot change his/her results, since he/she has already certified them to the federal government as his/her "best estimate of anticipated experience under the plan." Such an impasse, if it developed, would be most unfortunate for plan sponsors, plan participants, and all others concerned.

The provisions of S. 1541 to require reliance by each profession on the work of the other in their respective defined areas of practice and expertise would be quite beneficial in resolving such potential difficulties.

As indicated at the outset, we strongly endorse Section 3202 of S. 1541. We also feel that some additional amendments should be made to further clarify the relative roles of the two professions. These amendments are consistent with the division of responsibility between the two professions which we believe was contemplated by ERISA. These amendments are submitted for the consideration of the Committee in Appendix C. These amendments, coupled with Section 3202 of S. 1541 should resolve the differences which have arisen in this area.

Sec. 3204. Conformance with current reporting requirements.

This Section amends ERISA Section 103(d) by eliminating 103(d)(6), the requirement for an actuarial statement to include the present value of benefits in termination priority categories according to Section 4044 of ERISA. This would legislate the permanent removal of this requirement which is currently waived by Department of Labor regulations Section 2520.104-42. We support this provision because it permanently reduces the actuarial and administrative expenses of pension plans that would arise if the Department of Labor waiver were

removed. Information as to the value of accrued pensions will still be supplied in Schedule B on an optional basis for plans under 100 lives and on a mandatory basis for plans of 100 or more lives.

Secs. 3306, 3309, 4306. Changes in actuarial assumptions. Clarification and improvement of joint and survivor annuity requirements.

These sections provide, through the addition of ERISA Section 204(i), that a change in actuarial assumptions used to calculate actuarially equivalent benefits will not be deemed a decrease in benefits if the actuarial assumptions are set forth in a "separate document" available to plan participants. Further they provide that the calculation of death benefits actuarially equivalent to a qualified joint and survivor annuity must be made on the basis of actuarial assumptions in the "separate document" referenced in Section 204(i). The IRC is amended to provide that a plan and trust are to remain qualified if an accrued benefit is altered (reduced) solely by reason of a change in actuarial assumptions set forth in the "separate document" referred to in Section 204(i).

These sections overrule IRS Revenue Ruling 79-90 which requires that the actuarial equivalent basis be specified in the plan document such that a change in the basis may require a plan amendment. If this plan amendment leads to a reduction in an accrued benefit it may disqualify the plan. These sections will now provide that a reduction in benefits due solely to a change in actuarial assumptions is permissible and thus facilitate changes necessary to reflect current conditions.

We support these sections as consistent with the concept of actuarial equivalence. If changing circumstances of mortality and interest

indicate that revised factors are needed to maintain actuarial equivalence on a realistic basis, this should not be regarded as a decrease in benefits. However, we recommend that the word "separate" be deleted, since a change in assumptions set forth in the plan document should also not be deemed a decrease in benefits. These sections should permit the actuarial assumptions to be contained in the plan document or a separate document since both approaches are commonly used.

Sec. 3401(1). Clarification of funding standard account; improvement of alternative method.

This section clarifies that changes in actuarial liabilities due to changes in actuarial cost methods are to be amortized the same as gains or losses arising from changes in assumptions. We support this change because changes in methods have a similar effect to changes in assumptions.

Presently, IRS Revenue Prodecures 80-50 and 81-29 require a longer amortization period for decreases in actuarial liabilities due to a change in actuarial cost method than for increases. These Revenue Procedures do serve to strengthen funding requirements, but only marginally. The requirements are difficult to explain to plan sponsors. We believe that equal treatment of increases and decreases in actuarial liabilities resulting from a change in method will enhance the actuary's ability to make appropriate changes in actuarial cost methods as needed.

Sec. 3401(2). Clarification of funding standard account; improvement of alternative method.

This section provides that on a switchback from the alternative

funding standard, the deficiency would be amortized over 30 years rather than five years. The purpose of this liberalization presumably is to facilitate adoption of plan improvements. Many actuaries would agree that the present five-year period is unduly harsh. However, many actuaries might also think that 30 years is too liberal an amortization period compared to the 15-year period allowed to amortize a funding waiver. Perhaps a reasonable compromise might be to allow 15 years instead of 30 -- the same as for a funding waiver.

Sec. 3402. Approval of changes in funding methods or plan years.

This section would require IRS approval for a change in actuarial cost method only if more than one change is made in a three-year period.

We support this change. The allowable actuarial cost methods are specified in ERISA and regulations. The actuary is free to select any of them at the outset. The enrolled actuary, engaged on behalf of plan participants, must certify on Schedule B that the actuarial method and assumptions used are reasonable and must justify any change in the actuarial cost method. All of this is adequate protection to plan participants. The present rule results in unnecessary actuarial work and fees, and may discourage the actuary from making desirable changes.

Sec. 3403. Funding to take account of plan provisions providing for future benefit changes.

This section would require the actuary to take into account all provisions of the plan, including those which have not yet affected any participant as to entitlement to, or accrual of, benefits. This section also specifically authorizes anticipation of increases in the

maximum plan benefit allowed under IRC Section 415(b)(1). The actuary may also choose not to take account of scheduled benefit increases if he/she so discloses.

We support these changes because they will enable the actuary to reflect all relevant plan provisions in providing his/her "best estimate of anticipated experience under the plan."

Present IRS regulations require treating each increase in the Section 415 maximum as a plan amendment and thus cannot be prefunded. This prevents the actuary from making his best estimate reflecting anticipated future increases and prefunding them.

The proviso that the actuary need not take account of scheduled benefit increases if he/she so discloses will be most helpful in avoiding year-to-year plan amendments in collectively bargained plans which typically have scheduled benefit increases such as \$10-11-12 over a three-year period. The actuary would now be able to recognize for funding purposes the \$12 benefit beginning in the first year or; alternatively, \$10 the first year, \$11 the second year and \$12 the third year. The interests of plan participants are not harmed by the latter approach because it could be accomplished by three separate amendments anyway, by following present IRS stipulations.

Sec. 4807. Clarification of benefit limitation for defined benefit plans where retirement income benefit begins after normal retirement age.

This section would increase the maximum benefit limitation of 100% of high three-year average compensation to the actuarial equivalent of the benefit that would have been payable at normal retirement if the

participant defers retirement. ERISA presently does not provide such actuarial increase which would have the effect of increasing the maximum benefit in certain situations (such as late retirement). We express no opinion as to the desirability of so increasing the maximum benefit. We do wish to point out the possible actuarial consequences. The present maximum is independent of age as long as the actual retirement age is 55 or greater. For a plan with a retirement age of 55, actuarial equivalence for deferred retirement to age 65 can be as high as 300% with an interest assumption reflecting present high interest rates. A possible modification would be to relate actuarial equivalence to the later of age 65 or the plan's normal retirement age. The age 65 requirement could be tied to any changes in the earliest age for full pension in the Social Security system (there are currently proposals to increase age 65 to age 68). Even so, fairly large actuarial increases up to the dollar limit in the law would be available, but to a smaller population of participants deferring retirement after age 65.

Sec. 4808. Reduction of amortization period to five years in determining amount of past service or other supplementary pension or annuity credits on which deduction for contributions by employers to pension trusts may be based.

This section amends IRC Section 404(a)(1)(A)(iii) to allow a five-year amortization of past service bases rather than the current ten-year provision. We support this change because it may enhance the benefit security of plan participants by permitting a more rapid funding program (a quicker amortization of actuarial liabilities). The only opposing consideration is a temporary reduction in tax revenues but this would be recouped sooner in future years (five years rather than ten) when deductible past service payments have been completed.

Sec. 4811. Amendment of integration requirements for plan qualification.

This section would revise integration rules for offset plans and instructs the Secretary of Treasury to write similar rules for excess plans and for defined contribution plans.

Current integration rules are quite complex and some simplification would be desirable. Also, they are outdated in certain respects, e.g., they fail to recognize the 1977 amendments to the Social Security Act. Finally, in some ways they are inequitable, e.g., the failure to prorate the offset percentage for employees hired at older ages. Thus, we concur that changes to the current rules, either by legislation or by regulation, are in order.

Section 4811 may be interpreted to provide for testing a plan's integration each year based upon plan data rather than testing only the benefit formula at the outset of the plan. It needs to be clarified that the rules apply to the benefit formula, in order to prevent the administrative burden and cost of detailed individual benefit calculations.

Any provision that would require plan amendments for many plans needs to consider transition rules or allow an extended period for existing plans to adjust. The initial effective date should be at least six months after final regulations are adopted, since otherwise plans would not know how to comply, particularly excess plans and defined contribution plans.

There has been extensive investigation including new literature within the actuarial profession on the integration issue in recent years.

In addition, the Academy has another subcommittee specifically studying this issue. We would like to reserve the right to submit additional material on this important subject to the Committee as it becomes available.

III. SUMMARY AND CONCLUSIONS

In summary, we commend the intention of S. 1541 to resolve the difficulties created by ERISA. Many of the proposals in this bill are highly constructive in this regard. The comments presented in our statement are being offered in the same constructive spirit.

The Academy appreciates the opportunity to appear at these hearings. Actuaries have a vital interest in the development of amendments to ERISA and the Academy has a continued interest in this area. Representatives of the Academy are available to meet with the Committee or staff at your convenience to discuss these, or other, proposals in more detail.

Douglas C. Borton, Chairman
Pension Committee

Subcommittee on ERISA
Gerald Richmond, Chairman
William J. Callnan
Willard A. Hartman
Myron Hochheiser
Allan B. Keith
Diane K. Plank
Ross J. Wilson

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- A. Background Information on the American Academy of Actuaries
- B. Proposed Amendment Involving "Enrolled Actuaries"
- C. Proposed Amendment on Opinions of Actuaries and Accountants

APPENDIX ABACKGROUND INFORMATION ON THE
AMERICAN ACADEMY OF ACTUARIES

The American Academy of Actuaries is a professional organization 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. It includes members of three founding organizations -- the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

Requirements to become a member of the Academy can be summarized under two broad headings: (1) education and (2) experience. At the present time, the education requirements for membership can be satisfied by passing certain professional examinations given either by the Casualty Actuarial Society or the Society of Actuaries or by becoming an "enrolled actuary" under the Employee Retirement Income Security Act of 1974 (ERISA). The experience requirement consists of three years of responsible actuarial work.

As of the end of 1980, the Academy membership exceeded 6,200. The Academy is unique as the national actuarial organization for actuaries in all areas of specialization. These actuaries have a variety of types of employment, including insurance organizations, consulting firms, academic institutions, and government. A large majority of those individuals who have satisfied the education and experience requirements of the Academy have, in fact, joined the Academy.

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, liaison with other professions, and public relations.

APPENDIX B

PROPOSED AMENDMENT INVOLVING "ENROLLED ACTUARIES"

Sec. 3042(a)

The Joint Board Pension Actuary Enrollment Board (hereinafter referred to as the "Board") shall, by regulations, establish reasonable standards and qualifications for persons performing actuarial services with respect to pension plans to which this Act applies and, upon application by any individual, shall enroll such individual if the Joint Board finds that such individual satisfies such standards and qualifications. The term "enrolled pension actuary" means an actuary thus enrolled. With respect to individuals applying for enrollment before January 1, 1976, such standards and qualifications shall include a requirement for an appropriate period of responsible actuarial experience relating to pension plans. With respect to individuals applying for enrollment on or after January 1, 1976, such standards and qualifications shall include --

- (1) education and training in actuarial mathematics and methodology, as evidenced by --
 - (A) a degree in actuarial mathematics or its equivalent from an accredited college or university,
 - (B) successful completion of an examination in actuarial mathematics and methodology to be given by the Joint Board, or
 - (C) successful completion of other actuarial examinations deemed adequate by the Joint Board, and
- (2) an appropriate period of responsible actuarial experience.

Notwithstanding the preceding provisions of this subsection, the Joint Board may provide for the temporary enrollment for the period ending on January 1, 1976, of actuaries under such interim standards as it deems adequate.

Sec. 3042(b)

The Joint Board may, after notice and an opportunity for a hearing, suspend or terminate the enrollment of an individual under this section if the Joint Board finds that such individual --

- (1) has failed to discharge his duties under this Act, or
- (2) does not satisfy the requirements for enrollment as in effect at the time of his enrollment.

The Joint Board may also, after notice and opportunity for hearing, suspend or terminate the temporary enrollment of an individual who fails to discharge his duties under this Act or who does not satisfy the interim enrollment standards.

Conforming Amendments

All references to "enrolled actuary" in ERISA and the IRC are changed to "enrolled pension actuary." This would include redesignating present "enrolled actuaries" as "enrolled pension actuaries."

APPENDIX CPROPOSED AMENDMENT ON OPINIONS OF
ACTUARIES AND ACCOUNTANTS

Sec. 103(a)(3)(A) Except as provided in subparagraph (C), the administrator of an employee benefit plan shall engage, on behalf of all plan participants, an independent qualified public accountant, who shall conduct such an examination of any financial statements of the plan fund, and of other books and records of the plan, as the accountant may deem necessary to enable the accountant to form an opinion as to whether the financial statements of the fund and related and schedules required to be included in the annual report by subsection (b) of this section are presented fairly in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year. Such examination shall be conducted in accordance with generally accepted auditing standards, [except to the extent required by subparagraph (B),] and shall involve such tests of the books and records of the plan fund as are considered necessary by the independent qualified public accountant. The independent qualified public accountant shall also offer his opinion as to whether the separate schedules specified in subsection (b)(3) of this section and the summary material required under section 104(b)(3) present fairly, and in all material respects the information contained in the annual report therein when considered in conjunction with the financial statements taken as a whole. The opinion by the independent qualified public accountant shall be made a part of the annual report. In a case where a plan is not required to file an annual report, the requirements of this paragraph shall not apply. In a case where by reason of section 104(a)(2) a plan is required only to file a simplified annual report, the Secretary may waive the requirements of this paragraph.

Sec. 103(a)(3)(B) In offering his opinion under this section the accountant [may shall] rely on the correctness of any actuarial matter certified to by an enrolled actuary [, if he so states his reliance]. The opinion of the accountant under this section is limited to the status and operations in respect to the assets of the fund and excludes actuarial matters certified to by the enrolled actuary. "Actuarial matters" may be further defined by regulation by the Secretary and shall include, with respect to a pension benefit plan, the items required to be included in the actuarial statement under paragraphs (3) through (12) of subsection (d) of this section.

Sec. 103(a)(4)(D)

In making a certification under this section the enrolled actuary [~~may shall~~] rely on the correctness of any accounting matter under section 103(b) as to which any qualified public accountant has expressed an opinion [~~if he so states his reference~~].

Sec. 103(b)

An annual report under this section shall include a financial statement containing the following information:

- (1) With respect to an employee welfare benefit plan: a statement of assets and non-actuarial liabilities of the fund; a statement of changes in fund balance; and a statement of changes in financial position. In the notes to financial statements, disclosures concerning the following items shall be considered by the accountant: a description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of the plan fund.
- (2) With respect to an employee pension benefit plan: a statement of assets and non-actuarial liabilities of the fund; and a statement of changes in net assets available for plan benefits which shall include details of revenues and expenses and other changes aggregated by general source and application. In the notes to financial statements, disclosures concerning the following items shall be considered by the accountant: a description of the plan including any significant changes in the plan made during the period and the impact of such changes on benefits; the funding policy (including policy with respect to prior service cost), and any changes in such policies during the year; a description of any significant changes in plan benefits made during the period; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of such pension plan fund.

(3) With respect to all employee benefit plans funds, the statement required under paragraph (1) or (2) shall have attached the following information in separate schedules:

(A) a statement of the assets and non-actuarial liabilities of the plan fund aggregated by categories and valued at their current value, and the same data displayed in comparative form for the end of the previous fiscal year of the plan; ----

Note: Amendments contained in brackets are those contained in S. 1541.
All other amendments are proposed by the American Academy of Actuaries.

STATEMENT 1981-32

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. . SUITE 515 . WASHINGTON, D.C. 20006 . (202) 223-8196

November 9, 1981

Chairman, Accident & Health (B) Committee
Commissioner J. Michael Low
Arizona Insurance Department
1601 West Jefferson
Phoenix, AZ 85007

RE: Your New Orleans Meeting Agenda
Blue Cross & Blue Shield/HMO Statement of Actuarial Opinion

Dear Commissioner Low:

We believe your Committee will want to consider whether or not to adopt the recommendation that "A statement of opinion from a qualified actuary should be required in connection with the statutory financial statements filed by Corporations."

A copy of such an opinion is enclosed for your convenience.

Commissioner, we've talked about this subject before and in fact a copy of the draft of the opinion was sent to you on October 20. However, in view of our recent conversation I understand you would like some background concerning this and we are glad to supply it.

As you mentioned in one of our conversations, over the last few years there has been considerable study and discussion of various matters concerning Blue Cross/Blue Shield organizations and HMO's. The possibility of a statement of actuarial opinion was raised at least as early as 1980 by the NAIC. We understand this was raised by some states and the ex-C(4) Life, Accident and Health Insurance Technical Subcommittee. The Blue Cross/Blue Shields plans were naturally interested. One of the results of these developments was the formation of a "technical advisory committee on hospital and medical service corporations" by the industry. This industry committee submitted a report to the ex-C(4) Subcommittee on January 27. (A copy of this report is either enclosed or is being mailed to you under separate cover.) A copy of the recommendations contained on page 40 is attached. The first paragraph of the recommendations quoted above relates to an actuarial opinion.

The NAIC immediately asked the Academy to develop a draft of wording of a statement of actuarial opinion for its consideration. The request was made that work proceed on such an opinion for the NAIC's consideration with regard to whether or not the entire report of the industry committee was adopted.

We believe this approach is viable and hence understand you may well want to consider the matter of this opinion without regard to whether or not the whole report of the industry advisory committee has been or will be adopted. (Incidentally, I understand the industry people who worked on this report are trying to determine whether or not it has already been adopted by the NAIC and if it has not will submit it to you for consideration at your New Orleans meeting.)

Commissioner J. Michael Low
November 9, 1981

Commissioner, there is a second matter of considerable importance very closely related to this statement of actuarial opinion. The NAIC and industry were naturally concerned whether or not there is a sufficient supply of actuarial expertise to meet the needs required by such a statement of actuarial opinion and some of the other activities going forward in this area. At the request of the NAIC and the Blue Cross/Blue Shield organizations, which requests were made at least as early as 1980, the Academy undertook extensive investigation into the qualification of health insurance actuaries. A subcommittee of the Committee of Health Insurance of the American Academy of Actuaries was specifically formed for this purpose and later its stature increased to that of a full committee. That committee submitted to the Board of the Academy an extensive proposal for identifying people who are not members of the American Academy of Actuaries but do possess the qualifications needed to perform certain actuarial services for these corporations. To identify such people the Academy has undertaken to construct a whole new examination syllabus and develop a unique set of qualification criteria to recognize such people. Based on that earlier request of the NAIC and industry the Academy plans to use the qualification procedures just mentioned to identify people who are not members of the Academy who can perform these services for industry and the NAIC and certify the Academy's recognition of these qualifications to the NAIC, industry and other publics. This work is virtually completed. The syllabus for the examination is complete and the procedures are almost finished for administering the exams and considering the experience requirements of the individuals. The Academy has worked closely with industry and regulators in developing this program.

This material is being submitted to your committee since a subcommittee (namely the C(4)) of the predecessor committee asked that the statement of opinion be prepared. We understand the Blanks Committee may also be interested and therefore I am taking the liberty of sending a copy of this material to Commissioner Neff who chairs the Blanks Task Force of the Financial Condition (EX4) Subcommittee for his information.

I hope the above gives you the background you would like to have. If you need more information please let me or Paul Barnhart know and we will be glad to help you.

In brief, the attached draft of a statement of actuarial opinion has been prepared at the request of the NAIC so that it may be incorporated with an adoption of industry's recommendation that "A statement of opinion from a qualified actuary should be required in connection with the statutory financial statements filed by Corporations."

Sincerely,

W. H. Odell, FSA, MAAA
Chairman, Committee on Health Insurance

WHO/dw

cc: Commissioner John C. Neff

8. The effects of governmental intervention in the health care system, both federal and state, create an environment indicating that some conservatism is appropriate in determining optimum contingency reserve levels. This is especially true where the Corporation enjoys substantial preferential treatment in their relationships with providers. That is, the risk of loss of a discount or other preferential treatment should be provided for.

RECOMMENDATIONS

1. A statement of opinion from a qualified actuary should be required in connection with the statutory financial statements filed by Corporations. This statement should relate to the liability for unpaid claims, provision for experience rating refunds, and any other actuarial items appropriate for the financial statement.
2. A rate filing including an actuarial certification, as well as budget and other financial projections, should be required when a Corporation's contingency reserves fall outside of an acceptable range defined for the particular Corporation.
3. The convention blanks required for Corporations should be revised to improve the consistency of reporting requirements for insurance companies, Blue Cross and Blue Shield Plans, and health maintenance organizations.
4. Consistent accounting practices should be encouraged with regard to such items as the assignment of incurred dates to claims, rate stabilization and other refund and special reserves, and assets and liabilities arising from alternate financial arrangements with accounts.
5. The exposure of Corporation contingency reserves to unanticipated risks resulting from state guaranty funds for insurance carriers should be considered.

Draft of Instruction for Statement of Qualified Actuary
with respect to Statutory Financial
Statements of Hospital, Medical and Dental Service Corporations

- 9: (1) There is to be included on or attached to Page 1 of the annual statement the statement of a qualified health service corporation actuary setting forth his or her opinion relating to loss reserves, provision for experience rating refunds, and any other actuarial items. "Qualified health service corporation actuary", as used herein means a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation, or a person who otherwise has demonstrated his competency in such actuarial evaluation to the satisfaction of the commissioner.
- (2) Such a statement of opinion must consist of a paragraph identifying the actuary; a scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the actuary's work (see sections 5-7 below); and an opinion paragraph expressing his or her opinion with respect to such subjects (see sections 8-10 below). One or more additional paragraphs may be needed in individual cases if the actuary considers it necessary to state a qualification of his or her opinion or to explain some aspect of the annual statement which is not already sufficiently explained in the annual statement.
- (3) The opening paragraph should generally indicate the actuary's relationship to the corporation.

For a corporation actuary the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title of actuary), am an officer (employee) of (named corporation) and a member of the American Academy of Actuaries."

For a consulting actuary, the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of corporation) with regard to loss reserves, actuarial liabilities and related items."

For a person other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title), am an officer (employee) of (name of corporation), and I [have competency in actuarial valuations for corporations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for corporations of this kind]

or

"I, (name and title of consultant), am associated with the firm of (name of firm). I [have competency in actuarial valuations for corporations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for corporations of this kind] and have been retained by the (name of corporation) with regard to such valuation."

- (4) The following are examples, for illustrative purposes, of language which in typical circumstances would be included in the remainder of the statement of opinion. The illustrative language should be modified as needed to meet the circumstances of a particular case, and the actuary should in any case use language which clearly expresses his or her professional judgment.

- (5) The scope paragraph should contain a sentence such as the following:

"I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the annual statement of the corporation as prepared for filing with state regulatory officials, as of December 31, 19__."

The paragraph should list those items and amounts with respect to which the actuary is expressing an opinion. The list should include but not necessarily be limited to

- (i) Claims Unpaid (Page 3, Item 1)
 - (ii) Provision for deferred maternity benefits (Page 3, Item 2)
 - (iii) Provision for experience rating refunds (Page 3, Item 9A)
 - (iv) Other liabilities (Page 3, Item 10)
(opinion, under this Item, with respect to actuarial liabilities, if any)
 - (v) Premium items, such as receivables, due and unpaid, unearned, and paid in advance as they may relate to actuarial items
- (6) If the actuary has examined the underlying records and/or summaries, the scope paragraph should also include a sentence such as the following:

"My examination included such review of the assumptions and methods used and of the underlying basic records and/or summaries and such tests and calculations as I considered necessary."

- (7) If the actuary has not examined the underlying records and/or summaries, but has relied upon those prepared by the corporation, the scope paragraph should include a sentence such as one of the following:

- (i) "I relied upon underlying records and/or summaries prepared by the responsible officers or employees of the corporation. In other respects, my examination included such review of the assumptions and methods used and such tests of the calculations as I considered necessary."

- (ii) "I relied upon (name of firm) for the accuracy of the underlying records and/or summaries. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary."
- (8) The opinion paragraph should include a sentence which covers at least the points listed in the following illustration:

"In my opinion, the amounts carried in the balance sheet on account of the items identified above

- (i) are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,
 - (ii) are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Statement was prepared,
 - (iii) meet the requirements of the laws of (state of domicile),
 - (iv) make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the corporation under the terms of its contracts and agreements,
 - (v) are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding yearend,
 - (vi) include appropriate provision for all actuarial items which ought to be established."
- (9) If there has been any material change in the assumptions and/or methods from those previously employed, that change should be described in the statement of opinion by inserting a phrase such as:

"A material change in assumptions (and/or methods) was made during the past year but such change accords with accepted actuarial standards." A brief description of the change should follow.

The adoption of new coverages requiring underlying assumptions which differ from assumptions used for prior coverages is not a change in assumption within the meaning of this paragraph.

- (10) If the actuary is unable to form an opinion, he or she should refuse to issue a statement of opinion. If the opinion is adverse or qualified, the actuary should issue an adverse or qualified opinion explicitly stating the reason(s) for such opinion.
- (11) If the actuary does not express an opinion as to the accuracy and completeness of underlying listings or summaries used in his evaluation,

there should be included on or attached to Page 1 of the statement blank the statement of a corporation officer or accounting firm who prepared such underlying data similar to the following:

"I (name of officer of corporation), (title of officer), of (name of corporation and address of corporation), (or accounting firm), hereby affirm that the listings and summaries of data prepared for and submitted to (name of actuary) were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete.

Signature

Draft of Instruction for Statement of Qualified Actuary
with respect to Statutory Financial
Statements of Health Maintenance Organizations

9. (1) There is to be included on or attached to Page 1 of the annual statement the statement of a qualified health maintenance organization actuary setting forth his or her opinion relating to loss reserves, provision for experience rating refunds, and any other actuarial items. "Qualified health maintenance organization actuary", as used herein means a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation, or a person who otherwise has demonstrated his competency in such actuarial evaluation to the satisfaction of the commissioner.
- (2) Such a statement of opinion must consist of a paragraph identifying the actuary; a scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the actuary's work (see sections 5-7 below); and an opinion paragraph expressing his or her opinion with respect to such subjects (see sections 8-10 below). One or more additional paragraphs may be needed in individual cases if the actuary considers it necessary to state a qualification of his or her opinion or to explain some aspect of the annual statement which is not already sufficiently explained in the annual statement.
- (3) The opening paragraph should generally indicate the actuary's relationship to the organization.

For an actuary who is an employee of the organization the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title of actuary), am an officer (employee) of (named organization) and a member of the American Academy of Actuaries."

For a consulting actuary, the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) with regard to loss reserves, actuarial liabilities and related items."

For a person other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain a sentence such as:

"I, (name and title), am an officer (employee) of (name of organization), and I [have competency in actuarial valuations for organizations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind]

or

"I, (name and title of consultant), am associated with the firm of (name of firm). I [have competency in actuarial valuations for organizations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind] and have been retained by the (name of organization) with regard to such valuation."

- (4) The following are examples, for illustrative purposes, of language which in typical circumstances would be included in the remainder of the statement of opinion. The illustrative language should be modified as needed to meet the circumstances of a particular case, and the actuary should in any case use language which clearly expresses his or her professional judgment.

- (5) The scope paragraph should contain a sentence such as the following:

"I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 19__."

The paragraph should list those items and amounts with respect to which the actuary is expressing an opinion. The list should include but not necessarily be limited to

- (i) Claims Unpaid (Reported and Unreported)
 - (ii) Provision for deferred maternity benefits, if any.
 - (iii) Other actuarial liabilities
 - (iv) Dues items, such as receivables, due and unpaid, unearned, and paid in advance as they may relate to actuarial items
- (6) If the actuary has examined the underlying records and/or summaries, the scope paragraph should also include a sentence such as the following:

"My examination included such review of the assumptions and methods used and of the underlying basic records and/or summaries and such tests and calculations as I considered necessary."

- (7) If the actuary has not examined the underlying records and/or summaries, but has relied upon those prepared by the organization, the scope paragraph should include a sentence such as one of the following:

- (i) "I relied upon underlying records and/or summaries prepared by the responsible officers or employees of the organization. In other respects, my examination included such review of the assumptions and methods used and such tests of the calculations as I considered necessary."
- (ii) "I relied upon (name of firm) for the accuracy of the underlying records and/or summaries. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary."

- (8) The opinion paragraph should include a sentence which covers at least the points listed in the following illustration:

"In my opinion, the amounts carried in the balance sheet on account of the items identified above

- (i) are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,
 - (ii) are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Statement was prepared,
 - (iii) meet the requirements of the laws of (state of domicile),
 - (iv) make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements,
 - (v) are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding yearend,
 - (vi) include appropriate provision for all actuarial items which ought to be established."
- (9) If there has been any material change in the assumptions and/or methods from those previously employed, that change should be described in the statement of opinion by inserting a phrase such as:

"A material change in assumptions (and/or methods) was made during the past year but such change accords with accepted actuarial standards." A brief description of the change should follow.

The adoption of new coverages requiring underlying assumptions which differ from assumptions used for prior coverages is not a change in assumption within the meaning of this paragraph.

- (10) If the actuary is unable to form an opinion, he or she should refuse to issue a statement of opinion. If the opinion is adverse or qualified, the actuary should issue an adverse or qualified opinion explicitly stating the reason(s) for such opinion.
- (11) If the actuary does not express an opinion as to the accuracy and completeness of underlying listings or summaries used in his evaluation, there should be included on or attached to Page 1 of the statement blank the statement of an organization officer or accounting firm who prepared such underlying data similar to the following:

"I (name of officer of organization), (title of officer), of (name of organization and address of organization), (or accounting firm), hereby affirm that the listings and summaries of data prepared for and submitted to (name of actuary) were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete.

Signature

STATEMENT 1981-33

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

STEPHEN G. KELLISON, M.A.A.A.
EXECUTIVE DIRECTOR

November 13, 1981

Dear Commissioner:

On September 25, 1981, the Product Liability Risk Retention Act of 1981 (P.L. 97-45) was signed into law by President Reagan. In brief, the law permits certain commercial operations to create risk retention groups for the purpose of insuring their product liability exposure.

As you may know, one of the key issues debated during consideration of the bill related to the ongoing solvency of the risk retention groups. Although the Academy did not take a position on the bill, when it became apparent it would become law we did suggest careful consideration of the solvency question. As a result, both the relevant House and Senate Committee Reports recognize that among the information the commissioner of the licensing or chartering state may require from the risk retention group is a statement of actuarial opinion on the adequacy of loss reserves.

As stated in the relevant committee reports (Senate Report No. 97-172, p. 11 and House Report 97-190, p. 13) any chartering state may require "a statement of actuarial opinion...regarding the adequacy of a group's capital and surplus." We recognize this is less than a complete solution to the entire solvency question, nonetheless it does provide the regulator with one additional tool.

We hope this information will be of use to you as you commence regulation of the risk retention groups. As you know, the NAIC Fire and Casualty Annual Statement Blank contains a provision for a statement of actuarial opinion as to casualty loss reserves. Although this requirement has not as yet been adopted by all of the states, it does provide a format that you may wish to consider in connection with the risk retention groups.

If we can provide more specific information as to the related actuarial opinion, do not hesitate to call.

Yours very truly,

Stephen G. Kellison

SGK:cal

STATEMENT 1981-34

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

STEPHEN G. KELLISON, M.A.A.A.
EXECUTIVE DIRECTOR

November 30, 1981

Mr. George A. Fitzsimmons, Secretary
Securities and Exchange Commission
500 North Capitol Street
Washington, D.C. 20549

RE: Proposal to rescind Item 8(g) of proxy rules

Dear Mr. Fitzsimmons:

Pursuant to the notice in the Federal Register on August 27, 1981, this letter is offered by the American Academy of Actuaries as a comment on the question of whether the Securities and Exchange Commission should withdraw Item 8(g) of the proxy rules. This item was originally promulgated as Accounting Series Release No. 250 on June 29, 1978. We request that both this letter and our prior letter to Chairman Shad dated August 21, 1981 from Academy President Walter L. Grace be considered in your deliberations on the withdrawal of both ASR 250 and ASR 264.

By way of background, Item 8(g) requires any SEC reporting company to describe in its proxy materials the following: (1) each nonaudit service provided to the company; (2) the percentage relationship that the fee for that service bears to the fee for audit services; (3) the percentage relationship that the total fee for nonaudit services bears to the fee for audit services; and (4) whether the Board of Directors or its audit committee has approved the provision of each nonaudit service by the auditor after consideration of its possible effect on the auditor's independence.

As you know, the Academy has been an active participant in the Commission's efforts, which culminated in ASR 250 and 264, to define how the independence of an accounting firm is affected by the provision of management advisory services to its audit clients. The Academy has a keen interest in this issue because actuarial services are one of the principal nonaudit services offered by accounting firms. When these services are rendered to audit clients, a question as to the independence of the auditor is raised that affects not only the accounting firm itself but also those actuaries that are employed by it -- actuaries who are, most often, Academy members.

The Academy is opposed to the withdrawal of ASR 250, as well as ASR 264 which has already been withdrawn. Nonetheless, if the SEC does in fact withdraw Item 8(g), the Academy believes it is critical for the SEC to include in any release formally withdrawing the item: (1) a statement which recognizes the need for the independence of the auditor; (2) a statement that the SEC continues to adhere to the substance of ASR 264; and (3) a statement that the SEC fully expects the SEC Practice Section of the AICPA to meet the obligations it has accepted as to collecting and making

available "independence information." In addition, we request a statement encouraging the SEC Practice Section to expand the scope of information it collects from its members.

We now address each of these points in turn:

1. A Statement Recognizing the Need for Independence of the Auditor

If the Commission in fact withdraws Item 8(g), we believe in its statement accompanying the withdrawal, the Commission should recognize the ongoing need for the independence of the auditor. Such is clearly the Commission's position as expressed in its summary accompanying the notice of the proposal to rescind:

"Notwithstanding this proposal [to rescind Item 8(g)], the Commission views the independence of accountants as critical to the effective implementation of the federal securities laws and, in this release, reiterates its position on accountants' independence and on the continuing need for registrants and accountants to carefully evaluate their relationships to ensure that public confidence in the integrity of financial reporting is maintained."

A clear statement reiterating this principle in the material accompanying the withdrawal of Item 8(g) will simply reconfirm the Commission's historic position on the independence of the auditor as to statements filed with the SEC.

2. A Statement that the SEC Continues to Adhere to the Substance of ASR 264

Although the Academy recognizes that ASR 264 has already been formally withdrawn, we believe that a complete discussion of the merits of Item 8(g) must be accompanied by some observations about ASR 264.

In the event the Commission withdraws Item 8(g), we believe the withdrawal should be accompanied with a strong statement recognizing that the SEC continues to adhere to the substance of ASR 264. We specifically request the Commission to state that ASR 264 continues to reflect its views as to the kind of consideration that should be given (and that the Commission itself will give) to questions concerning the impact of nonaudit services on an auditor's independence. Indeed, in comments accompanying ASR 250 the Commission says "the Commission's views expressed in ASR 264 are unchanged."

The Academy believes this view should be reiterated and expanded upon in the statement accompanying the withdrawal of Item 8(g). Without such a statement, the withdrawal of ASR 264 read together with the proposed action on Item 8(g) will leave the public without any guidance as to what standards the Commission intends to employ in its continuing oversight in this area.

3. A Statement that the SEC Expects the AICPA to Meet the Terms of Its Self-Regulatory Commitment, as Well as a Statement that the SEC Expects the AICPA to Broaden its Proposed Reporting Requirement

In its proposal to rescind Item 8(g) the Commission noted that there is a need to make adequate information available to the public to assure ongoing auditor independence.

In a letter of comment filed in this matter by the Chairman of the SEC Practice Section of the AICPA, George D. Anderson states (in partial response to the SEC concern): "Accordingly, the [AICPA Executive] Committee voted at its September 9, 1981 meeting to amend the Section's membership requirements to require additional reporting to the Section of information with respect to fees for MAS services performed for SEC audit clients. This information will be open to public inspection."

Although the Academy strongly favors self-regulation of private professions, we believe that a direct statement by the Commission that it will anticipate ongoing AICPA fulfillment of that commitment will serve both the public and the Commission's concern about the availability of appropriate information about nonaudit services to enable adequate continued oversight of the services performed by independent auditors.

In addition, although we applaud the AICPA's initial step toward requiring disclosure of MAS fees, we feel that more data is required for meaningful oversight to be possible. In relevant part, the proposed form would extract the following information:

<u>Range of MAS Fees to Audit Fees for SEC Audit Clients</u>	<u>Number of SEC Audit Clients</u>
0 - 25%	
26 - 50%	
51 - 100%	
Over 100%	_____
Total Number of SEC Audit Clients	_____

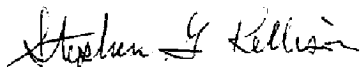
The Academy recommends that the AICPA reporting form be expanded to include more information (1) by type of management advisory service, and (2) by size of the client. These two additional factors are fundamental and critical if this information is to provide the necessary tools with which to assess independence.

Although the Academy has no reason to anticipate any difficulty, we believe it would be prudent for the Commission to be extremely sensitive to any problems with auditor independence which are brought to the attention of the Commission. Also, as circumstances and the manner of conducting business change, we believe this prospective sensitivity should extend to consideration of changes in the format or scope of the nonaudit information disclosed where needed to accomplish the Commission's stated goal of assuring auditor independence. This pledge of sensitivity is entirely consistent with the Commission's firm statement that it fully intends to continue meaningful oversight in the area of nonaudit services.

Finally, it is the Academy's intention to work closely with the AICPA and its SEC Practice Section in assuring public confidence in the integrity of financial statements of insurers and employee benefit plans. We hope that the SFC will acknowledge this pledge to cooperate to make self-regulation of both professions a viable posture.

If we can provide any additional information or proposed wording relating to any of our three points, please let me know.

Yours very truly,

A handwritten signature in cursive script that reads "Stephen G. Kellison". The signature is written in dark ink and is positioned above the typed name.

Stephen G. Kellison

SGK:bjn

STATEMENT 1981-35

STATEMENT OF THE
SUBCOMMITTEE ON PBGC - PENSION COMMITTEE
AMERICAN ACADEMY OF ACTUARIES
RETIREMENT INCOME INCENTIVES AND ADMINISTRATIVE
SIMPLIFICATION ACT OF 1981 (S. 1541) - TITLE VI
December 3, 1981

I. INTRODUCTION

The Subcommittee on PBGC of the Pension Committee of the American Academy of Actuaries appreciates the opportunity to present this statement on Title VI of the Retirement Income Incentives and Administrative Simplification Act of 1981 (S. 1541). This statement supplements our earlier statement dated November 9, 1981 which addressed the first five Titles of the bill.

II. ELIMINATING PBGC INVOLVEMENT IN CERTAIN PLAN TERMINATIONS - SECTION 6106

Under present law, most defined benefit pension plans that are terminated by solvent employers provide employees with either full accrued benefits, the vested portion of accrued benefits, or the PBGC-guaranteed portion of vested accrued benefits. PBGC's involvement in these terminations has been to verify that the termination has been properly done and, in some cases, to provide the employer with an alternative to purchasing annuities from an insurance company. The elimination of this involvement -- as proposed in the bill -- should substantially reduce PBGC's administrative expenses without significantly impairing the benefit security of plan participants.

For plans which have unfunded vested benefits when they are terminated, the bill would require employer funding of such benefits instead of permitting the option of having benefits cut back to the PBGC-guaranteed level. This

is, in essence, an increase in the level of benefits guaranteed to participants, with the attendant increase in employer costs. Employers no longer would have the flexibility of transferring liabilities to the PBGC. Therefore the PBGC would be exposed to less risk.

III. BILL DOES NOT ADDRESS TERMINATION OF FULLY FUNDED PLANS - SECTION 6106

Defined benefit plans generally are terminated for one of the following reasons:

- (a) the employer goes out of business,
- (b) operations are discontinued at a certain location, or
- (c) the employer cannot afford to continue the plan or wishes to replace it with a defined contribution plan.

Much of the bill is intended to cover the situation in which the employer becomes insolvent. Where a solvent employer goes out of business, it will typically wish to fully fund at least vested benefits (the bill would prevent cutting back benefits), and the bill enables it to do so on an immediately tax deductible basis. The bill is not clear, but should be, that in the going-out-of-business situation, an employer with an overfunded plan can voluntarily terminate it to achieve a reversion of excess assets -- it is not clear whether or not ERISA section 4044(d) would only apply to "insurable events".

Where operations are discontinued, employers are presently free to continue to fund vested benefits over generally a 30-year period, and the bill would not seem to prevent this. If assets exceed the value of vested benefits, employers will presently typically terminate the plan either to achieve a reversion of excess assets or to allocate excess assets to nonvested employees,

whichever is applicable. In some cases, the IRS will require such termination. The bill does not, but presumably should, clearly allow continuation of this practice.

Where operations continue, but the employer wishes to cease benefit accruals, employers are presently free to continue to fund accrued benefits over generally a 30-year period, provided service continues to accrue for vesting purposes, and the bill would not seem to prevent this. If the employer wishes to have nonvested benefits forfeited -- which is seldom the case where operations continue -- Section 6106 of the bill would accelerate funding as described in Section 6202 of the bill, and require annuities to be purchased when funding was completed. This latter requirement would seldom seem to have value and could, in fact, persuade an employer to fund such a plan as slowly as allowed. Furthermore, it could force an employer to purchase annuities at an inopportune time.

The bill does not make clear to what extent ERISA Section 4044 would apply when an insurable event does not coincide with plan termination. If assets exceed the value of vested benefits, the bill does not adequately provide that the plan can be terminated either to achieve a reversion of excess assets or to allocate excess assets to non-vested employees, whichever is applicable. The bill also does not address the situation where subsequent to plan termination, assets exceed the value of vested benefits even though they did not do so on the date of termination.

A limited number of solvent employers terminate plans under conditions where the value of unfunded benefits exceed 30% of the employer's net worth. In these situations, the PBGC presently shares in the cost of providing such benefits. The bill would eliminate this cost-sharing. This change would reduce the potential for abuse.

IV. NOTICE TO THE PBGC - SECTION 6115

Requiring notice of certain events suggestive of pending insolvency could strengthen the PBGC's position, provided the PBGC is able to put this information to its advantage, a task that is certainly formidable. In order to make the information available to the PBGC, the bill makes a potentially large group responsible for reporting this information to the PBGC. The bill also imposes personal financial liability which could be very large. This could make it difficult to find responsible individuals to serve plans in these capacities and could act as a drag on the adoption and improvement of defined benefit plans.

V. RETENTION OF LIABILITY UPON SALE OF BUSINESS - SECTIONS 6117 and 6119

The bill would affect controlled groups to which an insolvent employer formerly belonged. The bill would require such controlled groups to pay for such employer's unfunded benefits in certain circumstances. This could be required even where the employer's plan was fully funded for accrued benefits when it was spunoff from the controlled group. This requirement in that case could lead to the termination of plans at the time of sale simply to avoid a liability which could arise after the spinoff. Where benefits are not fully funded, some degree of protection for the PBGC seems

reasonable, but we feel the degree of protection ought not to depend on such a subjective test as to whether or not one purpose of the spinoff was the avoidance of liability to the PBGC.

VI. STRICTER MINIMUM FUNDING REQUIREMENTS - SECTION 6202

The bill would strengthen PBGC's position by accelerating the funding of certain plans during their active lifetime. Some employers may desire to achieve a similar effect by requesting the enrolled actuary to anticipate plan amendments where such amendments can reasonably be expected -- for example, a flat dollar benefit plan with a history of the flat dollar rate being amended upwards on account of rising pay levels every several years. Allowing such employers to do so on a tax-deductible basis would be consistent with the other provisions of the bill.

The requirement to fund vested benefits over 15 years could result in considerable increased actuarial expenses -- for small plans of under 100 participants, for plans partially funded by life insurance policies, and for larger plans which value vested benefits at assumptions differing from the valuation assumptions.

VII. PREMIUM EXEMPTION FOR SMALL PLANS - SECTION 6103

Plans with less than 35 participants are to be exempted from paying annual premiums, presumably because the cost of collection exceeds the amount of premiums. If this relationship is the case, we suggest the premiums be

restructured, for example a flat fee plus a per-participant fee. The elimination of premiums for small groups seems unfair.

VIII. LIABILITY UNDER MULTIPLE EMPLOYER PLANS - SECTION 6118

The bill provides for a liability to employers who withdraw from multiple employer plans, somewhat similar to the withdrawal liability established by the Multiemployer Pension Plan Amendments Act of 1980 for multiemployer plans, except this provision appears much simpler. This section will provide meaningful leverage for the insurance system to deal with the problem of providing promised plan benefits to the employees of withdrawing employers.

IX. CHANGE IN 30% NET WORTH LIMITATION - SECTION 6117

We have chosen not to comment on the priority status in bankruptcy of the PBGC's claim against employers. The bill changes the current 30% net worth limitation to an unlimited claim and gives it a status equal to that of other general creditors. We believe this could have significant impact on the willingness of employers to establish defined benefit plans or to grant benefit increases, as well as on their ability to obtain unencumbered credit instruments. This provision is an extremely important one and should receive the careful deliberation of the interested parties.

X. ISSUES NOT ADDRESSED BY THE BILL

We believe that a serious problem in the legislation is that it will cause the general public to believe that all the problems of termination insurance have been solved with its passage. Important inadequacies in the termination

insurance program are not addressed. The current premium rate could not support the present level of guarantees for single employer plans should the bankruptcy of a major industrial company occur. The concept of coinsurance as it exists in the multiemployer legislation is completely absent from the single employer provisions. The principles of plan reorganization which permit plans to restructure liabilities in advance of insurable levels also would not be available to single employers.

XI. CONCLUSION

In summary, we again wish to express our gratitude for this opportunity to supplement our earlier statement on S. 1541 with commentary on Title VI. Representatives of the Academy are available to meet with the Subcommittee or staff at your convenience to discuss these proposals in more detail.

Douglas C. Borton, Chairman
Pension Committee

Subcommittee on PBGC
Norman W. Clausen, Chairman
David H. Gravitz, Vice Chairman
Robert B. Aglira
Joseph H. Dittmer
Edward N. Fleischer
Keath P. Gibson
Harrison Givens, Jr.
Claude R. Poulin

STATEMENT 1981-36

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

December 10, 1981

REPORT: To the NAIC Subcommittee on Manipulation, Dividends and Lapsation

FROM: Committee on Dividend Principles and Practices

The purpose of this report is to provide the Subcommittee with background information with respect to the work of the Committee on Dividend Principles and Practices and its current activities.

The Committee on Dividend Principles and Practices was formed in December, 1978 in order to deal with issues emerging with respect to both the determination of dividends to existing policyholders and the illustration of dividends to prospective and existing policyholders. With respect to dividends determined for existing policyholders, there was a need to provide for standards of practice which would support the equitable distribution of dividends among classes of policyholders. With respect to dividend illustrations, there was a need to assure for purposes of cost comparison among companies that dividend illustrations reflected the company's current ability to pay dividends, so that competitive cost comparisons which were based upon dividend illustrations could be useful in comparing competitive price performance.

In October, 1980, the American Academy of Actuaries adopted Recommendations Concerning Principles and Practices in Connection with Dividend Determination and Illustration by mutual life insurance companies. Copies of these Principles and Practices, similar to the one attached, have been previously distributed to the Subcommittee.

These Principles and Practices provide that the actuary who recommends a dividend scale to his company must furnish with that recommendation a report which identifies the manner in which the dividend recommendation has followed these Principles and Practices. It also must highlight any deviations from these Principles and Practices. And, the actuary must be prepared to defend them.

The Committee on Dividend Principles and Practices recognizes that while the Recommendations define the actuary's responsibilities, they cannot by themselves guarantee either equitable treatment of policyholders with respect to dividends paid or comparable dividend illustrations. In its report to this Subcommittee in June, 1981, the Committee suggested a procedure through which the NAIC could make use of the existence of the actuary's report to achieve these ends. The Committee suggested a modification of Schedule M of the Annual Statement which would summarize the relevant material from the actuary's report, highlight deviations from the Recommended Principles and Practices and highlight the results of dividend scale changes. Suggested language for the actuary's certification of adherence to the Recommended Principles and Practices is also provided.

In addition, recommended language was suggested for the purpose of approaching a reasonable level of comparability of cost illustration. Suggestions were made with respect to modifications of the Buyer's Guide and of information to the company dividend illustrations. The text for each company's illustrations would depend upon the responses made in Schedule M.

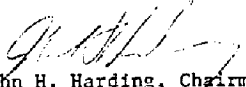
The NAIC accepted the report for exposure in June of 1981. The Committee on Dividend Principles and Practices stands ready to assist the NAIC in its consideration of the suggested modifications to the Annual Statement and to cost disclosure regulations.

The Committee would like to emphasize the fact that in order for the consumer disclosure portion of its suggestions to be effective, the suggested changes to the Annual Statement must also be made, since the consumer disclosure language relies upon disclosure in the Annual Statement.

At the present time, the Society of Actuaries Committee on the Theory of Dividends and Other Nonguaranteed Elements of Pricing has been at work in extending a framework for similar principles and practices, both to dividends for policies issued by stock life companies and to other elements of non-guaranteed pricing. Such elements would include those inherent in products known as "indeterminate premium" policies and "Universal Life" policies. When this work is completed, the Academy Committee will take whatever steps are necessary to establish appropriate recommended principles and practices and to make suggestions which are parallel to those for dividends for policies issued by mutual companies.

Because of the emerging nature of principles and practices in some of these areas, the process of establishing appropriate recommendations will be lengthy and time-consuming. The Committee believes it is important for the NAIC to proceed with the issues involving mutual company dividends without waiting for the elements now under consideration.

Respectfully submitted,



John H. Harding, Chairman
Committee on Dividend Principles
and Practices

JHH:sm

Enclosure

STATEMENT 1981-37

AMERICAN ACADEMY OF ACTUARIES

1835 K STREET, N.W. • SUITE 515 • WASHINGTON, D.C. 20006 • (202) 223-8196

December 21, 1981

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

Dear Brian:

RE: Proposed Audit Guide
Audits of Employee Benefit Plans
Chapter 4

Here are our comments on Chapter 4 of the proposed Audit Guide for Audits of Employee Benefit Plans.

Brian, in a number of cases, it seemed to us that a discussion of the questions would not be all that helpful to drafters; therefore, where we had a comment we often put down suggestive wording. I hope you won't think this is presumptuous. The suggested wording is there for you to use if you feel it is appropriate and helpful.

These comments were prepared by the Sub-committee ERISA Health and Welfare Plans of the committee on Health Insurance. The Sub-committee is chaired by Tony Houghton. Please feel free to call on Tony or myself if there are questions, or if we can be of further assistance to you.

Thanks again for this opportunity to comment.

Sincerely,

W. H. Odell, FSA, MAAA

WHO/gg

PROPOSED AUDIT GUIDE
AUDITS OF EMPLOYEE BENEFIT PLANS

CHAPTER 4

COMMENTS BY: AMERICAN ACADEMY OF ACTUARIES
COMMITTEE ON HEALTH INSURANCE

This Chapter, and indeed, the entire Audit Guide will we believe be of considerable help to practitioners in this complex field. We welcome the opportunity to comment on this early draft. The comments below are divided into two (2) groups - first general comments. Secondly, comments on specific paragraphs:

Our general comments are:

1. We believe that the benefits which may accrue for future service are not a liability of the plan. This matter was discussed in the "Statement to Financial Accounting Standards Board by the Sub-Committee on Pension Accounting Matters, American Academy of Actuaries, concerning the FASB discussion memorandum Re: Employer's accounting for pension and other post-retirement benefits" communicated to FASB on June 16th by Walter L. Grace, President of the Academy. A copy of this statement is attached for your convenience.

Also, some portions of this draft chapter can be read to include post-retirement benefit liabilities. Some of the suggestions below put forth wording that would remove this interpretation. This subject was also discussed in the above statement, and is still being studied. That is why we suggest post-retirement benefits not be considered at this time.

2. We are pleased, of course, at your reference to obtaining actuarial assistance in connection with evaluating certain claim liabilities. Actuaries feel they can also be of assistance in areas such as rate credits (Paragraph 12), eligibility credits (Paragraph 20), etc. We would like to think that the practicing auditor will call on specialist's help as appropriate. One of the paragraphs we have suggested adding touches on this.
3. One of the reasons this field is so complex is that there is a tremendous variety of risk arrangements. We suggest that the practicing auditor consider each risk arrangement separately, study it carefully, obtain actuarial estimates of liabilities for that particular risk arrangement, and be sure the disclosures differentiate between different risk arrangements existing under the same plan. Related to this is a question, which in part is semantics, namely, distinguishing between the different types

of organization which the plan may be using for financing purposes. For example, on Page 1 "a fund" and "an insurance company" are referred to; however, there may be a Blue Cross - Blue Shield Plan involved, an HMO, etc.

Turning to Specific Comments:

1. Section 12 -
Accrued Experience Rating Adjustments:

We believe that when a refund or dividend has been fully earned, the estimated value is a proper asset of the policyholder. However, when there is only a partial refund period and such period may be unrepresentative of the full insurance period because of either seasonal factors or fluctuations, it is doubtful whether such a potential gain or deficit should be established as part of the financial statement. To give an example, suppose a school system is on a calendar financial basis but its insurance contract begins on September 1, the start of the school year, and ends August 31 of the following year. The financial experience covering the period September 1 through December 31 may appear to be very favorable and the policyholder has earned a refund equal to 15% of the premiums earned during this four month period. This conclusion may be misleading because the immediate winter months may have higher claims and traditionally school teachers postpone elective medical care until the end of school and at that time, incur very large expenses during the months of June or July. Therefore, it is quite likely in the situation used for this example that no refund will materialize when the full policy year has ended after August of the following year.

We, therefore, think you might want to consider wording such as the following to be added to Section 12 - - "however, when the period covered by the estimated refund is only a portion of the policy year, care must be taken not to over-state the asset, especially where the experience with the remainder of the policy year can be expected to be less favorable than the experience for the portion of the policy year which has expired.

2. Section 13 -
Accrued Experience Rating Adjustment

This section suggests that a deficit which will be carried forward by a carrier should be established as a liability on the policyholder's financial statements. We believe this is doubtful unless there is a financial agreement that requires the policyholder to repay this deficit. The reasons for not establishing this liability include the following:

- a) The policyholder may transfer the insurance coverage to another carrier, thereby, erasing the deficit.
- b) If the carrier does not include a special margin for recovery, the policyholder is in almost exactly the same position had there been no deficit. The only difference is that before a refund is available the deficit must be recovered.
- c) Some policyholders will rebid their insurance contract and if it is awarded to the existing carrier, it still may result in eliminating the prior deficit.

We therefore suggest dropping what is now the second sentence of this Section and adding something like the following - - frequently, because of transfer of the insurance program, re-rating of the contract with the existing carrier, or for some other reason, the premium deficit will never be paid by the plan. However, if the premium deficit will probably be accrued against the plan, then it should be recorded as a liability of the plan". (We realize we probably do not have the appropriate accounting terminology to describe this situation when the premium deficit is "really" a liability).

3. Section ?

We suggest that at some point in the Chapter an indication be given to the practitioner of the variety of risk arrangements, etc. Perhaps the place to do this is after the present "financial statements" Section 7. In any event, we suggest something like the following:

"Health and Welfare Benefit Plans are arranged through a variety of risk arrangements. Under some risk arrangements the plan retains almost none of the risks, under other arrangements the plan retains almost all of the risks. Parties with whom the plan may contract include not only trustees, but also insurance companies, Blue Cross - Blue Shield organizations, health maintenance organizations, and other health care financing organizations. The exact nature of each risk arrangement needs to be determined. The actuarial estimates of liabilities discussed below need to be determined for each risk arrangement and the information for each arrangement disclosed as described below.

4. Sections 15, 16, and 17

Claims

We agree with the sentence in Section 15 that indicates the financial statements of a self-insured plan should include the amount of claims reported but not paid and claims incurred but not reported. We believe that it is not always desirable as indicated in Section 16 to determine separately and independently the claims reported but not paid and the claims incurred but not reported. We also believe that the language should not indicate claim liabilities may be determined by a plan's insurance consultant. While some insurance consultants are

actuarially trained to determine claim liabilities, for others it is not within their scope of expertise. We believe the calculation of claim liabilities should be determined by an actuary when they extend over any period of time which makes inventorying of actual amounts impractical.

It is unclear whether the claims referred to in Sections 15, 16 and 17 include only benefits which have accrued and are not contingent on future events or whether they include those types of benefits or ones for which contingencies still exist. For example, in the case of disability income, are these sections meant to include all benefits accrued throughout the end of the financial statement, or will they also include the present value of benefit payments which are contingent on the insured remaining disabled? In the case of death benefits, are these liabilities to represent only the amounts for those who have died prior to the financial statement or will they include in the case of a benefit that has a waiver of premium, the present value of the death benefits for those who have become totally disabled before the financial statement but who have not yet died?

We, therefore, suggest that in Paragraph 15 the following be added as a second sentence: "both the 'reported but not paid' category and the 'incurred but not reported' category include amounts for which the company as of the statement date is liable even though they will not become due until a future date as well as amounts past due. For example, under a disability income coverage these amounts include the estimated present value as of the statement date of payments which will become due after the statement date during the continuance of disability if the plan is liable for such benefits".

In Section 16, we would suggest changing the second sentence by deleting the words "insurance consultant or" and make the same change in Section 17. We understand that the independent auditor makes the final decision as to who is called upon as a specialist. In Paragraph 16, we suggest adding a sentence such as the following: "Actuarial techniques often involve estimating in the aggregate claims reported not paid and claims incurred, but not reported rather than developing the two components of the liability separately".

We also suggest adding a Section 18 containing a sentence such as the following: "the development of the claim liabilities is performed separately for each risk arrangement and type of benefit.

5. Section 20
Accumulated Eligibility Credits
It may be unclear to the practitioner from this section whether

this is referring to labor negotiated contracts where individual workers have accumulated the right to certain future insurance benefits independent of their future working status or whether it refers to the recognition of post-retirement medical benefits or life insurance benefits. In the case of the latter, there may be provisions which must be met in order for these benefits to be payable such as future vesting and changes in the plan which may occur before some or all of these post-retirement benefits become payable. In any event, as pointed-out above, we suggest post-retirement benefits not be considered at this time. We do not have specific wording to suggest as to clarifying the questions mentioned at the beginning of this paragraph.

6. Section 24
Disclosures

We suggest modifying line 25 slightly along the following lines: " - - the following additional disclosures by risk arrangement, if applicable: - - "

7. Illustration of Financial Statements - Page 15

On Page 13 under liabilities there are five separate items. The first two items, "Health Claims Payable" and "Estimated Health Claims Incurred But Not Reported", we understand to be the traditional liability for health claims which have been incurred but were unpaid. We believe both should include benefits which are unaccrued as of the statement date such as disability payments involving participants who are disabled on the valuation date with respect to the benefits payable for such disability which will continue into the future until the participants recover or die. Classification of amounts between these two line items has been very troublesome in insurance company financial statement reporting. We suggest something like the following:

"Health Claims - estimated future payments on incurred claims (includes incurred but not reported claims)"

If for tax reasons two lines are desired, then something like the following might do:

"Health Claims - liability for past-due payments", and

"Health Claims - estimated other future payments on incurred claims (includes incurred but not reported claims)"

The third item which related to future benefits based on participants' accumulated eligibility has some uncertainty. Based on the notes on page 15, this may result from contractual eligibility credits which can guarantee a participant up to one year's extended benefit. Presumably, this would not include any liability relating to future service.

The fourth item, estimated benefits to retired participants, may be similar to the previous item except pertaining to those participants who are now retired. This would be somewhat

different than establishing the accrued value of post-retirement death benefits. As indicated previously, we think that question is still not resolved and we do not think anything in this chapter should imply that there must be a liability for post-retirement benefits or that they must be recognized in a particular way.

The fifth item estimated future death benefits, may involve: (1) Unpaid death benefits for those already dead; (2) Present value of death benefits for those who are disabled and have continuous coverage under a waiver premium provision, or (3) based on the notes on Page 15 the present value of contractually paid up death benefits which result from contractual credits which exceed the maximum of one year's coverage. Two line items might help such as:

"Death Claims - unpaid death benefits" and

"Death Claims - present value of life insurance coverage on disabled employees and employees with excess eligibility credits"

We believe this example should be studied carefully to be sure it will not mislead an auditor into thinking he should require a liability be established for such things as future unaccrued benefits that are recommended in the case of labor negotiated contracts or post-retirement benefits.

We appreciate very much the opportunity to comment. We hope the above comments are helpful. This Chapter we think will be of assistance to everyone interested in this complex subject.

Health Committee
W. H. Odell, Chairman

STATEMENT 1981-38

AMERICAN ACADEMY OF ACTUARIES

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December 29, 1981

Mr. John L. McDonough, Jr.
Chairman, Insurance Companies Committee
American Institute of Certified Public Accountants
1211 Avenue of the Americas
New York, New York 10036

Re: "Discounting Claim Liabilities of Insurance Companies"

Dear Mr. McDonough:

In reviewing the draft Issues Paper entitled "Discounting Claim Liabilities of Insurance Companies," we have noted that its scope includes stock life insurance companies. Therefore, we have reviewed the draft with emphasis on how it would apply to life and health insurance written by life insurance companies.

In paragraph 7, the draft states that "at present, generally accepted accounting principles for insurance companies do not address the issue of recording claim liabilities at the present value of anticipated future cash disbursements." In fact, the life company audit guide does provide that the claim liability be computed as the present value of future benefits.

Paragraph 7 further states that "claim liabilities are generally recorded at the full cost of anticipated settlement, even though a substantial number and amount of claims are not paid within one year." Again, this statement is incorrect for life insurance companies.

In general, the conclusions reached in the draft are consistent with existing principles and practice for life insurance companies. However, there are several inconsistencies, including the following:

1. The draft recommends that the IBNR not be discounted. This is not consistent with the practice of most life companies. For example, in the case of disability income coverages, the IBNR may be calculated as the product of an estimated number of incurred but not reported claims times an estimated claim amount. The "claim amount" is then equal to the present value at the date of disability of the future claim payments, including discount for interest.
2. Similarly, liabilities for claims reported but not settled may be calculated as the discounted "claim amount," less an estimate of the extent to which claims will be settled for less than the amount claimed by the insured.
3. The recommendation in paragraph 49 is developed in terms of the company's portfolio interest rate. In fact, for most life insurance companies, it is possible to determine an interest rate which applies more specifically to the

Mr. John L. McDonough, Jr.
December 29, 1981

claim liabilities in question. This may be done through application of the investment year method or through allocation of specific investments. It is common practice for life insurers to base the discount rate on the invested assets which support the claim liabilities. We believe that the recommendation should be changed to recognize this practice.

4. The life company audit guide requires that the interest assumption be reduced by a margin for adverse deviation. Provision for such margins would be necessary in order to apply the recommendations to life insurers.

5. Use of a pre-tax interest rate is appropriate for life insurance companies which are taxed on operating income. But for many life insurers, all, or a portion, of federal income tax is derived from investment income. In these cases, it is necessary to reduce the interest rate by a provision for federal income taxes.

6. A provision for deferred taxes may be necessary if GAAP liabilities are established on a basis different than in the tax return.

7. Appendix A is not a correct description of the method used by life insurers to discount claim liabilities. Life expectancies are not used. Rather, a probability of claim payment is estimated for each future year, using actuarial tables and methods. This probability is then multiplied by the estimated amount of claim payment for the corresponding year. The product for such year is discounted to the valuation date. The claim liability is equal to the sum of the discounted amounts for all future years. For example,

<u>Year</u>	<u>(1) Probability of Claim Payment</u>	<u>(2) Estimated Payment Amount</u>	<u>(1) x (2)</u>
1	.70	\$1,000.	\$700.
2	.50	1,000.	500.
3	.40	1,000.	400.
4	.25	1,000.	250.
5	.10	1,000.	<u>100.</u>

Present Value at 10% \$1,583.

We appreciate the opportunity to comment on the draft Issues Paper. If you have questions about any of the points we have raised, or if we can be of further help, please let me know.

Sincerely,



Burton D. Jay
Chairman
Committee on Life Insurance
Financial Reporting Principles