



# Pension Section News

## OASDI Trust Fund

### Principal Economic and Demographic Assumptions

*Editor's Note: The following excerpt is taken from Section V, "Assumptions and Methods Underlying Actuarial Estimates," in the 2003 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. Copies of the OASDI 2003 Annual Report are available from Cece Enders (410-965-3015).*

The future income and cost of the OASDI program will depend on many economic, demographic and program-specific factors. Trust fund income will depend on how these factors affect the size and composition of the working population and the level and distribution of earnings. Similarly, program cost will depend on how these factors affect the size and composition of the beneficiary population and the general level of benefits.

Because projections of these factors and their interrelationships are inherently uncertain, estimates are shown in this report on the basis of three plausible sets of assumptions designated as intermediate (alternative II), low cost (alternative I) and high cost (alternative III). The intermediate set represents the Boards' best estimate of the future course of the population and the economy. In terms of the net effect on the status of the OASDI program, the low-cost alternative I is the most optimistic, and the high-cost number is the most pessimistic.

Although these three sets of economic and demographic assumptions have been developed using the best available information, the resulting estimates should be interpreted with care. The estimates are not intended to be specific predictions of the future financial status of the OASDI program, but rather, they are intended to be indicators of the expected trend and a reasonable range of future income and

cost, under a variety of plausible economic and demographic conditions.

The values for each of the demographic, economic and program-specific factors are assumed to move from recently experienced levels or trends, toward long-range ultimate values over the next five to 30 years. The ultimate values assumed after the first five to 30 years for both the demographic and the economic factors are intended to represent average experience or growth rates. Actual future values will exhibit fluctuations or cyclical patterns, as in the past.

#### Economic Assumptions

The basic economic assumptions are embodied in three alternatives that are designed to vary Social Security's financial status, and illustrate the likely range of outcomes that might be encountered.

The intermediate assumptions (alternative II) reflect the Trustees' consensus expectation of moderate economic growth throughout the projection period. The low-cost assumptions (alternative I) represent a more optimistic outlook, with relatively strong economic growth. The high-cost assumptions (alternative III) represent a relatively pessimistic forecast, with weak economic growth and two recessions in the short-range period. Economic cycles are not included in assumptions beyond the first five to 10 years of the projection period because they have little effect on the long-range estimates of financial status.

The principal demographic and economic assumptions for the three alternatives are shown in Tables V.A.3 and V.B.1 (see pages 4-6). ♦

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# Congratulations

The following are newly elected members of the Pension Section Council. They will each serve a 3-year term beginning in October, 2003.

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# Chairperson's Corner

by Marilyn Miller Oliver

The Pension Section provides information for its members through a variety of mediums. The information comes from different sources, one of which is research funded by the section. This column will bring you up-to-date on some of the retirement-specific information available on the SOA Web site and research projects currently underway. If there is other information that would be helpful to add to the Web site or if you have ideas for future research projects, let us know.

## Current Research Projects:

**Annuity:** One of the more interesting projects that the section is funding is an optimization model for the annuity decision process that will be available on the Pension Section Web site. The model is designed as an aid to practicing actuaries and will be quite flexible in terms of input assumptions, including the asset allocation of non-annuitized funds. The project is expected to be completed in the next six to 12 months.

**Joint and Survivor Elections:** This project, conducted by the Urban Institute, takes a new and very thorough look at the joint and survivor election process using data from the Health and Retirement Survey database, with potentially interesting results. It is in the final review process. (The Health and Retirement Survey is a large, ongoing longitudinal study of a nationally representative group of individuals who are retired or near retirement. It is funded by the National Institute on Aging.)

**Interdisciplinary Literature Review of Pre-Retirement Influences on Retirement Decisions:** This project is a comprehensive literature review of research done on variables that influence attitudes and decisions related to retirement. Topics explored in this literature review include employee understanding of retirement benefits, employee satisfaction with retirement benefits, influences on early retirement decisions and influences on pension plan participation choices.

**Survey of Retirement Plan Preferences:** This survey includes an exploration of worker and retiree satisfaction with defined benefit and defined contribution plans and factors influenc-

ing worker and retiree satisfaction with their retirement plans. It is in the final review process.

## SOA Web site:

**Investment Returns:** The newest addition is Investment Statistics for Actuaries, available at: [http://soa2.syn.net/Stats/stats\\_employee.html](http://soa2.syn.net/Stats/stats_employee.html)

The Moody's AA Long-term Corporate Bond Index and Citibank Pension Discount Curve and Pension Liability Index are available at: [http://www.soa.org/sections/pension\\_resources.html](http://www.soa.org/sections/pension_resources.html)

**Other Statistics for Employee Benefit Actuaries:** Currently being updated, includes historical values of OBRA '87 rates, Canadian Transfer Values, average weekly wages and salaries, health expenditure information and more, available at: [http://www.soa.org/sections/pension\\_resources.html](http://www.soa.org/sections/pension_resources.html)

**Mortality Tables:** The RP-2000, 1994 GAM Static Table and UP-1994 Tables are available through the Mortality Table Manager at: <http://www.soa.org/tablemgr/tablemgr.asp>

**Research: Monographs in the Retirement Area** are available at: <http://www.soa.org/bookstore/mono.html>

They include a comprehensive paper on DROPs (Deferred Retirement Option Plans)—including valuation techniques and a survey of plan provisions.

**Papers:** The papers from the recent symposium on Pension Actuarial Practice in Light of Financial Economics may be found at: [http://www.soa.org/sections/pension\\_financial\\_econ.html](http://www.soa.org/sections/pension_financial_econ.html)

**Post-Retirement Financial Risks and Needs:** A useful chart setting out a framework for analyses in this area as well as survey and other information may be found at: <http://www.soa.org/sections/retirement/framework.html> ♦



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Table V.A3 Period Life Expectancies

Life Expectancy \*  
(at Age 65)

Calendar Year	Male	Female	Calendar Year	Male	Female
<b>Historical Data</b>			<b>Low Cost</b>		
1940	11.9	13.4	2005	15.9	18.9
1945	12.6	14.4	2010	16.0	18.9
1950	12.8	15.1	2015	16.2	19.0
1955	13.1	15.6	2020	16.3	19.1
1960	12.9	15.9	2025	16.4	19.2
1965	12.9	16.3	2030	16.5	19.3
1970	13.1	17.1	2035	16.7	19.5
1975	13.7	18.0	2040	16.8	19.6
1980	14.0	18.4	2045	16.9	19.7
1985	14.4	18.6	2050	17.0	19.8
1990	15.0	19.0	2055	17.1	20.0
1995	15.3	19.0	2060	17.2	20.1
1996	15.4	19.0	2065	17.4	20.2
1997	15.5	19.1	2070	17.5	20.3
1998	15.6	19.0	2075	17.6	20.4
1999	15.7	18.9	2080	17.7	20.5
2000 +	15.8	18.9			
2001 +	15.8	19.0			
2002 +	15.9	19.0			
<b>Intermediate</b>			<b>High Cost</b>		
2005	16.1	19.0	2005	16.2	19.2
2010	16.4	19.3	2010	16.8	19.7
2015	16.7	19.6	2015	17.3	20.2
2020	17.0	19.9	2020	17.9	20.8
2025	17.3	20.2	2025	18.4	21.3
2030	17.7	20.5	2030	19.0	21.8
2035	18.0	20.8	2035	19.5	22.4
2040	18.3	21.1	2040	20.1	22.9
2045	18.5	21.4	2045	20.6	23.4
2050	18.8	21.7	2050	21.1	23.9
2055	19.1	21.9	2055	21.6	24.3
2060	19.4	22.2	2060	22.1	24.8
2065	19.6	22.5	2065	22.5	25.3
2070	19.9	22.7	2070	23.0	25.7
2075	20.2	23.0	2075	23.4	26.2
2080	20.4	23.2	2080	23.9	26.6

\* The period life expectancy at a given age for a given year represents the average number of years of life remaining if a group of persons at that age were to experience the mortality for that year over the course of their remaining lives.

+ preliminary or estimated

Table V.B1 Principal Economic Assumptions

Average Annual percentage  
(Increase In-)

Calendar Year	Average Annual Wage in Covered Employment	Consumer Price Index *	Real Wage Differential ** (Percent)
<b>Historical Data</b>			
1960-1965	3.2	1.2	2.0
1965-70	5.8	4.2	1.6
1970-75	6.6	6.8	-0.1
1975-80	8.7	8.9	-0.2
1980-85	6.7	5.2	1.4
1985-90	4.7	3.8	0.9
1990-95	3.4	3.0	0.4
1995-00	5.6	2.4	3.2
1992	4.9	2.9	2.0
1993	1.9	2.8	-0.9
1994	3.4	2.5	1.0
1995	4.0	2.9	1.1
1996	4.4	2.9	1.5
1997	5.9	2.3	3.6
1998	6.1	1.3	4.8
1999	5.5	2.2	3.3
2000	6.2	3.5	2.7
2001	1.8	2.7	-0.9
2002	1.9	1.4	0.5
<b>Intermediate</b>			
2003	3.9	2.5	1.5
2004	4.4	2.4	2.0
2005	4.3	2.7	1.6
2006	4.3	2.9	1.4
2007	4.4	3.0	1.4
2008	4.3	3.0	1.3
2009	4.3	3.0	1.3
2010	4.2	3.0	1.2
2015	4.1	3.0	1.1
2020	4.1	3.0	1.1
2025	4.1	3.0	1.1
2030	4.1	3.0	1.1
2035	4.1	3.0	1.1
2040	4.1	3.0	1.1
2045	4.1	3.0	1.1
2050	4.1	3.0	1.1
2055	4.1	3.0	1.1
2060	4.1	3.0	1.1
2065	4.1	3.0	1.1
2070	4.1	3.0	1.1
2075	4.1	3.0	1.1
2080	4.1	3.0	1.1

\* The Consumer Price Index is the annual average value for the calendar year of the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).

\*\*The real-wage differential is the difference between the percentage increases, before rounding, in average annual wage in covered employment, and the average annual Consumer Price Index.

Table V.B1 Principal Economic Assumptions

		Average Annual percentage (Increase In-)		
Calendar Year	Average Annual Wage in Covered Employment	Consumer Price Index *	Real Wage Differential ** (Percent)	
<b>Low Cost</b>				
2003	4.4	2.2	2.3	
2004	4.2	2.0	2.2	
2005	3.9	2.0	1.9	
2006	3.7	2.0	1.7	
2007	3.8	2.0	1.8	
2008	3.7	2.0	1.7	
2009	3.7	2.0	1.7	
2010	3.7	2.0	1.7	
2015	3.6	2.0	1.6	
2020	3.6	2.0	1.6	
2025	3.6	2.0	1.6	
2030	3.6	2.0	1.6	
2035	3.6	2.0	1.6	
2040	3.6	2.0	1.6	
2045	3.6	2.0	1.6	
2050	3.6	2.0	1.6	
2055	3.6	2.0	1.6	
2060	3.6	2.0	1.6	
2070	3.6	2.0	1.6	
2075	3.6	2.0	1.6	
2080	3.6	2.0	1.6	
<b>High Cost</b>				
2003	2.5	2.5	0.0	
2004	5.5	3.0	2.5	
2005	5.8	4.5	1.3	
2006	4.8	5.8	-1.1	
2007	6.2	5.8	0.4	
2008	6.9	4.9	2.0	
2009	5.0	4.1	0.9	
2010	4.5	4.0	0.5	
2015	4.6	4.0	0.6	
2020	4.6	4.0	0.6	
2025	4.6	4.0	0.6	
2030	4.6	4.0	0.6	
2035	4.6	4.0	0.6	
3040	4.6	4.0	0.6	
3045	4.6	4.0	0.6	
2050	4.6	4.0	0.6	
2055	4.6	4.0	0.6	
2060	4.6	4.0	0.6	
2065	4.6	4.0	0.6	
2070	4.6	4.0	0.6	
2075	4.6	4.0	0.6	
2080	4.6	4.0	0.6	

\* The Consumer Price Index is the annual average value for the calendar year of the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).

\*\*The real-wage differential is the difference between the percentage increases, before rounding, in average annual wage in covered employment, and the average annual Consumer Price Index.

# Comments to the ERISA Advisory Council

by Jeremy Gold

Chair Thierman and Members of the Advisory Council, thank you for inviting me to talk with you today about funding defined benefit pension plans.

The “issue of the day” in defined benefit funding is the search for a discount rate to be used to determine the current liability as referenced in Internal Revenue Code Section 412(l). After having operated under a lenient temporary standard for the past two years, we are warned that imposing a strong standard in the near term might inflict a disastrous shock upon the system. Thus it appears that stronger standards can only be phased in over several years. The length and strength of the phase-in is primarily a political concern. The endpoint of the phase-in is a matter of science. Today I address where we need to place that endpoint.

## *Why do we, society, require defined benefit pensions to be funded?*

Realizing that pension plans are promises made by employers to employees, we have collectively concluded that promises made must become promises kept. This is the message of ERISA which included provisions to form the PBGC and to require employers to set aside funds to back pension promises. Unfortunately ERISA's implementation fell far short of its message.

## *Why do we require both federal insurance AND funding?*

We provide insurance because it is the people's will that promises be kept. We insist on minimum funding levels with the goal that every employer will pay for the benefits that it has promised and not become a burden on the rest of corporate America.

Funding becomes critical when the employer goes bankrupt and the plan beneficiaries and the PBGC must depend on the funded assets to meet the benefit promises. If, at bankruptcy, the plan has enough money to buy a portfolio of liability-matching Treasury securities, the assets are adequate. If the assets are less, some party—the employees, the PBGC, other companies or taxpayers—must provide additional money or accept the risk that assets will be inadequate in the future.

## *What do we find under current standards and what might we expect under the standards proposed by Representatives Portman and Cardin and under the most recent administration modifications thereto?*

Companies that sponsor defined benefit plans do go bankrupt and are more likely to do so during periods of economic weakness. During these same periods, pension plans invested in equities are likely to be poorly funded and there is a substantial correlation between bankruptcy and poor funding. Companies approaching insolvency often fund at minimum statutory levels.

The Portman-Cardin legislation proposes that the

existing rules be weakened by substituting corporate bonds for the no-longer-issued 30-year Treasury bond. It is clear that weaker future standards mean that tomorrow's bankruptcies will inflict more damage on the PBGC and—in turn—on the entire system.

The administration argues that its proposed liability measurements will be more accurate than those using the existing standards because it will use a yield curve and because 90-day averaging will replace four-year averaging. Although I agree that this will be more transparent and more plan and date sensitive, the use of corporate bond rates rather than Treasury bond rates guarantees us that the standard will be weaker than it must be. Companies that meet all of the proposed funding rules will continue to go bankrupt and will have insufficient assets when they do so.

Companies approaching bankruptcy will aggravate any insufficiency by making the smallest contributions allowed while taking investment risk in the hope that their gamble will pay off.

A sound system should not only specify strong permanent standards but must be designed to encourage prudent behavior by plan managers. Society's rules should incent managers to be:

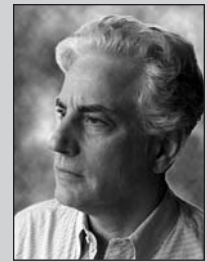
- Cautious in granting benefits
- Quick to fund promised benefits
- Reluctant to mismatch assets and liabilities

Society must hold promise makers responsible. Some suggest that allowing greater funding in good times is an effective substitute for the prudence that we should encourage. Being well-funded when the stock market is bubbling is not the answer; any additional funding allowed during the run-up to the stock market peak in March of 2000 would merely have increased the aggregate losses that have been suffered since. Full funding at all times, within practical limits, should be the endpoint of the process we now begin.

I have provided three additional documents in my written testimony. These address:

- 1) A Treasury yield curve to define the current liability (See <http://users.erols.com/jeremygold/usingtreasury.pdf>).
- 2) Solvency as the paramount societal issue—we should discard all statutory funding rules that do not directly relate to solvency (See “How to Stop the Insanity!”, *Pension Section News*, June 2003, pages 6-7).
- 3) How the PBGC is effectively forced to guarantee loans made to our weakest companies. (See page 22).

Thank you for your attention. ◆



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# HI Trust Fund

## Actuarial Methodology and Principal Assumptions

*Editor's Note: The following excerpt is taken from Section III.A, "Actuarial Methodology and Principal Assumptions for the Hospital Insurance Cost Estimates," in the 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Copies of the 2003 Annual Report are available from Sol Mussey (410-786-6386).*

**T**his section describes the basic methodology and assumptions used in the estimates for HI (Medicare Part A) under the intermediate assumptions. In addition, projections of program costs under two alternative sets of assumptions are presented.

### Assumptions

The economic and demographic assumptions underlying the projections shown in this report are consistent with those in the 2003 Annual Report of the Board of Trustees of the Federal Old Age and Survivors Insurance and Disability Insurance Trust Funds. These assumptions are described in more detail in that report.

### Program Cost Projection Methodology

The principal steps involved in projecting the future HI costs are (a) establishing the present cost of services provided to beneficiaries, by type of service, to serve as a projection base; (b) projecting increases in HI payments for inpatient hospital services; (c) projecting increases in HI payments for skilled nursing, home health and hospice services covered; (d) projecting increases in payments to managed care plans; and (e) projecting increases in administrative costs. The major emphasis is directed toward expenditures for fee-for-service inpatient hospital services, which account for approximately 71 percent of total benefits.

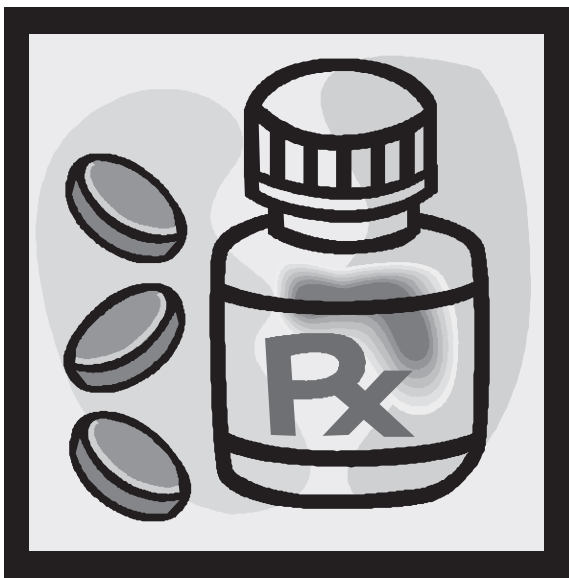
### Projection Base

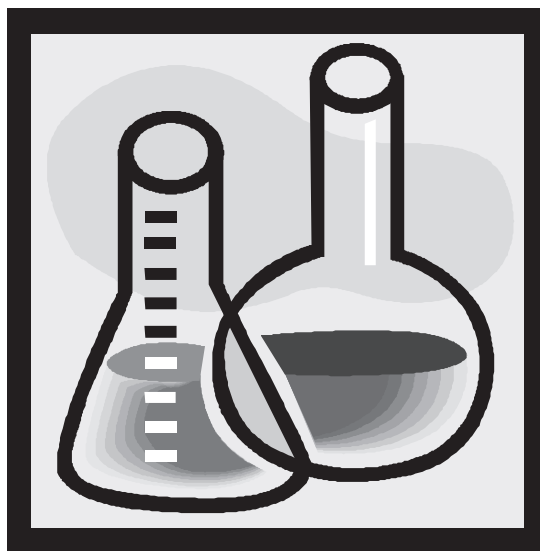
In order to establish a suitable base from which to project the future HI costs, the incurred payments for services provided must be reconstructed for the most recent period for which a reliable determination can be made. Therefore, payments to providers must be attributed to dates of service, rather than to payment dates. In addition, the nonrecurring effects of any changes in regulations, legislation or administration and of any items affecting only the timing and flow of payments to providers must be eliminated. As a result, the rates of increase in the incurred cost differ from the increases in cash expenditures shown in the tables in section II.B (not shown).

For those expenses still reimbursed on a reasonable cost basis, the costs for covered services are determined on the basis of provider cost reports. Due to the time required to obtain cost reports from providers, to verify these reports, and to perform audits (where appropriate), final settlements have lagged behind the original costs by as much as several years for some providers.

Additional complications are posed by changes in legislation or regulation, or in administrative or reimbursement policy, the effects of which cannot always be determined precisely.

The process of allocating the various types of HI payments made to the proper incurred period—using incomplete data and estimates of the impact of administrative actions—presents difficult problems, the solutions to which can be only approximate. Under the circumstances, the best that can be expected is that the actual HI incurred cost for a recent period can be estimated





within a few percent. This process increases the projection error directly, by incorporating any error in estimating the base year into all future years.

### **Fee-for-Service Payments for Inpatient Hospital Costs**

Almost all inpatient hospital services covered by HI are paid under a prospective payment system. The law stipulates that the annual increase in the payment rate for each admission will be related to a hospital input price index (also known as the hospital market basket), which measures the increase in prices for goods and services purchased by hospitals for use in providing care to hospital inpatients. For the fiscal year 2003, the prospective payment rates have already been determined. For fiscal years 2004 and later, current statute mandates that the annual increase in the payment rate per admission equal the annual increase in the hospital input price index.

Increases in aggregate payments for inpatient hospital care covered under HI can be analyzed in five broad categories:

- Labor factors—the increase in the hospital input price index that is attributable to increases in hospital workers' hourly earnings (including fringe benefits).

- Nonlabor factors—the increase in the hospital input price index that is attributable to factors other than hospital workers' hourly earnings, such as the cost of energy, food and supplies.
- Unit input intensity allowance—the amount added to or subtracted from the input price index (generally as a result of legislation) to yield the prospective payment update factor.
- Volume of services—the increase in total output of units of service (as measured by hospital admissions covered by the HI program); and
- Other sources—a residual category, reflecting all other factors affecting hospital cost increases (such as intensity increases).

Table III.A1 on page 10 shows the estimated historical values of the principal components, as well as the projected trends used in the estimates. Unless otherwise indicated, the following discussions apply to projections under the intermediate assumptions. ♦

(continued on page 10)

Table III.A1 Components of Historical and Projected Increases in HI Inpatient Hospital Payments \*

Calendar Year	Labor			Nonlabor			Units of Service							
	Average Hourly Earnings	Hospital Hourly Earning Differential	Hospital Hourly Earnings	CPI	Hospital Price Differential	Nonlabor Hospital Prices	Input Price Index	Unit Input Intensity Allowance **	HI Enrollment	Managed Care Shift Effect	Admission Incidence	Calendar Year	Other sources	HI Inpatient Hospital Payment
<b>Historical Data</b>														
1993	1.4%	2.1%	3.5%	2.8%	-0.3%	2.5%	3.0%	-0.5%	2.1%	-0.6%	2.8%	1993	-1.1%	5.8%
1994	1.7	1.2	2.9	2.5	-0.4	2.1	2.7	-0.6	1.8	-1.0	2.4	1994	1.6	7.1
1995	3.3	-0.9	2.4	2.9	0.5	3.4	3.1	-0.7	1.7	-2.0	2.4	1995	0.1	4.7
1996	4.9	-2.4	2.9	2.9	-1.1	1.8	2.3	-0.5	1.4	-2.7	5.1	1996	1.4	7.1
1997	4.2	-2.3	1.8	2.3	-0.8	1.5	2.1	-0.8	1.1	-3.2	2.3	1997	-0.7	1.0
1998	5.3	-2.6	2.6	1.3	2.5	3.8	3.0	-2.6	1.0	-3.1	0.6	1998	0.3	-0.9
1999	4.8	-1.7	3.0	2.2	-0.1	2.1	2.5	-2.2	0.8	-1.8	1.3	1999	1.7	2.2
2000	6.4	-2.4	3.8	3.5	-0.5	3.0	3.8	-2.2	1.3	0.4	-0.1	2000	-1.5	1.7
2001	2.9	2.3	5.3	2.7	0.3	3.0	3.9	-0.9	0.8	2.2	1.6	2001	1.7	9.7
2002	2.8	2.1	5.0	1.4	0.2	1.6	3.3	-0.7	2.7	2.4	0.5	2002	1.5	10.0
<b>Projections ++</b>														
2003	3.4%	0.9%	4.3%	2.3%	0.2%	2.5%	3.5%	-0.4%	0.9%	0.1%	1.2%	2003	-0.5%	4.9%
2004	4.1	0.0	4.1	2.4	0.2	2.4	3.5	0.0	1.5	-0.1	0.1	2004	0.7	5.8
2005	4.2	0.2	4.4	2.7	0.0	2.7	3.7	0.0	1.6	0.2	0.0	2005	0.7	6.4
2006	4.4	0.2	4.6	2.9	0.0	2.9	3.9	0.0	1.4	0.9	-0.2	2006	0.7	6.8
2007	4.4	0.2	4.6	3.0	0.0	3.0	4.0	0.0	1.7	0.2	-0.2	2007	0.6	6.5
2008	4.3	0.1	4.4	3.0	0.0	3.0	4.0	0.0	1.9	0.2	-0.4	2008	0.7	6.4
2009	4.3	0.1	4.4	3.0	0.0	3.0	3.9	0.0	2.2	0.0	-0.3	2009	0.7	6.6
2010	4.2	0.1	4.4	3.0	0.0	3.0	3.9	0.0	2.5	0.0	-0.3	2010	0.7	6.9
2015	4.1	0.0	4.1	3.0	0.0	3.0	3.8	0.0	3.0	0.0	-0.5	2015	0.8	7.2
2020	4.1	0.0	4.1	3.0	0.0	3.0	3.8	0.0	3.0	0.1	-0.2	2020	0.8	7.5
2025	4.1	0.0	4.1	3.0	0.0	3.0	3.8	0.0	2.6	0.0	0.1	2025	0.9	7.5



\* Percent increase in year indicated over previous year, on an incurred basis.

\*\* Reflects the allowances provided for in the prospective payment update factors.

++ Under the intermediate assumptions

*Note: Historical and projected data reflect the hospital input price index which was recalibrated to a 1992 base year in 1997.*

# SMI Trust Fund

## Estimates Under Alternative II Assumption for Aged and Disabled Enrollees (Excluding End-Stage Renal Disease)

*Editor's Note: The following excerpt is taken from Section III.B, "Actuarial Methodology and Principal Assumptions for Cost Estimates for the Supplementary Medical Insurance Program," in the 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Copies of the 2003 Annual Report are available from Sol.Mussey (410-786-6386).*

**T**his section describes the basic methodology and assumptions used in the estimates for SMI (Medicare Part B) under the intermediate assumptions. In addition, projections of program costs under two alternative sets of assumptions are presented.

### Assumptions

The economic and demographic assumptions underlying the projections shown in this report are consistent with those in the 2003 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors

Insurance and Disability Insurance Trust Funds. These assumptions are described more fully in that report.

### Program Cost Projection Methodology

Estimates under the intermediate assumptions are prepared by establishing for each category of enrollee and for each type of service the allowed charges or costs incurred per enrollee for a recent year (to service as a projection base) and then projecting these charges through the estimation period. The per-enrollee charges are then converted to reimbursement amounts by subtracting the per-enrollee values of the deductible and coinsurance. Aggregate reimbursement amounts are calculated by multiplying the per-enrollee reimbursement amounts by the projected enrollment. In order to estimate cash disbursements, an allowance is made for the delay between receipt of and payment for the service.

#### a. Projection Base

To establish a suitable base from which to project the future costs of the program, the incurred payments for services provided must be reconstructed for the most recent period for which a reliable determination can be made. Therefore, payments to providers must be attributed to dates of service, rather than payment dates. In addition, the nonrecurring effects of any changes in regulations, legislation or administration of the program and of any items affecting only the timing and flow of payments to providers must be eliminated. As a result, the rates of increase in the incurred cost of the program differ from the increases in cash disbursements.

#### • Carrier Services

Reimbursement amounts for physician services, durable medical equipment (DME), laboratory tests performed in physician offices and independent laboratories and other services (such as physician administered drugs, free-standing ambulatory surgical center facility services, ambulance and supplies) are paid through organizations acting for the Centers for Medicare & Medicaid Services (CMS). These organizations referred to as "carriers," determine whether billed services are covered under the program and establish the allowed charges for the covered services. A record of the allowed charges, the applicable deductible and coinsur-



ance and the amount reimbursed after the reduction for coinsurance and the deductible is transmitted to CMS.

The data are tabulated on an incurred basis. As a check on the validity of the projection base, incurred reimbursement amounts are compared with cash expenditures reported by the carriers through an independent reporting system.

### • Intermediary Services

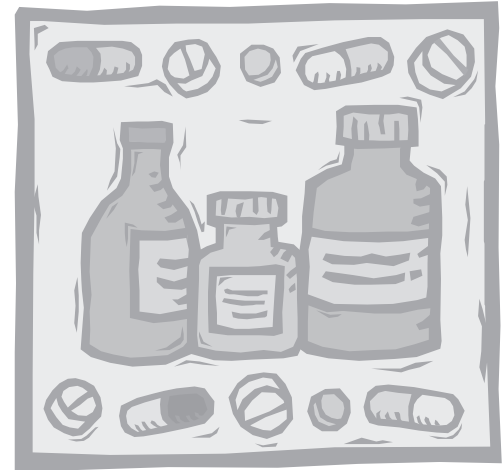
Reimbursement amounts for institutional services under the SMI program are paid by the same fiscal intermediaries that pay for HI services. Institutional services covered under the SMI program are outpatient hospital services, home health agency services, laboratory services performed in hospital outpatient departments, and other services such as renal dialysis performed in free-standing dialysis facilities, services in outpatient rehabilitation facilities, and services in rural health clinics. Reimbursement for institutional services occurs in two stages. First, bills are submitted to the intermediaries and interim payments are made on the basis of these bills. The second stage takes place at the close of a provider's accounting period, when a cost report is submitted and lump-sum payments or recoveries are made to correct for the difference between interim payments and final settlement amounts for providing covered services (net of coinsurance and deductible amounts). Tabulations of the bills are prepared by date of service and the lump-sum settlements, which are reported only on a cash basis, are adjusted (using approximations) to allocate them to the time of service.

### • Managed Care Services

Managed care plans with contracts to provide health services to Medicare beneficiaries are reimbursed directly by CMS on either a reasonable cost or capitation basis. Comprehensive data on such direct reimbursements are available only on a cash basis. Certain approximations must be made to allocate expenses to the period when services were rendered.

### b. Fee-for-Service Payments for Aged Enrollees and Disabled Enrollees without End-Stage Renal Disease (ESRD)

Disabled persons with ESRD have per-enrollee costs that are substantially higher and quite different in nature from those of most other disabled persons. Hence, program costs for them have been excluded from the analysis in this section and are contained in a later section. Similarly, costs associated with beneficiaries enrolled in managed care plans are discussed separately.



### Physician Services

Medicare payments for physician services are based on a fee schedule which reflects the relative level of resources required for each service. The fee schedule amount is equal to the product of the procedure's relative value, a conversion factor and a geographic adjustment factor. Payments are based on the lower of the actual charge and the fee schedule amount. Increases in physician fees are based on growth in the Medicare Economic Index (MEI), plus a performance adjustment reflecting whether past growth in the volume and intensity of services met specified targets under the sustainable growth rate mechanism.

Table III.B1 on page 16 shows the projected MEI increases and performance adjustments for 2004 through 2012.

The physician fee updates shown through 2003 are actual values. The modified update shown in column four reflects the growth in the MEI, the performance adjustment, as well as any legislative impacts such as the addition of preventative services.

Per capita physician charges also have increased each year as a result of a number of other factors besides fee increases, including more physician visits per enrollee, the aging of the Medicare population, greater use of specialists and more expensive techniques and certain administrative actions. The fifth column of Table III.B1 shows the increases in charges per enrollee resulting from these residual factors. Because the measurement of increased allowed charges per service is subject to error, this error is included implicitly under residual causes.

(continued on page 14)

Based on the increases in Table III.B1, Table III.B2 (not included here) shows the estimates of the incurred reimbursement for carrier services per fee-for-service enrollee.

### **DME, Laboratory and Other Carrier Services**

As with physician services over time other unique fee schedules or reimbursement mechanisms have been established for virtually all other non-physician carrier services.

Table III.B1 on page 16 shows the increases in the allowed charges per fee-for-service enrollee for DME, laboratory services and other carrier services. Based on the increases in Table III.B1, Table III.B2 (not included here) shows the corresponding estimates of the average

incurred reimbursement for these services per fee-for-service enrollee.

The fee schedules for each of these expenditure categories are updated by increases in the Consumer Price Index (CPI), together with applicable legislated limits on payment updates. In addition, per capita charges for these expenditure categories have grown as a result of a number of other factors, including increased number of services provided, the aging of the Medicare population, more expensive services and certain administrative actions. This growth is projected based on recent past trends in growth per enrollee.

### **Intermediary Services**

Over the years, legislation has been enacted to establish new payment systems for virtually all SMI intermediary services. A fee schedule was established for tests performed in laboratories in hospital outpatient departments. The Balanced Budget Act of 1997 (BBA) implemented a prospective payment system (PPS), effective August 1, 2000, for services performed in the outpatient department of a hospital. It also implemented a PPS for home health agency services, which began October 1, 2000.

The historical and projected increases in charges and costs per fee-for-service enrollee for intermediary services are shown in Table III.B3 (see page 17). The projected increases shown in this table reflect the impact of the BBA, provisions of which include the transfer of a substantial portion of home health agency services from the HI trust fund to the SMI trust fund starting in 1998. All benefit payments for those home health agency services being transferred are to be paid out of the SMI trust fund beginning January 1998. However, for the 6-year period 1998 through 2003, sums of money will also be transferred from the HI trust fund to the SMI trust fund to phase in the financial impact of the transfer of these services. It should be noted that in this section with the exception of Table III.B8 (not shown), the estimates for home health agency costs for 1998 through 2003 are the gross amounts associated with the payment of benefits and are not adjusted for the funds transferred from the HI trust fund.

Based on the increases in Table III.B3, Table III.B4 (not included here) shows the estimates of the incurred reimbursement for the various intermediary services per fee-for-service enrollee. Each of these expenditure categories is projected on the basis of recent past trends in growth per enrollee, together with applicable legislated limits on payment updates.



### c. Fee-for-Service Payments for Persons Suffering from ESRD

See SMI 2003 Annual Report.

### d. Managed Care Costs

Program experience with managed care payments has generally shown a strong upward trend. However, in recent years, there has been a slowdown in the number of Medicare beneficiaries choosing to enroll in managed care plans, and in 2001, 2002 and 2003, an overall reduction in this number. Capitated plans currently account for approximately 95 percent of all SMI managed care payments. For capitated plans, per capita payment amounts have grown following the same trend as fee-for-service per capita cost growth, based on the formula in the law to calculate managed care capitation amounts. The projection of future per capita amounts follows the requirements of the Balanced Budget Act of 1997 as related to the Medicare + Choice capitation amounts, which increase at rates based on the per capita growth for all of Medicare, less specified adjustments in 1998 to 2002.

The projected rates are further adjusted by the Benefits Improvement and Protection Act of 2000. Table III.B6 (not included here) shows the estimated number of SMI beneficiaries enrolled in a managed care plan and the aggregate incurred reimbursements associated with those enrollees.

A decline in Medicare + Choice enrollment is projected for the next few years as the provisions of the BBA (as subsequently modified) continue to limit growth in capitation rates. Thereafter, Medicare+Choice enrollment is assumed to gradually accelerate. In addition, there will be preferred provider plan demonstrations conducted 2003 through 2005 that will increase total managed care enrollment for those years. ♦



'Hypertext versions of the 2003 Social Security and Medicare Trustees Reports as well as "A Summary of the 2003 Annual Reports" are available on the Internet at the following addresses:

**Social Security (OASDI):**

<http://www.ssa.gov/OACT/TR/TR03/index.html>

**Medicare (HI and SMI):**

<http://www.cms.hcfa.gov/publications/trusteereport/>

**Summary:**

<http://www.ssa.gov/OACT/TRSUM/trsummary.html>

**Other information about Social Security benefits and services is available at:**

<http://www.ssa.gov>

or by calling toll-free 1.800.772.1213

**Other information about Medicare benefits and services is available at:**

<http://www.cms.hhs.gov>

or by calling toll-free 1.800.663.4227

**Table III.B1** Components of Increases in Total Allowed Charges Per Fee-for-Service Enrollee for Carrier Services (in Percent)

The diagram shows a flow from 'Physician Fee Schedule' to 'Increase Due to Price Changes'. 'Increase Due to Price Changes' is then broken down into components: MEI, MPA, Net Increase in Allowed Fees, Residual Factors, Total Increase, CPI, DME, Lab, and Other Carrier. The table below provides the numerical data for these components from 1998 to 2012, categorized by 'Aged' and 'Disabled' enrollees.

Calendar Year	MEI	MPA <sup>1</sup>	Net Increase in Allowed Fees <sup>2</sup>	Residual Factors	Total Increase <sup>3</sup>	CPI	DME	Lab	Other Carrier
<b>Aged</b>									
1998	2.2	1.2	2.9	1.3	4.2	1.3	-2.1	-9.3	10.1
1999	2.3	0.0	2.7	1.2	3.9	2.2	5.0	-0.1	10.7
2000	2.4	3.0	5.8	3.5	9.5	3.5	10.1	7.3	14.2
2001	2.0	3.0	5.7	3.5	9.4	2.7	12.7	7.7	16.6
2002	2.6	-7.0	-4.0	7.9	3.6	1.4	9.4	6.8	14.4
2003	3.0	-1.1	1.4	3.0	4.5	2.3	3.0	4.5	11.2
2004	2.0	-6.1	-4.2	4.4	0.1	2.4	6.7	6.0	10.4
2005	2.2	-4.6	-1.7	3.7	2.0	2.7	5.8	5.1	10.9
2006	1.8	-3.6	-0.9	3.6	1.7	2.9	6.1	5.2	10.5
2007	2.1	-2.5	-0.5	3.3	2.8	3.0	6.2	5.4	9.9
2008	2.1	-1.8	0.3	3.1	3.3	3.0	6.3	5.6	9.2
2009	2.1	-1.6	0.5	3.0	3.5	3.0	6.3	5.6	8.4
2010	2.2	-1.5	0.7	3.0	3.7	3.0	6.3	5.6	7.9
2011	2.1	-1.6	0.5	3.0	3.5	3.0	6.4	5.6	7.9
2012	2.1	-1.8	0.3	3.1	3.3	3.0	6.4	5.6	8.0
<b>Disabled</b> (excluding ERSD)									
1998	2.2	1.2	2.9	1.9	4.8	1.3	2.7	-5.9	10.9
1999	2.3	0.0	2.7	0.9	3.6	2.2	2.7	3.1	11.3
2000	2.4	3.0	5.8	3.5	9.5	3.5	11.0	3.9	11.9
2001	2.0	3.0	5.7	5.3	11.3	2.7	16.7	9.6	21.1
2002	2.6	-7.0	-4.0	7.1	2.9	1.4	11.0	7.3	15.6
2003	3.0	-1.1	1.4	3.0	4.5	2.3	6.4	5.0	10.7
2004	2.0	-6.1	-4.2	4.4	0.0	2.4	6.7	5.9	10.1
2005	2.2	-4.6	-1.7	3.7	1.9	2.7	5.8	5.1	10.6
2006	1.8	-3.6	-1.9	3.6	1.7	2.9	6.0	5.2	10.3
2007	2.1	-2.5	-0.5	3.3	2.8	3.0	6.2	5.4	9.7
2008	2.1	-1.8	0.3	3.1	3.3	3.0	6.3	5.6	9.1
2009	2.1	-1.6	0.5	3.0	3.5	3.0	6.3	5.6	8.3
2010	2.2	-1.5	0.7	3.0	3.7	3.0	6.3	5.6	7.8
2011	2.1	-1.6	0.5	3.0	3.5	3.0	6.3	5.6	7.9
2012	2.1	-1.8	0.3	3.1	3.3	3.0	6.4	5.6	7.9

<sup>1</sup> Medicare performance adjustment

<sup>2</sup> Reflects the growth in the MEI, the performance adjustment as well as any legislative impacts

<sup>3</sup> Equals combined increases in allowed fees and residual factors

**Table III.B3** Components of Increases in Recognized Charges and Costs Per Fee-for-Service Enrollee for Intermediary Services (in Percent)

Calendar Year	Outpatient Hospital	Home Health Agency <sup>1</sup>	Outpatient Lab	Other Intermediary
<b>Aged</b>				
1998	-1.4	3017.2 <sup>2,3</sup>	4.1	-4.0
1999	9.5	- 1.4 <sup>2,3</sup>	12.6	-21.0
2000	-2.9	14.7 <sup>3</sup>	5.1	22.0
2001	13.9	-49.5 <sup>3</sup>	4.3	19.2
2002	3.9	10.4 <sup>3</sup>	14.6	11.6
2003	4.2	- 2.3 <sup>3</sup>	5.0	-0.5
2004	4.5	6.7	5.9	-4.6
2005	8.4	6.7	5.2	5.5
2006	8.0	6.3	5.2	5.3
2007	8.1	6.4	5.4	5.3
2008	8.1	5.7	5.6	5.3
2009	8.0	4.9	5.6	5.3
2010	8.0	4.9	5.6	5.3
2011	7.4	4.5	5.6	5.3
2012	7.4	3.9	5.6	5.4
<b>Disabled</b> (excluding ERSD)				
1998	-3.6	— <sup>2,3</sup>	0.7	-1.4
1999	9.2	- 1.5 <sup>2,3</sup>	14.6	-9.8
2000	45.3	14.6 <sup>3</sup>	8.2	-8.2
2001	51.0	-51.7 <sup>3</sup>	11.6	1.2
2002	-16.6	10.4 <sup>3</sup>	13.0	11.9
2003	-27.0	-4.2 <sup>3</sup>	11.0	0.1
2004	4.5	6.4	12.0	-0.6
2005	8.4	6.4	9.8	7.0
2006	7.9	6.4	5.2	7.0
2007	8.0	6.7	5.4	7.0
2008	8.1	6.3	5.6	7.0
2009	8.0	5.5	5.6	7.0
2010	8.0	5.5	5.6	7.0
2011	7.4	5.4	5.6	7.0
2012	7.4	5.4	5.6	7.0

<sup>1</sup> From July 1, 1981 to December 31, 1997, home health agency services were almost exclusively provided by the Medicare HI program. However, for those SMI enrollees not entitled to HI, the coverage of these services was provided by the SMI program. During that time, since all SMI disabled enrollees were entitled to HI, their coverage of these services was provided by the HI program.

<sup>2</sup> Effective January 1, 1998, the coverage of a majority of home health agency services for those individuals entitled to HI and enrolled in SMI was transferred from the HI program to the SMI program. As a result, as of January 1, 1998, there was a large increase in SMI expenditures for these services for the aged enrollees, and SMI coverage for these services resumed for disabled enrollees.

<sup>3</sup> Does not reflect the impact adjustments for monies transferred from the HI Trust Fund for HHA costs, as provided by Balanced Budget Act of 1997.

# Summary of E&E Proposals Adopted by The Board of Governors in June 2003

by Emily Kessler

## New examination syllabus announced

By now you hopefully have seen the announcement from the EQ2005 committee on the plan for the redesign of the examination system for candidates studying to become ASAs/FSAs. We've reprinted the summary here, along with information about how to contact the SOA with your comments on the redesign.

## Preliminary Education

**T**he subgroup working on the Preliminary Education (PE) component has had three guiding principles:

1. Travel time should be reduced when compared to completing current Courses 1-4. This should not be accomplished by shifting material later in the syllabus.
2. Appropriate education and validation methods should be used.
3. While the main purpose for preliminary education is to set the theoretical foundation for actuarial work, there should be a connection between theory and practice.

The proposal calls for three components:

1. Prerequisites. Topics, which will not be directly validated: calculus, linear algebra, introductory accounting, business law elements and mathematical statistics.
2. Validated by educational experience. Topics where candidates will demonstrate proficiency by submitting transcripts and course descriptions from formal courses which will be reviewed to determine whether they meet the stated criteria. These subjects will include economics, corporate finance and applied statistical methods.
3. Traditional Examination. These subjects will be validated by a traditional examination: probability, mathematics of finance, models for quantifying risk, construction and evaluation of risk models.

## ASA Course

The subgroup assigned to work on the ASA course had several parameters and goals in mind:

1. Expose candidates to common situations and useful tools in all practice areas to enable an understanding of the business environment.
2. The premise of the control cycle served as a model for the design. Use of this model allows us to introduce practical experience earlier in the candidate's career.
3. Focus on enhancing the educational aspects of the course while making use of both formal and informal validation methods.
4. Integrate the principles of effective instruction (introduction of key concepts, elaboration of key concepts, practical application of the concepts, assessment of concept understanding and application of the concepts in other contexts) via a modularized, learner-centered, and active and applied learning experience.

The current proposed design includes the completion of eight modules along with Preliminary Education and the Associateship Professionalism Course (APC), in order to earn the ASA designation. Candidates would be able to begin the ASA course prior to completing the PE requirements. Throughout the eight modules, candidates will be exposed to themes of professionalism, result validation, applications of law and wherever appropriate, stochastic versus point estimates. Each module will include coverage of a required body of knowledge within a practical application context; interactive segments which the candidate will use to assess his or her level of understanding and an exercise or exercises in which the candidate will demonstrate understanding of the subject matter.

The emphasis of the entire ASA course design is *education over accreditation*. Some exercises for selected candidates will be formally validated; a process for informally validating exercises prepared by other candidates will be created for candidates who elect this help. Candidates must pass a multiple-choice examination following Module 4 and Module 8.

## FSA Component

Following the attainment of the ASA, candidates continuing to work for the FSA designation will need to complete the following:

1. Modules similar in format and delivery to those used in the ASA course, most of which may be practice-area specific.
2. Two examinations, each similar in size to the current Course 8 examinations.
3. A capstone module that may be similar in structure to the ASA course modules or may use a seminar format.
4. A concluding seminar equivalent to the FAC.

All candidates will be required to complete the two FSA-level examinations within the same practice area. The examinations will reflect coverage of the following topics, as applicable to the individual practice areas:

1. Regulatory Considerations (including accounting, taxation)
2. Valuation
3. ALM/Risk Management
4. Product Design
5. Pricing (including underwriting, selection of assumptions)

## Next Steps

### Preliminary Education

- Appoint a PE Design Team, which will be charged with enacting the proposal, with a target implementation date of May 2005.

### ASA Course

- Appoint a coordinating design team. The team's first task will be to further define the desired content and accreditation for the course modules with input from the practice area advisory groups.
- Form individual module development teams within six months of appointing the coordinating design team. These teams will then proceed with the development of the course.
- Concurrently, detailed cost specifications and an implementation plan will be developed.

## Citigroup Pension Discount Curve and Liability Index available back to 1995

The Citigroup (formerly Solomon Brothers) Discount Curve and Liability Index has been updated through June 30, 2003. In addition, the new Excel file includes complete information dating back to 1995. It's updated periodically, and is available on SOA Web site through the Pension Section Web page or directly at <http://www.soa.org/sections/pendis03.html>.

### FSA Component

- Refine the learning objectives on the basis of a two-exam-plus modules approach. This will necessitate the prioritization of the learning objectives (validated by exam vs. modules) as well as the drafting of a framework.

### Overall

- A complete report to the membership, covering the status and plans for each of the three components, was distributed to the membership and candidates in August. Readers have been encouraged, and are now submitting, comments to:

*Eq2005@soa.org*

or

Society of Actuaries

Core Studies and Global Initiatives

475 N. Martingale Road, Suite 600

Schaumburg, IL 60173

- A conversion plan will be finalized and presented to the general membership and candidates by the end of this calendar year. ♦

## What's new from the SOA?

### GAO discovers what the SOA already knew

The GAO recently released a report titled *Private Pensions: Participants Need Information on Risks They Face in Managing Pension Assets at and during Retirement*. The report notes that "retiring participants need information and education on various risks that affect the level of income needed during retirement . . . Our expert panel also noted the importance of information and education on how to assess needs in retirement, how to compare annuity and lump sum amounts, the value of expected benefit from DB and

(continued on page 20)

DC plans, how annuities provide retirement income, and strategies for drawing down pension assets during retirement.” The GAO report is available at <http://www.gao.gov/new.items/d03810.pdf>.

The SOA Committee on Post-Retirement Needs & Risks has known about the knowledge gap and has been working diligently to create a body of work illustrating the misunderstandings people have about their retirement needs and risks. They’ve produced, with help from the Committee on Retirement Systems Research and your own Pension Section, several calls for papers, the Post-Retirement Risk Chart, several surveys, and there’s more on the way. The SOA has decided to take that body of work and build it into a public education campaign, initially targeted at the media, plan sponsors and business press. The goal is to use the work done by the committee to educate the media and, through the media, start to educate the public. The SOA will also actively seek partners for direct consumer education.

Stay tuned to the SOA Web site and more information about post-retirement needs and risks. If you want to know more about what the committee has done, go to the Committee’s Web page at <http://www.soa.org/sections/retirement/framework.html>. For more information about the current activities of the committee, or how you can help, contact Emily Kessler at [ekessler@soa.org](mailto:ekessler@soa.org) or 847/706-3530.

### **DROPs**

A new paper on deferred retirement option programs (DROPs), titled *Design and Actuarial Aspects of Deferred Retirement Options Programs*, has been published as an online monograph. These “Deferred Retirement Option Programs” (hence the name DROPs) provide a way for participants to continue to accrue benefits while working beyond the normal retirement age. DROPs have been popular in public sector plans and there is growing interest among private plan sponsors. The paper provides an overview of DROPs looking at common features, case studies, actuarial issues in their valuation, administrative issues in their design and qualification, and DROPs from the point of view of participants and plan sponsors. An excellent way to understand these common.

The paper was sponsored by the Committee on Retirement Systems Research, and can be found at [http://www.soa.org/library/monographs/retirement\\_systems/m-rs03-2/m-rs03-2\\_tableofcontents.pdf](http://www.soa.org/library/monographs/retirement_systems/m-rs03-2/m-rs03-2_tableofcontents.pdf)

Interested in more on retirement plan design or the issue of how people retire? Don’t forget the papers from the Retirement Implications on Demographic and Family Change Symposium (held in June, 2002). The symposium may be long past, but the ideas presented are still relevant. Three papers presented at that forum on gradual retirement, phased retirement and factors

influencing participants in selecting a retirement age, were published in the July issue of the *North American Actuarial Journal*. The complete series of papers from the symposium can be found at [http://www.soa.org/library/monographs/retirement\\_systems/m-rs02-2/m-rs02-2\\_tableofcontents.html](http://www.soa.org/library/monographs/retirement_systems/m-rs02-2/m-rs02-2_tableofcontents.html).

### **Pharmacy Drugs for the Medicare-Eligible Population**

And finally, of particular interest to those who work with postretirement medical plans ... check out the recently published *Projected Cost Analysis of Potential Medicare Pharmacy Plan Designs*. The Health Practice Area and Health Section jointly sponsored this study of the potential cost of introducing prescription drug coverage for Medicare enrollees. The study, conducted by Reden and Anders, estimates and compares the current costs of providing prescription drug coverage for approximately 30 representative benefit plans. For two of the plans, the study forecasts these costs over the next 10 years. Of equal importance, the study points out the myriad of factors that can impact these costs now and in the future to better inform readers who are comparing proposals currently under consideration by Congress.

The study is a great primer on how different plan designs can affect the cost of a plan, and how prescription drug claims are distributed (both by total claim dollars and cost per prescription). It’s no substitute for a good health actuary, but it can help you understand the issues as you talk to clients and colleagues.

The study is available on the Web site at [http://www.soa.org/research/medicare\\_pharmacy.pdf](http://www.soa.org/research/medicare_pharmacy.pdf).

For more information about these items, or anything else going on at the SOA, contact Emily Kessler at [ekessler@soa.org](mailto:ekessler@soa.org), or 847.706.3530. ♦

# Pension Section Council Summary of Activities

by Tonya B. Manning

**D**uring the second quarter of 2003, the Pension Section Council had meetings via conference calls in April and May and met in person in Vancouver, BC on June 21, 2003. Following is a summary of the current activities of the Pension Section Council:

- **Spring SOA Meeting in Vancouver / Seminars**

The Pension Section sponsored several sessions at the Spring SOA meeting. Also, in conjunction with the SOA Meeting, a symposium, "The Great Controversy: Current Pension Actuarial Practice in Light of Financial Economics" was held. The sessions and the symposium were very successful. The symposium sparked many discussions and revealed intriguing new insights to both common practices and current regulations related to pension valuations.

The Council is currently planning several pension-related seminars for 2003 and 2004.

- **Research Projects**

Projects that the Pension Section is promoting:

- A voluntary annuitization project by Moshe Milevsky, which will examine financial issues faced by individuals when they convert lump sum retirement savings balances into ongoing income streams.
- A project on pre-retirement influences by Linda Smith-Brothers, which will examine the various items that influence an employee's decision to retire.
- A project surveying retirement plan design preferences of both active workers and retirees. (Results from the survey were presented at the Spring SOA meeting.)
- The Pension Section is in the process of initiating a survey of what assumptions and methods are used for FAS 87 and FAS 106 calculations. The survey will include information regarding both the prior and the current fiscal year. The results from the survey will be posted on the SOA Web site.



- **Guiding Principles**

The mission of the Pension Section is to provide or support educational opportunities for its members and to support research that will enhance the ability of its members to work with their clients. The Pension Section Council is responsible for carrying out this mission by directing and managing the activities of the Pension Section. The council has now established guiding principles that will serve as a guide for future decisions and activities of the council as it carries out its mission. A link to the guiding principles may be found on the Pension Section page of the SOA Web site.

- **Coordination with RSPAC**

The council, along with the Retirement Systems Practice Area Committees (RSPAC), continues to explore revised structures and procedures that would better coordinate the efforts of the two groups with regard to pension-related issues and activities.

- **Financial Statement**

Following is a summary of the council's 2003 income and expenses through March 2003:

Assets as of January 1, 2003	\$137,000
Income	\$74,000
Expenses	
Ongoing Expenses	\$27,000
Ongoing Services to Members	\$20,000
Special Projects	\$1,000
<b>Assets as of March 31, 2003</b>	<b>\$163,000</b>

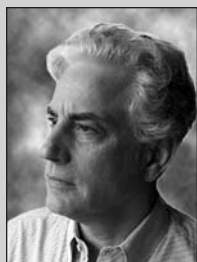
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# Weak Pension Funding Standards

## Backdoor Loan Guarantees

by Jeremy Gold



Jeremy Gold, FSA, MAAA, is president of Jeremy Gold Pensions in New York, NY. He can be reached at [jeremyg@alumni.upenn.edu](mailto:jeremyg@alumni.upenn.edu).

The latest proposal from Representatives Portman and Cardin of the House Ways and Means Committee is reported by Mary Williams Walsh in the *New York Times*, April 11, 2003.

Many members of Congress who would not support loan guarantees for weak airlines and weak auto companies may be inclined to go along with weak pension funding standards. In substance, however, weak funding standards for weak companies are loan guarantees. Consider:

A promise of future cash flows (in effect, a debenture) made by a weak auto or airline might be exchanged in the capital markets (a bond issue or a borrowing) for \$80. That same promise, if it were made by a strong company, might raise \$120 in new loans.

A promise of those same cash flows to the firm's employees in exchange for wage concessions amounts to borrowing from one's own employees. In the absence of guarantees, the employees would concede no more than \$80 worth of wages. But, in the form of pensions that are protected by the Pension Benefit Guaranty Corporation, the employees recognize that the promise is worth \$120. Thus they are happy to concede \$100 worth of wages for such guaranteed promises.

In effect the PBGC has written a loan guarantee to cover this special form of private borrowing. The company gets \$100 in wage concessions when similar borrowing would net only \$80 in the capital markets. The employees get a promise worth \$120 in exchange for only \$100 in wages. The remaining \$40 is "contributed" by the PBGC. Every weak company that sponsors a weakly funded pension plan can effect this transaction in union negotiations—the checkbook of the PBGC may be signed by almost anyone.

Is this backdoor what Congress really wants to provide?

Interestingly, although the guarantee is made by a federal agency, the burden is likely to fall upon strong companies. When the pension plans of the weak firms do fail—and some will—more in bad times, fewer in good times—the PBGC must eventually raise the premiums that it charges to all companies. In some ways Congress really gets to write checks to weak companies on the accounts of strong companies. Of course, if things get bad enough, the cost will be borne by taxpayers. ♦



# Post-Retirement Risks Highlight 2004 LIMRA/LOMA/SOA Pension Conference

by Karen Gentilcore and John Riley

**M**any people approaching retirement are not knowledgeable about how best to manage their assets during retirement. In particular, the prospect of outliving one's assets and healthcare needs associated with aging are frequently overlooked.

The Post Retirement Needs & Risks Committee is sponsoring new research to way to address post-retirement risks using traditional solutions or innovative new approaches. These papers will be presented in conjunction with the Annuity and Pension Conference, March 31-April 2, 2004, in Las Vegas at the Flamingo Hotel. Topics will include: optimal distribution strategies—how and when alternate product, and risk-pooling alternatives.

LOMA, LIMRA and the Society of Actuaries have developed this multidisciplinary conference to deal with the marketing, sales, operations and development of pension and annuity plans. The 2004 Pension and Annuity Conferences will continue the tradition of providing informative sessions with excellent content that will help pension providers improve their distribution and operational effectiveness.

Visit <http://www.loma.org/pension.asp> for more information on the pension conference or contact John Riley via e-mail to [jriley@soa.org](mailto:jriley@soa.org). Also, mark your calendars for the Pension Issues for Multi-National Employers seminar to take place on November 13-14 at the Sheraton New York in New York City. Information on this seminar can be found at [www.soa.org](http://www.soa.org). ♦

## Journal of Actuarial Practice Call For Papers

Papers may be on any subject related to actuarial science or insurance. Preference will be given to practical or pedagogical papers that explain some aspect of current actuarial practice. As an international journal, JoAP welcomes papers pertaining to actuarial practice outside North America. JoAP also accepts technical papers, commentaries and book reviews. Papers may be submitted via e-mail in PDF format, or send five copies via postal mail to the address below. All papers are subject to a peer referee process. Deadline for submission is November 30, 2003. ♦

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## Articles Needed for the *Pension Section News*

Your help and participation is needed and welcomed. All articles will include a byline to give you full credit for your effort. *News* is pleased to publish articles in a second language if a translation is provided by the author. For those of you interested in working on the *News*, several associate editors are needed to handle various specialty areas such as meetings, seminars, symposia, continuing education meetings, teleconferences and cassettes (audio and video) for Enrolled Actuaries, new pension study notes, new research and studies by Society committees, etc. If you would like to submit an article or be an associate editor, please call Dan Arnold, editor, at 860.521.8400.

As in the past, full papers will be published in *The Pension Forum* format, but now only on an ad hoc basis.

### **News is published quarterly as follows:**

<b>Publication Date</b>	<b>Submission Deadline</b>
December 2003	October 10, 2003
March 2004	January 6, 2004
June 2004	April 5, 2004
September 2004	July 9, 2004

### **Preferred Format**

In order to efficiently handle articles, please use the following format when submitting articles:

E-mail your articles as attachments in either MS Word (.doc) or Simple Text (.txt) files. We are able to convert most PC-compatible software packages. Headlines are typed upper and lower case. Please use a 10-point Times New Roman font for the body text. Carriage returns are put in only at the end of paragraphs. The right-hand margin is not justified.

If you must submit articles in another manner, please call Joe Adduci, 847.706.3548, at the Society of Actuaries for help.

Please send a hard copy of the article to:

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Thank you for your help.

