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IN THE PUBLIC INTEREST

THE SOCIAL INSURANCE LAW OF PEOPLES' REPUBLIC OF CHINA—PART 1

By Wenliang Wang

Editor's Note: *This article is a summary of a new, upcoming Social Insurance Law in China. This summary is being published as Part 1 since the details of the new law are still in the works. Part 2, which will focus on those details, will be published in the next newsletter. Part 1 is being presented to heighten your awareness of what's happening in China.*

BACKGROUND OF CURRENT SOCIAL INSURANCE SCHEMES IN CHINA

China has a different set of issues to address regarding public medical plans than other countries do. The most pressing issues, among others, include:

1. Imbalanced economic development among areas has led to an unfortunate situation. Most rural areas don't have adequate medical facilities. This affects nearly 60 percent of the Chinese population. Establishment of adequate public medical facilities is a top agenda item for the Chinese government. But the medical facilities in China are primarily operated under a government controlled system. Unfortunately the government system cannot bear all the costs of establishing medical systems in rural areas.

2. In 2005, the central Chinese government launched medical insurance reform committed to extending coverage to all rural populations. The process is still going on. The rural medical plans so far have been pooled and operated at a provincial level—with support from lower levels of government. The central government has provided a significant subsidy to local rural medical plans in addition to the required subsidy from local governments. The local governments also choose to

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IN THE PUBLIC INTEREST

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LETTER FROM THE EDITOR

By Bill Cutlip

Welcome to another edition of the newsletter of fastest-growing section in the Society. The subject matter evolves with daily changes in society keeping the membership on its toes.

This edition again brings thoughts, ideas and information from around the globe. There's public medical insurance from New York; Part 1 of an article on newly enacted public medical insurance from China; how can actuaries learn from and help the CDC; changes in the Caribbean; and, the problems with public finance and taxation for retirement programs in Europe.

There's also a new feature in this edition—"This and That"—noteworthy and newsworthy items to whet your appetite to do some more research on your own.

So much is happening in the world that impacts actuaries. Social insurance and public finance may not be specific areas of practice for you but the results of government and social financial actions certainly affect your personal if not professional lives.

We also have opportunities to help friends, the public and legislators. Our skills in understanding and measuring risks can put new perspective on questions. We may not be able to supply all the answers but at least we can raise questions for others to ask and perspectives that will cause people to ask questions.

Read the SIPF newsletters. They will help you keep abreast of issues and where to find answers.

Bill Cutlip
FSA, MAAA, FAC, CLU, ChFC, CPCU
Editor for this Issue

provide statutory rural medical plans. Because the rural plan was recently established, no meaningful buffer has been established to allow for any adverse experience in the near future, particularly when the rate set for rural plans is quite low, usually RMB 60 per year. An additional challenge is that the rural population hasn't gotten used to any form of public medical plan and they are usually the lowest income group in our society.

3. Concern about cost has been emerging over the last several years for developed economic areas such as Shanghai and Beijing. Currently, the mandatory urban medical plan for retirees is very generous. It doesn't require any payment from retirees once they reach their retirement age, but retirees have an individual account which can receive an annual personal allowance from the public plan. These medical plans are subject to a small deductible and a small co-share, but have a generous ceiling. Unfortunately, this can lead to over-use by those on the public plan. The local government needs to reconsider this policy.

4. The incentive system for current medical plans in China doesn't support cost control. The hospitals are primarily owned and operated by the government. They achieve their budget balance primarily through the collection of service fees and the sale of prescription drugs. The price of drugs is hovering at a high level and over-prescribing is common. No pay-for-service or pay-for-performance system has been established. In absence of an initiative from the government side, the hospital is the dominant stakeholder as investor, owner and sponsor of any public medical plan. Some local governments have decided to try different incentive systems, but face strong resistance from the hospitals and pharmaceutical companies. The Ministry of Health has taken a series of steps to standardize the treatment and prescription process for the purpose of controlling cost, but the results remain to be seen.

5. The segmentation of medical plans (currently, every type of public medical plan is a pure, local-only plan) has produced a lot of inconvenience for the migrant population. The migrant population can often be covered by two or more medical plans; often one of them is a waste of financial resources for them, while the remaining plan is not fully appropriate for them either.

More information in regard to public pension plans and their general history in China will be discussed in part 2 of this article.

INTRODUCTION OF THE SOCIAL INSURANCE LAW OF PEOPLES' REPUBLIC OF CHINA

The first ever national legislation on social insurance was recently completed in China. The first move to legislation in this area dates back to 1999 after legislation of the Labor Law was completed, and it took almost 11 years to finalize the Social Insurance Law. On Oct. 28, 2010, the Standing Committee of the National People's Congress voted for the Social Insurance Law and ruled that the legislation will come into force on July 1, 2011.

The legislation sets forth a set of basic principles for a social insurance plan in China, including the provision of extensive coverage and basic benefits in a multi-level structure in a sustainable way. In addition, the social insurance level will be kept in line with the social and economic development in China.

The legislation has restated that all five of the current social insurance plans need to be maintained in a framework of multiple funding channels in the future; including basic pension plans, basic medical plans, workers' compensation plans, unemployment plans, and maternity leave plans.

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The basic pension plan has a total of four sub-plans to cover the workforce in urban areas, civil servants and the employees of a public institution (such as schools, colleges and hospitals), the residents in urban areas who are uncovered otherwise, and the farm workers and residents in rural areas. Each sub-pension plan has its own contribution schedule, funding sources and benefit target, and is pooled and operated by itself. All sub-plans are subject to a requirement for progressive integration into a nationwide pool. But the sub-plan for civil servants and employees of a public institution has been explicitly subjected to a different regime at the discretion of the State Council.

The basic medical plan has a total of three sub-plans to cover the workforce in urban areas, the residents in urban areas who are uncovered otherwise, and the farm workers and residents in rural areas.

The worker's compensation (WC) plan has expanded the benefit coverage somewhat and for the first time has allowed experience-based rating and schedule rating to be applied to different employers.

The unemployment benefit level has been unified into a nationwide standard under the unemployment plan. The entitlement and maintenance requirements for a qualified claimant have also been stated and unified in replacement of various treatments in existing local plans.

The maternity leave plan has been expanded to provide coverage for the otherwise uncovered spouse of a covered participant to the extent of medical expenses incurred in maternity treatment.

All WC, unemployment, maternity leave and basic medical plans are currently pooled and operated at lower government levels, usually at a city level. The legislation has established that all those social insurance plans shall be integrated into the provincial pooling level in a progressive way without any details or timeline given.

The legislation requires that the current gap in funding the cost of social insurance plans be balanced in the governmental budgeting process. A government body, named Social Insurance Supervision Committee, will be established at each level of the government ladder. This government body has been given the authority to supervise, audit and monitor the operation, investment and use of the social insurance fund.

The legislation has not made any decisions on retirement age, which was (and is) an important subject in the Labor Law of Peoples' Republic of China. The legislation has only given a framework to provide, maintain, fund and implement a social insurance plan. Some critical details of the plan, such as contribution rate, calculation of benefit level and method for changing it in the future haven't yet been decided. Nevertheless, the legislation retains the current entitlement requirement of the basic pension plan for the workforce in urban areas, meeting the statutory retirement age (currently 60 for males, 50 for females) and having an accumulative 15 years' of work contribution.

SOCIAL INSURANCE LAW PART 2: DISCUSSION ITEMS

The items listed below will be discussed in the next newsletter in part 2 of this article:

1. Separate treatment of population and its implications in the long-term.

2. Funding issues with regard to historical liabilities.

3. Role of government in funding the Social Insurance plan.

4. Transparency (benefit, contribution, retirement age setting, credit rate with individual retirement account).

5. Funding and contribution decision making process.

6. Affordability (lack in the general principles and the potential unaffordability of the medical plan).

7. Means testing under city residence retirement plan.

8. Integration of national social insurance pool and provincial-level social insurance pools.

9. Participation by the insurance market.

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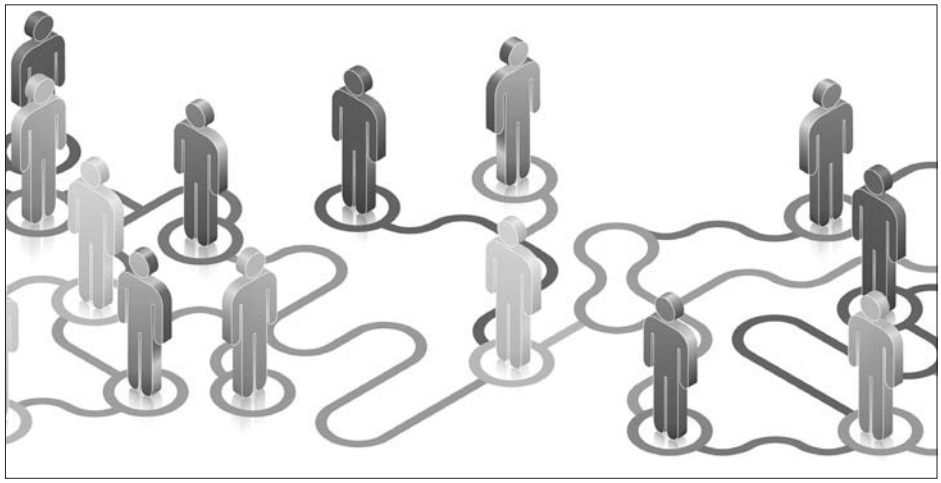
A VIEW FROM THE SOA'S STAFF FELLOW FOR RETIREMENT-MARCH 2011

By Andrew Peterson

Do you remember completing dot to dot exercises as a kid? Or perhaps you've even done one recently on the kids menu while waiting for your food to arrive at a family restaurant. Sometimes the pictures were obvious even before starting while other times it took the work of making the connections before the picture came into focus. I believe that a key role of the staff fellows here at the SOA is to connect the dots. This connecting can be both an internal effort within the profession with respect to various committees and research efforts or an external effort where we work with individuals outside the actuarial profession in areas where we have common interests or opportunities to learn from one another.



NATIONAL ACADEMY OF SOCIAL INSURANCE

One such example of connecting the dots is the actuarial profession's participation in the annual National Academy of Social Insurance (*www.nasi.org*) conference held each January in Washington, D.C. The National Academy of Social Insurance is "a nonprofit, nonpartisan organization made up of the nation's leading experts on social insurance. Its mission is to promote understanding of how social insurance contributes to economic security and a vibrant economy." NASI has about 1,000 members from various professions who have interest and expertise in social insurance.

Actuaries were involved with NASI from its founding 25 years ago and include a growing group of members. The SOA, American Academy of Actuaries (AAA) and The Actuarial Foundation have all been involved with NASI over the years. The SOA and the Academy provide regular financial assistance for their annual meeting. The Actuarial Foundation has supported the development of some issues briefs, including *When to Take Social Security Benefits: Questions to Consider*, which included advice and review by three actuaries: Joseph Applebaum, Anna Rappaport and Alice Wade.

Involvement with NASI has been an important way for us to connect the dots to how academics and policy makers are thinking of the evolution of social insurance systems. This knowledge helps the SOA support our members with research and continuing education programs, building a bridge from what most actuaries do (private insurance and pensions) to social insurance programs.

2011 ANNUAL CONFERENCE

NASI held its two-day annual conference at the National Press Club in Washington, D.C. (the standing conference site) on Jan. 27 and 28, 2011. This year's event was titled, *"Meeting Today's Challenges in Social Security, Health Reform and Unemployment Insurance."* The conference included a mix of topics and speakers including keynote addresses by the Honorable Kathleen Sebelius, U.S. Secretary of Health and Human Services and Kenneth Feinberg who is known for administering disaster payout funds, including the September 11th and BP Horizon disaster compensation funds.

What I found most interesting were several sessions that focused on possible Social Security

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reforms and general retirement security policy. In particular, there was a session that focused on Social Security reforms titled, *"Should We Adopt the Social Security Recommendations of the Fiscal Commission Co-Chairs?"* Speaking at this session were Charles Blahous, a public trustee of Social Security and Medicare and formerly a Bush administration official, Andy Stern, a fellow at the Georgetown Public Policy Institute and formerly the president of the Service Employees International Union (SEIU), and Janice Gregory, president of NASI. This session focused on the report of the Obama-appointed Fiscal Commission that issued a major report in December 2010 with a whole litany of proposals for long-term deficit reduction.

Also known as the Simpson-Bowles plan, the key Social Security reforms in the proposal include:

1) Making the retirement benefit formula more progressive,

2) Providing an enhanced minimum benefit for low-wage workers,

3) Enhancing benefits for the "very old" and long-time disabled,

4) Gradually increasing the early and full retirement ages and tie to life expectancy,

5) Giving more flexibility in claiming benefits and creating a hardship exemption for those who cannot work past age 62,

6) Gradually increasing the taxable wage base to cover 90 percent of all wages,

7) Adopting an improved CPI measure,

8) Covering future state/local employees in Social Security (after 2020),

9) Improving SSA's communication to beneficiaries, and

10) Beginning a broad dialogue on the importance of personal retirement savings.

I had reviewed the key Social Security provisions of the Fiscal Commission's report upon its release and personally thought it was a pretty good proposal. In addition, having heard a fair amount of criticism from both sides of the political spectrum on the proposal I presumed that it might actually be a reasonable compromise between "progressive" and "conservative" views. Not surprisingly, the panelists found much to debate and disagree about.

Charles Blahous' overall view of the recommendations was that the plan "strikes a reasonable compromise between containing costs and raising revenues to close the shortfall." On the other hand, Andy Stern, who was a member of the Fiscal Commission, argued that there are better alternatives to the Simpson-Bowles plan and that he would prefer to focus on the bigger issue of retirement security (as described in point 10 above) rather than just Social Security. Finally, Janice Gregory argued against any benefit cuts to the current program, pointing to the increasing reliance of individuals on Social Security for retirement security as a reason to avoid cuts. She argued instead that the program could be supported by additional payroll taxes through raising the taxable wage base and/or slowly raising the FICA tax percentages. (All the presentations can be downloaded by visiting *http://www.nasi.org/events/119/presentations*, and the formal agenda and video recordings can be viewed by visiting *http://www.nasi.org/events/119/agenda-videos*.)

Both Andy Stern and Janice Gregory argued for the need to focus on a retirement age range, although this seemed to be different than increasing the retirement eligibility ages (as summarized in point 4 above) which is something that has been discussed at length in the actuarial profession.

COMMENTARY & CONCLUSIONS

Since this a personal column, I will take the liberty of inserting some personal opinions (that

do not reflect an official position of the SOA or any other actuarial organization). I found the presentation by Charles Blahous the most convincing. While I don't profess to be a Social Security expert, it seems to me that any solution to the long-term Social Security sustainability questions should include changes on both sides of the balance sheet. The Simpson-Bowles plan does this by including both increases in contributions by increasing the wage base and decreases in projected benefits through changes in the CPI formula and an additional bend point in the retirement benefit formula (as examples).

Clearly, one's personal political philosophy will drive one's own opinions on where to land when it comes to decisions about what is the right answer for issues like Social Security reforms. However, as actuaries, I believe we need to be present in these discussions because we can bring an intellectual integrity to discussions where numbers and statistics are thrown about to make political points. Our presence can help to connect the dots between numbers and inform the philosophical discussions which hopefully results in better long-run policy.

Feel free to shoot me an email with your thoughts (*apeterson@soa.org*).

Clearly, one's personal political philosophy will drive one's own opinions on where to land when it comes to decisions about what is the right answer for issues like Social Security reforms.

HEALTH DISPARITIES AND INEQUALITIES IN THE UNITED STATES: A ROLE AND OPPORTUNITY FOR ACTUARIES

By Jay M. Jaffe

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On Jan. 14, 2011 the Centers for Disease Control and Prevention (CDC) published a report titled "CDC Health Disparities and Inequalities Report — United States, 2011." The Foreword of the Report starts as follows:

> Since 1946, CDC has monitored and responded to challenges in the nation's health, with particular focus on reducing gaps between the least and most vulnerable U.S. residents in illness, injury, risk behaviors, use of preventive health services, exposure to environmental hazards, and premature death. We continue that commitment to socioeconomic justice and shared responsibility with the release of *CDC Health Disparities and Inequalities in the United States – 2011*, the first in a periodic series of reports examining disparities in selected social and health indicators.

Actuaries will probably react that the Report's findings are generally expected and consistent with what we have learned from our training and observed from our daily activities.

The purpose of this article is to briefly outline the findings of the CDC and to "throw down the gauntlet" to the actuarial profession. If the actuarial profession believes in serving the public as stated in Precept 1 of the Actuarial Code of Conduct and to be advocates in the public interest, we now have an ideal situation to fulfill these objectives by demonstrating our knowledge and creativity to find ways to break many of the repetitive problems the CDC has identified.

Men of all ages and race/ethnicities are approximately four times more likely to die by suicide than females.

CDC'S REPORT

The CDC's Report is more than 100 pages (including many tables). Its key findings are as follows:

- The correlation between poor health and health inequality at the state level holds at all levels of income.
- Racial/ethnic minority groups, who are more likely to live in urban counties, continue to experience a disparately larger impact from air pollution-related disparities associated with fine particulates and ozone.
- Infants born to black women are 1.5 to three times more likely to die than infants born to women of other races/ethnicities.
- Men of all race/ethnicities are two to three times more likely to die in motor vehicle crashes than are women, and death rates are twice as high among American Indians/Alaska Natives (AIs/ANs).
- Men of all ages and race/ethnicities are approximately four times more likely to die by suicide than females. AIs/ANs share the highest rates with Non-Hispanic whites who in contrast account for nearly five of six suicides. The suicide rate among AIs/ANs and non-Hispanic whites is more than twice that of blacks, Asian Pacific Islanders and Hispanics.
- Rates of drug-induced deaths increased between 2003 and 2007 among men and women of all race/ethnicities, with the exception of Hispanics, and rates are highest among non-Hispanic whites. Prescription drug abuse now kills more persons than illicit drugs, a reversal of the situation 15–20 years ago.
- Men are much more likely to die from coronary heart disease, and black men and women are much more likely to die of heart disease and stroke than their white counterparts.
- Rates of preventable hospitalizations increase as incomes decrease.

- Racial/ethnic minorities, with the exception of Asians/Pacific Islanders, experience disproportionately higher rates of new human immu¬nodeficiency virus diagnoses than whites, as do men who have sex with men (MSM).
- Hypertension is by far most prevalent among non-Hispanic blacks (42% v. 28.8% among whites), while levels of control are lowest for Mexican Americans. Uninsured persons are only about half as likely to have hypertension under control than those with insurance, regardless of type.

- While rates of adolescent pregnancy and childbirth have been falling or holding steady for all racial/ethnic minorities in all age groups, Hispanics and non-Hispanic blacks are three and 2.5 times those of whites, respectively.

- The prevalence of binge drinking is higher in groups with higher incomes and higher educational levels, although people who binge drink and have lower incomes and less educational attainment levels binge drink more frequently and, when they do binge drink, drink more heavily. American Indian/Native Americans report more binge drinking episodes per month and higher alcohol consumption per episode than other groups.

- Smoking rates decline significantly with increasing income and educational attainment.

Based on its findings, the CDC concluded that while the United States "… has made substantial progress in improving residents' health and reducing health disparities" there are "… ongoing racial/ethnic, economic, and other social disparities in health [which] are both unacceptable and correctable." Herein lays the challenge and opportunity for the actuarial profession: how can actuaries contribute their expertise to finding ways to help correct some of the problems identified by the CDC?

NEXT STEPS

Any actuary who has an interest in using his or her talents to help address the problems described by the CDC should start by reading the report. The Report can be obtained at *http://www.cdc.gov/mmwr/pdf/other/su6001.pdf*.

The next step might be for actuaries to have discussions within the profession about the problems discussed in the CDC report. One outgrowth of these conversations may be to furnish our expertise to help quantify the cost of particular situations versus the expense to fix the problems. In some of the situations described by the CDC it may not only be good public policy, but also good economics to fix a problem because corrective actions in the United States are very often in response to economic opportunities.

For example, data from the Agency for Healthcare Research and Quality indicate that eliminating preventable hospitalizations would eliminate approximately 1 million hospitalizations and save $6.7 billion in health care costs each year. Since actuaries are involved in pricing of medical programs (both private and public), we should be anxious to find ways to reduce preventable hospitalizations to improve the financial well being of health plans and/or to be able to use funds for other health services (which, in turn, should provide dividends either in terms of costs or better health.)

Another approach that has been followed in law and some other professions is the creation of public interest professional firms. There have only been a few actuaries who have devoted their careers to these types of activities, but maybe there is now a need and opportunity for actuarial firms dedicated to public interest work.

The proposals just described are likely going to involve multiple disciplines which means actuaries will need to partner with other professionals with non-actuarial expertise in order to produce the most effective solutions. Developing partnerships with other professionals will help to expand actuaries' roles and influence on some of the problems the CDC's report highlighted. However, as part of this process actuaries will need to learn to communicate with these other parties by adapting our internal terminology to the terms and phrases used by non-actuaries.

Any actuary who has an interest in using his or her talents to help address the problems described by the CDC should start by reading the report.

SOCIAL SECURITY IN THE ENGLISH-SPEAKING CARIBBEAN

By Derek Osborne

The Caribbean is a region consisting of the Caribbean Sea and many islands. It is located southeast of the Gulf of Mexico and North America, east of Central America, and to the north of South America. It comprises French, Dutch and English-speaking islands, a reflection of former and current colonial ties to France, The Netherlands and England, respectively.

This article features the social security programs (SSPs) in the English-speaking Caribbean. The 16 countries that fall under this umbrella are Anguilla, Antigua & Barbuda, The Bahamas, Barbados, Belize, British Virgin Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, St. Lucia, St. Christopher & Nevis, St. Vincent & the Grenadines, Trinidad & Tobago and the Turks & Caicos Islands. Ranging in size from 5,000 in Montserrat to 2.9 million in Jamaica, the total population of these countries is approximately 7 million.

When combined, there are close to 1.5 million employed and self-employed persons making contributions to Caribbean social security programs

BACKGROUND

Caribbean social security programs began to emerge in the mid-1960s with the guidance and support of the International Labour Office (ILO). Referred to locally as National Insurance or Social Security, these SSPs can best be described as being:

- defined benefit in structure,
- partially funded,
- publicly administered with public oversight of investments, with
- final average pensions that are weighted for short service.

When combined, there are close to 1.5 million employed and self-employed persons making contributions to Caribbean SSPs and approximately 350,000 receiving monthly pensions.

GOVERNANCE FRAMEWORK

Established through Acts of Parliament, all but one of the 16 Caribbean SSPs are administered by a tripartite (government, employer and employee) board which is accountable to a government minister. The sole exception, Jamaica, has its National Insurance Scheme administered as part of the Ministry of Labour and Social Security. Each SSP is headed by a director/CEO who is supported by a team of executives and staff who together are responsible for administering that country's SSP. Although leaders of regional SSPs meet regularly to discuss issues and challenges common to all, each SSP is independent of others.

BENEFITS

Benefits offered by Caribbean SSPs can be categorized and described as follows:

Short-term benefits:

- Sickness: typically 60 percent of average insurable wages for up to 26 weeks.
- Maternity: 60- to 67-percent of average insurable wages for up to 13 weeks.
- Unemployment (only in two SSPs): 50- or 60-percent of average insurable wages for up to 13 weeks (Bahamas) and 26 weeks (Barbados).
- Funeral grant: one-time payment to assist with burial expenses.

Long-term (or pensions) benefits:

- Old-Age/Retirement: lifetime pension based on age and/or retirement status. (In most countries, the pension is not affected by continued employment beyond normal pension age.)
- Invalidity: pension for as long as being incapable of economic employment.
- Survivors: pension to spouse and/or children of a deceased insured person.

Employment Injury benefits:

- Injury: 67 percent of average insurable wages for up to 26 weeks if injury is job-related.
- Disablement: lifetime pension based on percentage of disability due to job-related injury or disease.
- Medical care: reimbursement of reasonable medical expenses associated with a job-related injury or disease.
- Death (Survivors): pension to spouse and/or children of an insured person who dies due to a job-related injury or disease.

In a few countries, the SSP also finances a non-contributory pension that is paid to older persons who failed to make sufficient contributions for a contributory pension but are now deemed to be in need.

More than 65 percent of Caribbean SSPs expenditure relates to the long-term benefits (pensions). While pension eligibility requirements and benefit calculations vary among SSPs, the typical SSP Retirement/Old-age pension has the following characteristics:

- 10-year contribution requirement;
- Normal pension ages between 60 and 65 with several increasing to 65 over a 10- to 15-year period;
- Where 65 is the normal pension age, reduced pensions are payable from age 60;
- Benefit rate of 30 percent for first 10 years of contributions plus 1 percent for each additional year of contributions;
- Insurable wages averaged over the best three or five years in the 10 years prior to benefit award.

Automatic cost of living adjustments to pensions only exist in four of the 16 English-speaking SSPs. In the others, pensions are increased on an ad hoc basis, with the timing and size of the adjustment at the sole discretion of the current government.

FINANCING

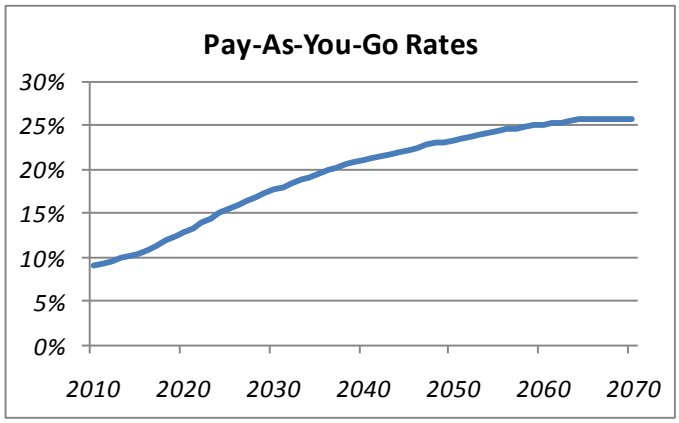
With traditional ILO design, all SSPs remain partially funded, defined benefit systems. The initial contribution rate was deliberately set below the expected average cost of future benefits with the expectation that contribution rates would be increased periodically as the program matured. As a result of this funding approach, accumulated reserves (or assets) are considerably less than accrued projected liabilities.

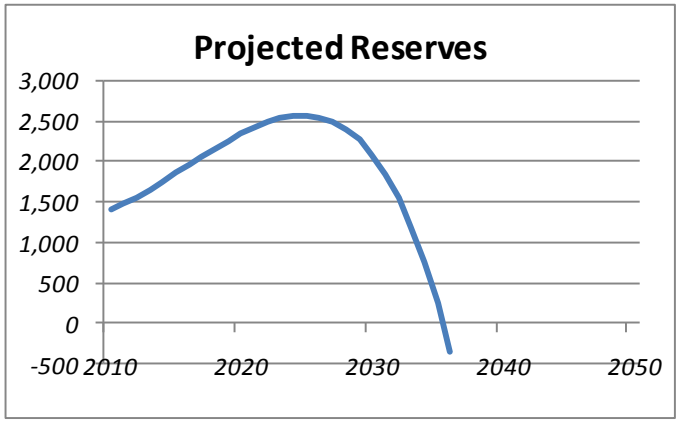
Contribution rates for the typical benefits package as described earlier vary widely among Caribbean SSPs from 5 percent in Jamaica to 18.25 percent in Barbados, with most having a contribution rate of between 8- and 11-percent. These contributions are applied to insurable wages, which are limited by a fixed-dollar earnings ceiling. These earnings ceilings range from approximately 80- to 300-percent of average national wages.

At current contribution rates, many of which have not changed since inception, all but one or two Caribbean SSPs are unsustainable with depletion of reserves expected between 2030 and 2050 in most.

The projected financial state of most Caribbean SSPs is depicted by the following two charts which illustrate projected reserves and projected pay-as-you-go rates for a typical Caribbean SSP. The projected year for fund depletion or ultimate pay-as-you-go rates vary depending on the SSPs age, past and current contribution rates, and adjustments to pension provisions.

Derek Osbourne
Derek Osborne, FSA, is actuary for the National Insurance Board in the Bahamas.





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INVESTMENTS

Caribbean SSPs have amassed large pools of reserves, with many exceeding 40 percent of national GDP. Most SSPs invest the lion's share of the reserve funds in local investments, predominantly in their Government's debt instruments. A few have varying portions of their assets invested regionally and internationally.

Given the close links between Caribbean countries and the United States, from which most imports originate, inflation in most countries has been relatively low in the past two decades, averaging between 2.5- and 3.5-percent per annum. Nominal rates of return have for most of the last decade been quite good, at 6- to 7-percent per annum, but have experienced gradual declines in recent years.

ACTUARIAL REVIEWS

By law, each social security program must have an actuarial review conducted at three- to five-year intervals. Social Security and National Insurance Acts all require that the actuary prepare a report on the financial condition of the Fund and advise on the adequacy or otherwise, of contributions to support promised benefits. Although this requirement is primarily technical (demographic and financial projections), it has become the norm that the actuary also provide policy advice. This advice usually includes an assessment of the coverage offered by the earnings ceiling, benefits and their qualifying conditions, the level of minimum pension rate and other key parameters, and recommendations aimed at ensuring overall relevance of the program and its long-term sustainability.

In some respects, this expectation of policy advice takes the actuary beyond his/her traditional training and expertise. However, the actuaries conducting these reviews typically have policy experience either from having worked with an international organization, such as the ILO, or at a regional social security scheme.

Once completed, the report of the actuarial review must be tabled in Parliament. The report thus becomes public and permits the general public to become aware of the current and projected states of its social security scheme.

In 1990, actuaries practicing in the Caribbean formed an association known as the Caribbean Actuarial Association (CAA). The CAA's main goals are to support the development of actuarial science in the Caribbean and to maintain the high standards and image of the actuarial profession. The CAA recently attained Ordinary Membership status with the IAA.

While the CAA does not yet have a Standard of Practice for work conducted on social security programs, one is currently being drafted and is expected to be adopted in December 2011. The proposed social security standard will provide guidance to actuaries performing work on Caribbean SSPs. The two existing CAA practice standards cover pensions and life insurance.

STRENGTHS AND CHALLENGES

Across the region, SSPs have earned the respect and confidence of their local constituents and are considered, in many countries, to be among the better administered public sector institutions. They provide a good source of funding for both public and private infrastructure and other development projects, and are a significant source of funds for commercial banks. SSPs play an important role in the social and economic development of Caribbean countries by providing reliable income support to insured persons, especially the elderly, when they are unable to work.

Most programs, however, are plagued by low coverage among self-employed persons, high administrative costs, poorly diversified investment portfolios, long-term unsustainability at current contribution rates and benefit promises, and varying degrees of political interference. Many also suffer from the slow action of governments to implement adjustments to key dollar parameters, such as the wage ceiling and pensions in payment and actuarial recommendations designed to enhance benefit adequacy and financial sustainability.

RECENT REFORMS

As Caribbean SSPs mature and expenditure rates approach or surpass current contribution rates, many SSPs have either recently made or are about to make reforms aimed at enhancing long-term sustainability. Typical reforms include:

- Gradually increasing the normal pension age to 65 (to 67 in Barbados);
- Reducing the accrual rates payable for the first 10 years of contributions;
- Increasing the number of years over which final average wages are determined;
- Automatic adjustments of the wage ceiling and pensions in payment; and
- Increasing the contribution rate.

One reform measure often recommended by actuaries that has not yet been well received by policymakers is having pensions based on indexed career earnings instead of on final average earnings.

The recent global economic crisis has had a tremendous impact on Caribbean economies with most experiencing economic declines in 2009 and 2010. SSPs have not been spared; most have experienced a decline in contribution income as the number of contributors and average insurable wages have fallen. Investment returns have also declined. Although short-term benefits also fell slightly given their link to current employment, pension payments continue to increase each year as more persons qualify for larger benefits. Due to rising unemployment, The Bahamas National Insurance Board introduced an unemployment benefit in 2009 and a few other countries are considering adding this to their benefits package.

Although there are slight variations between countries, Caribbean countries have aging populations due to declining fertility rates and improving life expectancy. Total fertility rates range from around 1.7 to 2.2 and life expectancies at birth are approximately 70 for men and 75 for women. Outward migration to North America and Europe, a Caribbean phenomenon for decades, continues. There is also growing inter-regional migration as efforts to form a single market and economy are being gradually realised. To ensure that contributors who migrate within the region do not suffer loss of social security benefits, the CARICOM Social Security Agreement was adopted in 1997. This agreement allows those who fail to qualify for a pension in one or more countries due to insufficient contributions, to receive a proportionate pension from these countries once the total combined contributions made in these countries would allow him/her to qualify for a pension in at least one of the countries. Several SSPs also have reciprocal agreements with Canada and the United Kingdom.

The promises that Caribbean Social Security programs have made to current and former workers are quite generous when compared with those offered in OECD countries. This is partly due to the low concentration of private sector pension schemes in the region. Each SSP is currently adequately funded to meet its obligations for the short-term, and in most cases the medium-term, but almost all are unsustainable in the long-term at current contribution rates and benefit provisions. Timely and appropriate reforms, coupled with growing economies and good governance practices, will therefore be required to ensure that adequate pensions will be paid to future generations of Caribbean pensioners without requiring excessive contribution rates by tomorrow's employers and workers.

EUROZONE: MUDDLING THROUGH OR DEFAULT?

By Doug Andrews

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Gradually they are toppling—first Greece, then Ireland, now Portugal. Spain is rumoured to be next. There is a crisis within the Eurozone. Can it be managed? Will it have broader implications? About 10 years ago William Hague likened the Euro to a burning building with no exits. It appears that the fire is raging. Will the building be consumed? There are at least two plausible outcomes.

Speaking to an Institute of Actuaries' seminar, Steven Major, CFA, Global Head of Fixed Income Research at HSBC, said that he thought the Eurozone would "muddle through." As the name suggests, muddling through is not a well-defined policy. It implies working through each new development as it occurs on a basis that it is the most acceptable to the majority of member states at the time of the troubles and trying to take preventative measures to reduce the impact of any further challenges. Muddling through means that the Eurozone will hold together, but it certainly does not mean an equally easy or difficult ride for all participants.

In Major's view any Eurozone country that needs financial assistance to avoid defaulting on its debts, i.e., bankruptcy, will receive a bailout. However, the terms of the bailout will mean that the country will be placed in an extremely painful financial straightjacket for the next 10 years or so. This is the situation in which both Greece and Ireland now find themselves. A concern for Major though is whether, in a few years, countries requiring financial assistance may decide to take a haircut on any remaining bonds that are not due to the Eurozone or International Monetary Fund (IMF) financing. In a few years, the financing from the Eurozone and the IMF will be the majority of the outstanding debt, so any haircut on the remaining outstanding debt could be substantial. This possibility raises issues of the seniority of various debt issues.

When Greece required financial assistance, there was grumbling regarding why Germans should be lending funds so that Greeks could retire on generous state pensions earlier than Germans could retire. With the financial assistance extended to the Irish, there was grumbling that the Irish corporation tax rates were too low, giving it an unfair advantage, and that the corporate tax rates should be raised. It would seem that a consequence of muddling through will be pressure to try to harmonize fiscal policies, which includes tax rates and spending on publicly provided pensions. A monetary union without a fiscal union would encourage free-riding, of which Germany, as the strongest financial nation in the union, is aware.

The other plausible outcome is that the Eurozone will gradually dissolve. On the one hand, the financially weaker countries that require financial assistance may find the terms placed on the assistance too onerous. Both Greece and Ireland may find the demands of their creditors too unpopular with their own voters. They may wish to abandon the Euro and have more control over their financial affairs. At the time of writing this article, it is still too early to know how things will unfold in Portugal, but the Portuguese are suggesting that they would rather default than accept the type of terms imposed on Greece and Ireland. If the Portuguese de-

cide to default, surely they would have to leave the Eurozone.

On the other hand, if the number of bailouts increases significantly or if the amount of funds required for bailout gets large, will the financially stronger nations be willing to bear the pain to support their more profligate partners. That pain may mean the inability to be elected in the home country. There may be an opportunity for politicians to promise a breakup in the Euro in return for being elected in their home country.

Regardless of which alternative outcome occurs, the investment prospects for European, not just Eurozone, countries do not look promising. Muddling through will create a seniority structure for debt, with private investors assuming a junior position; although, it may mean the worst that occurs is a haircut, not a default. But the credit rating of the stronger countries will be weakened causing prices for those countries' debt to fall. While outright default by a few countries would, in some ways, be beneficial for the credit rating of the stronger nations, the turmoil and uncertainty created would not be good for any of the European countries. Investors would flee the uncertainty seeking quality elsewhere. This situation extends beyond the Eurozone to nations such as the United Kingdom that has not adopted the Euro. The reason is such nations have strong trading relations with the Eurozone, so, for example, the United Kingdom made substantial emergency funds available to Ireland because Ireland is one of the United Kingdom's most important trading partners. With the announcement of that loan, the £ Sterling suffered some depreciation. This is a further concern for investors outside the Eurozone. Even if there is not a default, will the value of the currency in which they receive their return be depreciated when valued in their home currency?

Although Europe has survived the fall off the precipice brought on by the financial crisis, the climb back up the hill will be arduous and lengthy. Most European nations need to restructure their public finances—cutting public spending and raising taxes. Will they have the gumption to stay the course and take the bitter fiscal medicine or will free-riding within the Eurozone provide a less painful salve for the weaker nations? In which case, the weaker nations will not cut expenses or raise taxes sufficiently and the rest of the burden will be borne by the stronger nations. In such a situation the stronger nations strength will be eroded as will the value of the Euro.

POTENTIAL MEDICAL INSURANCE SOLUTIONS FOR UNINSURED INDIVIDUALS IN NEW YORK

By Michael L. Frank

Editor's Note: *This article describes New York's answer to publicly-financed health insurance needs. It is highly detailed. You may at first think that it is more detailed than you wanted to know. But we offer it as a challenge to you since you are an actuary and have a responsibility to the public. What's happening in your state? What needs are there? What plans exist? What have you done to make yourself knowledgeable? How can you make your actuarial voice heard? How can you, as an actuary, help your public? Read on and get educated about the issues.*

For those of you that have medical insurance and those that do not have coverage, one thing we all know is that premiums are very expensive. Whether you are an individual or part of an employer group plan, insurance coverage is not cheap. Group plan insurance averages more than $600.00 per month for single employees and more than $1,800.00 per month for family coverage. Medical plans for individuals (not part of an employer group plan) are higher in cost and will have less medical benefits than traditional employer (company) sponsored plans. As a result, we are seeing a growing population of uninsured people, especially in our community. Job layoffs due to the economy have not helped the situation.

Many individuals do not have the luxury to wait and see if health care from the state and federal level will result in affordable health care. For those individuals today without insurance due to financial, unemployed or uninsurable reasons, there might be some immediate solutions. Many of you may not be aware that the New York State Department of Health (NYSDOH) offers insurance for those without the financial ability to obtain it. The purpose of this article is to educate those that might not have the resources or assistance to find health care. If you are aware of people that might benefit from reading this article, please forward it along. Since insurance carriers participate at the county level, there will be variations of insurance companies and HMOs by county. For illustrative purposes, we showed county level information for Westchester County, however, these government programs are offered statewide. Many of the websites and sources listed further in this document are applicable to all counties in New York and not solely Westchester County.

School district and local municipality officials will find this article beneficial since it will identify solutions for lower cost health care for uninsured members of their community as well as students in their school district that might be without health care.

MEDICAID

The New York State government offers medical insurance through Medicaid. The income level (needs basis) to obtain this coverage is very low and might be difficult to meet. In addition to income levels, you may be eligible to be covered by Medicaid if you have high medical bills, receive Supplemental Security Income (SSI) or you meet certain resource, age or disability requirements. To learn more about Medicaid eligibility, the toll free number is 1-877-472-8411.

For information about your local Department of Social Services Offices (Children's Medicaid), contact the following:

Westchester County DSS
County Office Building #2
112 East Post Road
White Plains, NY 10601
1-914-995-5000

CHILD HEALTH PLUS

Other New York state benefits offered include a health insurance plan for kids, called Child Health Plus. Depending on your family's income, your child may be eligible to join a medical program. Coverage is available through dozens of providers (health plans) throughout the state. For this coverage, there is no monthly premium for families whose income is less than 1.6 times the poverty level. That's about $563 a week for a three-person family, about $678 a week for a family of four. Families with somewhat higher incomes pay a monthly premium of $9, $15, $30, $45, $60 or more per child per month, depending on their income and family size as posted on the New York Department of Health website in February 2011.

For larger families, the monthly fee is capped at three children. If the family's income is more than four times the poverty level, they pay the full monthly premium charged by the health plan. There are no co-payments for services under Child Health Plus, so you don't have to pay anything when your child receives care through these plans. This is important since traditional health insurance plans will have deductibles, coinsurance and/or copays (cost per visit) requiring a covered person to spend additional out-of-pocket costs beyond medical insurance premium.

To be eligible for coverage, children must be under the age of 19 and be residents of New York State. Qualifications will depend on gross family income. To obtain more information, please call the 1-800-698-4KIDS (1-800-698-4543). Resources are available for non-English speaking people as well. For additional information about Child Health Plus, please visit *http://www.health.state.ny.us/nysdoh/chplus/*.

FAMILY HEALTH PLUS

Besides Medicaid & Child Health Plan, another program exists called Family Health Plus, which is a state insurance program for adults between the ages of 19 and 64 who do not have health insurance (either on their own or through their employers), but have income or resources too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents with limited income who are residents of New York State and are United States citizens or fall under one of many immigration categories.

Most of the carriers that participate in Child Health Plus also offer the Family Health Plus plan. To learn more about these coverages, please visit *http://www.health.state.ny.us/nysdoh/fhplus/*.

Access is available in all counties in New York State. In this document, we are illustrating Westchester County, but the New York State Department of Health website above will provide information by county.

The Family Health Plus will provide comprehensive health care coverage to adults, with and without children, who have incomes or assets greater than the current Medicaid eligibility standards. Individuals meeting the following criteria will be eligible to enroll in Family Health Plus:

- Permanent residents of New York State.
- Age 19 through 64.
- Citizens or Medicaid eligible qualified aliens.
- Not eligible for Medicaid based on income and/or resources.
- Not in receipt of "equivalent" health care coverage or insurance.

Parent(s) living with a child under the age of 21 will be eligible if the gross family income is up to:

- 120 percent of the Federal Poverty Level (FPL) as of Jan. 1, 2001;
- 133 percent FPL as of Oct. 1, 2001; and
- 150 percent FPL as of Oct. 1, 2002.

Individuals without dependent children in their households will qualify with gross incomes up to 100 percent FPL.

CONTINUED ON PAGE 20

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ACCESS IN WESTCHESTER

For health plans that participate in Westchester County, the phone numbers are as follows:

- Affinity Health Plan: 1-866-247-5678
- Empire BlueCross BlueShield: 1-800-431-1914
- Fidelis Care New York: 1-888-343-3547
- Health Insurance Plan of Greater NY: 1-800-542-2412
- Hudson Health Plan: 1-800-339-4557

The above numbers are posted on the NYSDOH website and are provided in this article for those that do not have internet access. Phone numbers and available health plans vary by county, so if you reside outside of Westchester, but still reside in New York, then there are other health plan solutions available to you. In addition, there are community organizations that can help you enroll state wide. For example, residents of Westchester can contact Westchester County Department of Health at 914-813-5048.

Individuals with internet access can go online to if they qualify for state programs such as Medicaid, Child Health Plus, and Family Health Plus. As an example, one company, Hudson Center for Health Equity & Quality (Hcheq), which is a non-for-profit organization in Tarrytown, has a website www.enrollny.org. Individuals can go online to this site and see if they qualify for benefits and start the enrollment process. It is available for use throughout New York State.

HEALTHY NEW YORK

Lastly, if you are not eligible for any of the plans above, New York State offers another program called Healthy New York. This coverage is available to individuals and small employers. To find out more information about Healthy New York, the toll free number is 866-HEALTHY-NY (866-432-5849) or visit website at the New York State Insurance Department at link *http://ins.state.ny.us/website2/hny/english/hny.htm.*

New York State lists 15 HMOs offering coverage though there participation varies by county. Carriers in Westchester include Aetna, ConnectiCare, Empire, GHI, HIP, and Oxford. Note that ConnectiCare, GHI and HIP are all part of the same company EmblemHealth. In general, each company offers four health plan options. The standard plan and a high deductible health plan with each option offered with and without prescription drug coverage. Depending on the health care plan and coverage selected, the monthly cost of coverage for a single person in Westchester could be slightly above $200.00 (low end) to $400.00 (high end).

In order to participate, you must meet the following eligibility criteria: (1) reside in New York State; (2) must either be currently employed or must have been employed within the past 12 months' (3) Your employer does not currently provide you with health insurance; (4) You have not had health insurance in effect for the twelve-month period preceding application or have lost that coverage due to a qualifying event. Qualifying events are described on the NYSDOH website. Healthy New York is not only available to individuals, but also small employers. Eligibility requirements are described on the NYSDOH website.

Individuals without insurance today might find this program beneficial. In addition, children graduating high school and college without employment might find this beneficial. Hopefully this information will benefit those that need it. Please note that this is not an advertisement nor is the writer of the article compensated for this, nor support a political agenda. This information is solely being provided as a service to the community that may not be aware of options for the uninsured. Again, the above information for all of these plans come from the NYSDOH website and is public information. Information will periodically change, so see website for updates. Healthcare Reform at the state and federal level could change some of the coverages and requirements in the future.

If you have any questions pertaining to whether or not you may qualify for coverage, please

call any of the phone numbers listed through this document and you should be able to obtain guidance. Although this article is geared towards to Westchester county residents, coverage for the above programs (Medicaid, Child Health Plus, Family Health Plus, and Healthy NY) is accessible to all New York State residents though premium rates and health plan participants may vary.

INDIVIDUAL (DIRECT PAY) PLANS

The last alternative that we would mention available to individuals is the direct pay plans. These plans are significantly higher in cost to consumers than the other plans referenced above. These benefits are not income-means tested so available to all consumers that are uninsured. Carriers in Westchester County include Aetna, ConnectiCare, Empire, GHI, HIP, and Oxford.

These rates are posted on the New York State Insurance Department website by county, carrier and plan design. For current rates, visit *http://www.ins.state.ny.us/hmorates/html/hmowestc.htm.* For single (individual) coverage, the lowest cost plan is slightly below $900 per month with the highest cost plans at or exceeding $2,000 per month. Family coverage will be significantly more expensive (approximately three times the single rates). These plans are typically very expensive due to the guaranteed issue and guaranteed renewable nature of these policies. These plans typical waive pre-existing conditions and have no underwriting requirements making them very expensive to the consumer.

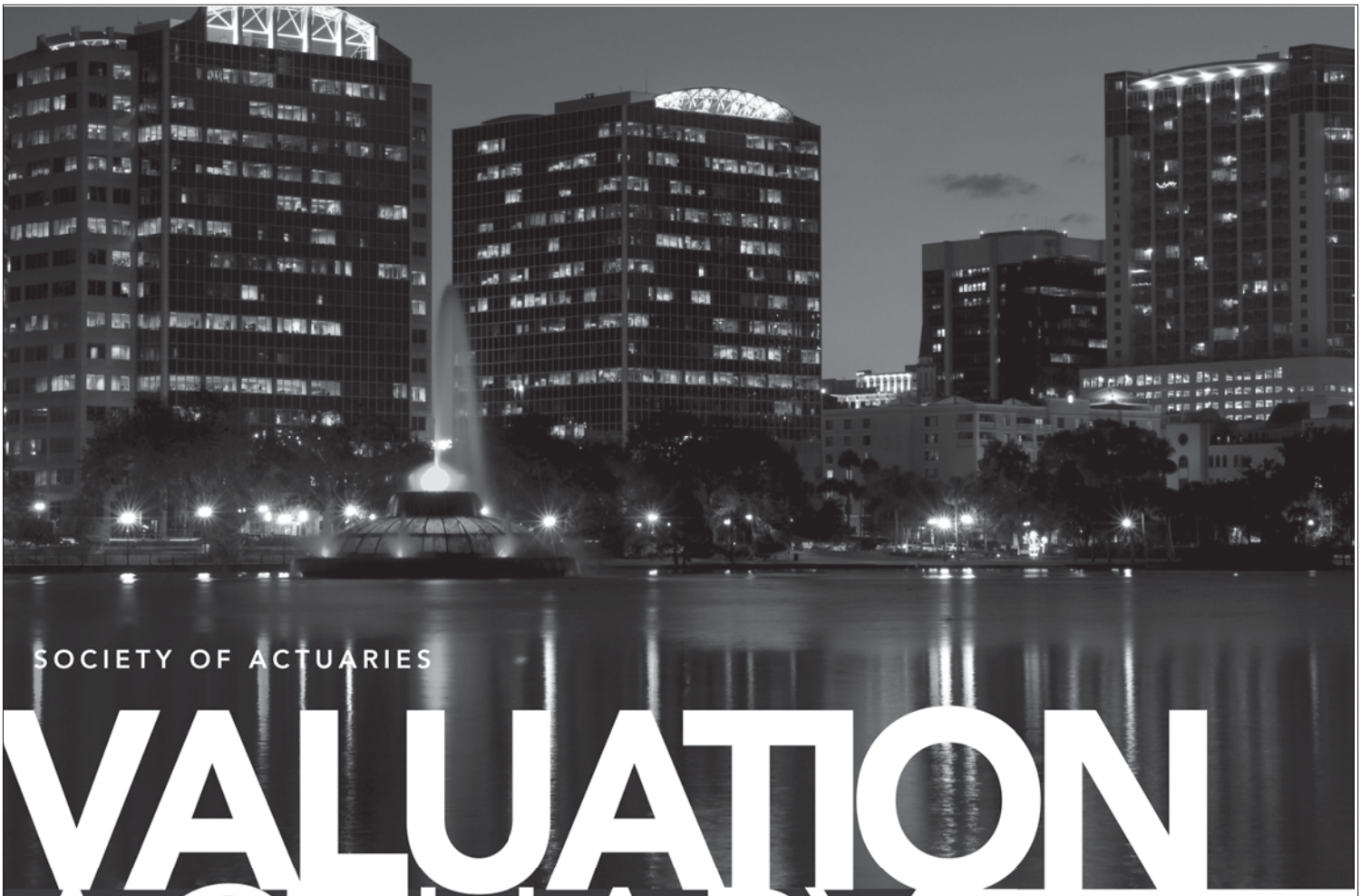
Despite the very high cost for these plans, this line of business is not profitable to the HMO community due to the adverse selection of the participants that join the plan. As high as the premium rates are, the claim cost to insurance companies may be materially higher.

For individuals interested in learning more about the coverages available, visit websites for the New York State Department of Health and New York State Insurance Department. Both provide a variety of information and might be able to assist you in identifying solutions.

We hope that the above information is beneficial to the reader. If you have any comments on the article, please call (914) 933-0063 or alternatively e-mail at *michael.frank@aquariuscapital.com.* The writer of this article is an actuary in healthcare and insurance as well as an insurance/reinsurance broker. He is also a resident of Westchester County, New York.

About the Author. Michael L. Frank, is President & Actuary of Aquarius Capital, an organization that provides customized solutions in insurance, reinsurance and employee benefits in the life, accident and health insurance fields. He has twenty four years of experience in providing consulting to employers, including school districts, townships and other municipalities, as well as insurance companies/HMOs, Medicaid providers and government organizations. He has also completed more than 500 Other Postemployment Benefits (OPEB) valuations including GASB 45, FAS 106, SOP92-6 and other retiree valuations for employers and insurance companies. For information on his company, please see website *www.aquariuscapital.com.*

Michael Frank is credentialed as an actuary and licensed as a broker, reinsurance intermediary and managing general underwriter, and is very active in various Healthcare Reform task forces. He was recently elected President of the Actuarial Society of Greater New York (ASNY) and will serve as President in 2011.



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THIS AND THAT

Noteworthy and Newsworthy items of interest to SIPF Members:

1. Check out a recent article by Nino Boezio titled "Taking Stock …" in the February 2011 issue of the Risk and Rewards Investment Section newsletter. It provides a perspective that we think will be of interest to section and other SOA members.

2. Brad Smith is the incoming President-Elect. A major mission is to shed light on the "issues of the day" that have actuarial implications. Social Security, Medicare, health care reform, public pension plans, etc., We are fortunate to have Brad focusing on these topics. They are consistent with the focus of SIPF.

3. Several spring articles from the New York Times (a couple with Brad Smith quotes) have focused on Public Finance issues. We recommend the following in particular:

   "Public Pensions, Once Off Limits, Face Budget Cuts" – NYT 4/25/11
   (http://www.nytimes.com/2011/04/26/us/26pensions.html?_r=1&ref=marywilliamswalsh)

   "The Burden of Pensions on States" – NYT 3/11/11
   http://www.nytimes.com/2011/03/11/business/11pension.html?ref=marywilliamswalsh

   "Illinois Pension Bonds to Test Investors' Faith" NYT 2/17/11
   (http://www.nytimes.com/2011/02/18/business/18illinois.html?ref=marywilliamswalsh)

4. Currently evolving SIPF QRAs (quick response analyses) pick up on current issues of the day. They are intended to be a quick response to what's happening now. As such, they appear on the SIPF website (http://www.soa.org/professional-interests/social-ins/quick-response.aspx). The first QRA was on Medicare and the Sustainable Growth Rate (SGR) Formula and was authored by Andy Rarus.

5. SIPF is planning 2 sessions at the 2011 SOA Annual Meeting in Chicago. Check for those and related topics when making your meeting plans.

6. Also keep a heads-up for future SIPF Webinars. There was one in May on the unique challenges actuaries face when working in the public domain that had an A-Team panel. Recordings of the webcast can be ordered from the SOA's website.

7. Upcoming International Actuarial Association Colloquia
   Sponsored by the Pension Benefits Social Security Section

September 26 – 27, 2011	Edinburgh, United Kingdom
May 6 – 9, 2012	Hong Kong, China

   See *www.actuaries.org/calendar/* for more details.

SOCIETY OF ACTUARIES Social Insurance & Public Finance Section

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