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SOCIETY OF ACTUARIES

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 2002 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. *Copies of the OASDI 2002 Annual Report are available from Cece Enders (410-965-3015).*

The future income and outgo 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, trust fund outgo 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 the 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 outgo, 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.

(continued on page 4)

contents

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475 N. Martingale Road, Suite 800
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Phone: 847-706-3500
Fax: 847-706-3599
World Wide Web: http://www.soa.org

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Dan Arnold, Newsletter Editor
Hooker & Holcombe
65 LaSalle Road
West Hartford, CT 06107
PHONE: (860) 521-8400
FAX: (860) 521-3742
E-MAIL: darnold@hhconsultants.com

Joe Adduci, DTP Coordinator
PHONE: (847) 706-3548
FAX: (847) 273-8548
E-MAIL: jadduci@soa.org

Bryeanne Summers, Graphic Designer
E-MAIL: bsummers@soa.org

Clay Baznik, Publications Director
E-MAIL: cbaznik@soa.org

Lois Chinnock, Staff Liaison
E-MAIL: lchinnock@soa.org

Articles Needed for the *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 and so on. 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.

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February	December 26, 2002
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September	July 21, 2003
December	October 21, 2002

Preferred Format

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

Please 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:

Daniel M. Arnold, FSA
Hooker & Holcombe, Inc.
65 LaSalle Road
West Hartford, CT 06107
Phone: 860-521-8400
Fax: 860-521-3742
E-mail: darnold@hhconsultants.com

Thank you for your help.

Chairperson's Corner

Represent *This!*

by Paul Angelo

"Taxation without representation is tyranny."
Attributed to James Otis, circa 1761.

On September 13 I attended my last meeting of the Pension Section Council (PSC). Our September meetings are the "overlap" meetings, meaning that this one was attended by both the outgoing Class of '02 and the incoming Class of '05. One of the highlights of the overlap meeting is where Judy Anderson, the tireless SOA staff fellow for the Retirement Systems Practice Area, does her Power Point presentation on the SOA structure. I'm convinced that the reason PSC members serve three-year terms is that it takes that long to understand just exactly how the Pension Section fits into the overall SOA structure.

The SOA locus for things pension is the Retirement Systems Practice Area, which is overseen by the Retirement Systems Practice Advancement Committee (RSPAC). This time through her presentation, Judy casually mentioned that while the RSPAC is normally chaired by one of the SOA vice presidents with a pension background, this year that would not be so, because there were none.

Wait. Six SOA vice presidents, and none from the retirement industry. How can that be? Voter fraud? Butterfly ballots and dimpled chads? No. It's that we pensioneers don't bother to vote.

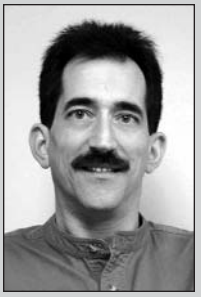
If you feel a lecture coming on, you got it. (*Note: this means that if you voted or are not eligible to vote, you may move on to other distractions*). For the rest of you, get ready. As anyone who ever dated an ex-smoker can tell you, there are none so self-righteous as the recently reformed. Yes, my friends, I was once like you. SOA ballot? Sure, but not right now, I've got this deadline, see. Besides, what difference does it really make? Nobody else votes so it all balances out, right?

Let's start with some data. Among SOA members listing "Retirement Systems" as their primary practice area, 18 percent of eligible voters returned ballots in the recent SOA election. The only practice areas with lower percentages were "Retired" and "No Area Defined". Swell. For comparison, 28 percent of our Health Benefits Systems friends managed to eke out ballots, along with 29 percent of those Life Insurance types. In absolute terms, I understand that at least one of the VP candidates with strong pension credentials missed out by only a handful of votes.

As for "what difference does it make", as this is my last column and I'm now off the PSC, I will invoke one of my favorite lyrics by Jesse Winchester, "if you're treading on thin ice, you might as well dance!" The SOA is a complex organization representing many constituencies, all vying for its finite resources. The squeaky wheel gets greased. Will funding for pension related research suddenly evaporate because there are no pension VPs for a year? No. Will pension issues be as well represented as they could be with a strong pension voice at the VP table? Again, no.

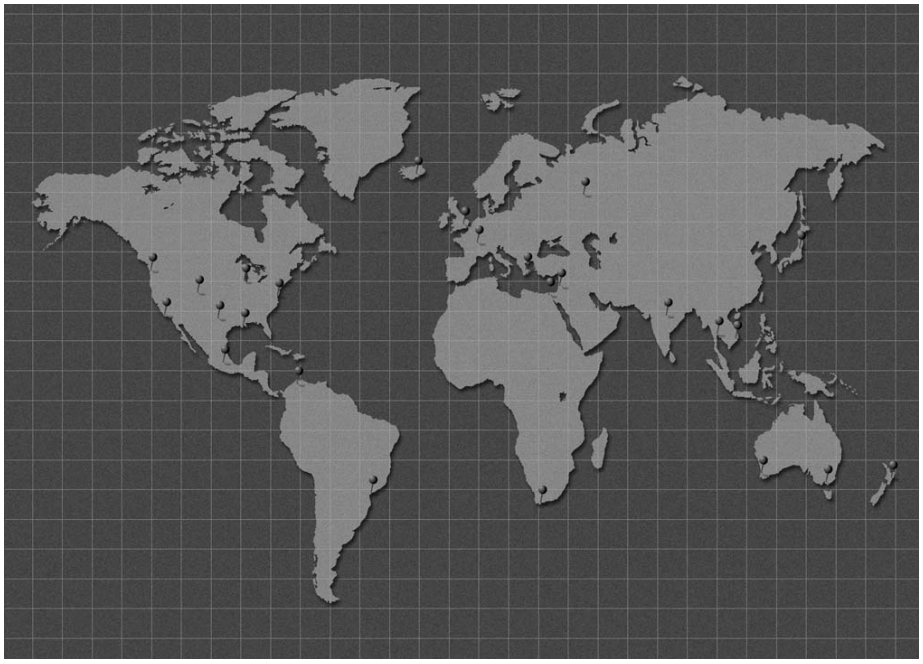
I can hear the rebuttals. The overall voting percentage was down this year, perhaps related to electronic balloting. The new SOA president-elect is a solid pension person, so what is your problem? And why are you encouraging this attitude of factionalism among the practices? That's all fine, but we pension fellows pay our dues and thereby earn the right to representation. Taxation without representation may be tyranny, but to pay the taxes and then just take a pass on representation is foolishness.

If you're treading on thin ice, you might as well dance!



Paul Angelo, FSA, FCA, MAAA, EA is vice president and actuary with the Segal Company in San Francisco. He was 2001-2002 chair of the Pension Section Council and can be reached at pangelo@segalco.com.

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 ten years of the projection period because they have little effect on the long-range estimates of financial status.



Demographic Assumptions

The principal demographic assumptions for the three alternatives are shown in Table V.A3 (see page 7).

The values for each of the economic and demographic factors are assumed to move from recently experience levels or trends, toward long-range ultimate values over next five to 30 years.

Table V.B1 Principle Economic Assumptions

Calendar Year	Average Annual percentage (Increase In-) Average Annual Wage in Covered Employment	Consumer Price Index *	Real Wage Differential ** (Percent)
Historical Data			
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
1991	3.0	4.1	-1.1
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	4.5	2.9	1.6
1997	6.0	2.3	3.7
1998	5.7	1.3	4.4
1999	5.4	2.2	3.2
2000	6.6	3.5	3.1
2001	5.6	2.8	2.8
Intermediate			
2002	3.1	1.3	1.8
2003	4.9	2.5	2.4
2004	4.2	2.7	1.5
2005	4.1	2.9	1.2
2006	4.2	3.0	1.2
2007	4.1	3.0	1.1
2008	4.0	3.0	1.0
2009	4.0	3.0	1.0
2010	4.1	3.0	1.0
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 Principle Economic Assumptions

Calendar Year	Average Annual percentage (Increase In-) Average Annual Wage in Covered Employment	Consumer Price Index *	Real Wage Differential ** (Percent)
Low Cost			
2002	3.7	1.2	2.6
2003	4.7	2.0	2.7
2004	4.0	2.0	2.0
2005	3.4	2.0	1.4
2006	3.3	2.0	1.3
2007	3.3	2.0	1.3
2008	3.4	2.0	1.4
2009	3.5	2.0	1.5
2010	3.5	2.0	1.5
2011	3.6	2.0	1.6
2015	3.6	2.0	1.6
2020	3.5	2.0	1.5
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
High Cost			
2002	2.5	1.4	1.0
2003	5.5	3.2	2.3
2004	5.4	4.6	0.8
2005	4.3	5.8	-1.6
2006	5.7	5.8	-0.1
2007	6.4	4.9	1.5
2008	4.6	4.1	0.5
2009	4.3	4.0	0.3
2010	4.4	4.0	0.4
2011	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 [ercentage increases, before rounding, in average annual wage in covered employment, and the average annual Consumer Price Index

Table V.A3 Period Life Expectancies

Calendar Year	Life Expectancy * (at Age 65) Male	Female	Calendar Year	Male	Female
Historical Data			**Low Cost**		
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	16.1	19.0
1955	13.1	15.6	2020	16.2	19.2
1960	12.9	15.9	2025	16.4	19.3
1965	12.9	16.3	2030	16.5	19.4
1970	13.1	17.1	2035	16.6	19.6
1975	13.7	18.0	2040	16.7	19.7
1980	14.0	18.4	2045	16.9	19.8
1985	14.4	18.6	2050	17.0	19.9
1990	15.0	19.0	2055	17.1	20.0
1995	15.3	19.0	2060	17.2	20.2
1996	15.4	19.0	2065	17.3	20.3
1997	15.5	19.1	2070	17.4	20.4
1998	15.6	19.0	2075	17.5	20.5
1999	15.7	18.9	2080	17.6	20.6
2000 +	15.7	19.0			
2001 +	15.8	19.0			
Intermediate			**High Cost**		
2005	16.0	9.1	2005	16.2	19.4
2010	16.4	19.4	2010	16.8	19.9
2015	16.7	19.7	2015	17.4	20.4
2020	17.0	20.0	2020	17.9	21.0
2025	17.3	20.3	2025	18.5	21.5
2030	17.7	20.6	2030	19.1	22.1
2035	18.0	20.9	2035	19.6	22.6
2040	18.3	21.2	2040	20.1	23.1
2045	18.6	21.5	2045	20.7	23.6
2050	18.8	21.8	2050	21.2	24.1
2055	19.1	22.1	2055	21.7	24.6
2060	19.4	22.4	2060	22.2	25.1
2065	19.7	22.6	2065	22.7	25.6
2070	19.9	22.9	2070	23.1	26.0
2075	20.2	23.1	2075	23.6	26.5
2080	20.4	23.4	2080	24.1	26.9

* 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 remainng life.

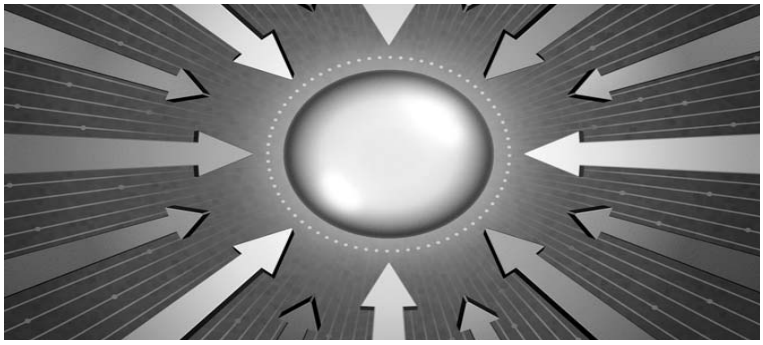
+ preliminary or estimated

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 2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *Copies of the 2002 Annual Report are available from Sol Mussey (410-786-6386).*

This 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 2002 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 69 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 Tables II.D1 and II.D2 (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 2002, the prospective payment rates have already been determined. The projections contained in this report are based on the assumption that for fiscal year 2003, the prospective payment rates will be increased by the increase in the hospital input price index less the percentages specified by Public Law 106-554, the Benefits Improvement and Protection Act of 2000. 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:

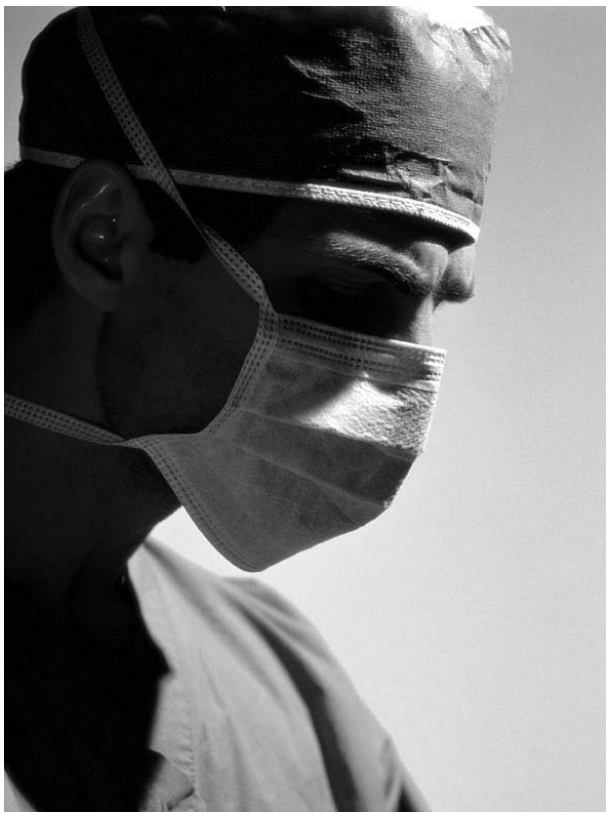
- Labor factors—the increase in the hospital input price index that is attributable to increases in hospital workers' hourly earnings (including fringe benefits).
- Nonlabor factors—the increase in the hospital input price index that is attributable to factors other than hospital workers' hourly earnings,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

HI Trust Fund • from page 9

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

	Labor			Nonlabor			Units of Service							
Calendar Year	Average Hourly Earnings	Hospital Hourly Earnng Differential	Hospital Hourly Earnings	CPI	Hospital Price Differential	Nonlabor Hospital Prices	Input Price Index	Unit Input Intensity Allowance t	HI Enrollment	Managed Care Shift effect	Admission Incidence	Calendar Year	Other sources	HI Inpatient Hospital Payment
Historical Data														
1992	6.3%	-2.3%	3.9%	2.9%	-0.9%	2.0%	3.2%	-0.3%	2.1	-0.4	0.0	**1992**	7.0%	11.9%
1993	1.4	2.1	3.5	2.8	-0.6	2.2	3.0	-0.3	2.1	-0.6	2.8	**1993**	-1.3	5.8
1994	1.7	1.4	3.1	2.5	-0.6	1.9	2.7	-0.7	1.8	-1.0	2.4	**1994**	1.7	7.1
1995	3.3	-0.7	2.6	2.9	1.1	4.0	3.1	-1.0	1.7	-2.0	2.4	**1995**	0.4	4.7
1996	4.9	-2.0	2.8	2.9	-1.5	1.4	2.3	-0.7	1.4	-2.7	5.1	**1996**	1.8	7.2
1997	4.2	-1.4	2.7	2.3	-1.2	1.1	2.1	-0.8	1.1	-3.2	2.6	**1997**	-0.3	1.4
1998	5.2	-1.8	3.3	1.3	1.2	2.5	3.0	-2.6	1.0	-3.1	0.4	**1998**	-0.2	-1.6
1999	4.9	-1.6	3.2	2.2	-0.9	1.3	2.5	-2.2	0.8	-1.8	1.3	**1999**	1.2	1.8
2000	4.8	-0.7	4.1	3.5	-0.1	3.4	3.8	-2.2	1.0	0.3	0.3	**2000**	-1.5	1.8
2001	5.6	-0.9%	4.6	2.8	-0.1	2.7	3.9	-0.2	1.2	2.3	-0.2	**2001**	0.4	7.7
Projections ++														
2002	3.1%	0.5%	3.6%	1.3%	-0.9%	0.4	2.4	-0.7	0.9	1.7	0.1	**2002**	1.7	6.3
2003	4.6	-0.4	4.2	2.5	0.0	2.5	3.6	-0.5	1.1	0.5	0.2	**2003**	0.2	5.2
2004	4.0	0.0	4.0	2.8	0.0	2.8	3.6	0.0	1.3	0.4	0.0	**2004**	0.7	6.1
2005	4.1	0.0	4.1	2.9	0.0	2.9	3.7	0.0	1.3	0.5	-0.1	**2005**	0.7	6.2
2006	4.1	0.0	4.1	3.0	0.0	3.0	3.7	0.0	1.5	0.0	0.0	**2006**	0.7	6.0
2007	4.1	0.0	4.1	3.0	0.0	3.0	3.7	0.0	1.8	0.0	-0.3	**2007**	0.8	6.2
2008	4.1	0.0	4.1	3.0	0.0	3.0	3.7	0.0	2.1	-0.2	-0.3	**2008**	0.8	6.3
2009	4.2	0.0	4.2	3.0	0.0	3.0	3.8	0.0	2.1	-0.2	-0.2	**2009**	0.7	6.3
2010	4.2	0.0	4.2	3.0	0.0	3.0	3.8	0.0	2.1	-0.2	-0.1	**2010**	0.8	6.3
2015	4.2	0.0	4.2	3.0	0.0	3.0	3.8	0.0	3.0	0.1	-0.5	**2015**	0.8	7.3
2020	4.2	0.0	4.2	3.0	0.0	3.0	3.8	0.0	3.0	0.1	-0.2	**2020**	0.8	7.7
2025	4.2	0.0	4.2	3.0	0.0	3.0	3.9	0.0	2.6	0.0	0.1	**2025**	0.9	7.6



* 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 except is taken from Section III.B, "Actuarial Methodology and Principal Assumptions for Cost Estimates for the Supplementary Medical Insurance Program," in the 2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *Copies of the 2002 Annual Report are available from Sol Mussey (410-786-6386).*

This 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 *2002 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 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 free-standing ambulatory surgical center facility services, ambulance and supplies) are paid though organizations acting for the centers for Medicare and Medicade 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 coinsurance 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 occur 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 not 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 2003 through 2011.

The physician fee updates shown through 2002 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.

Based on the increases in Table III.B1, Table III.B2 (not included here) shows the estimates of the incurred reimbursement for physician 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.

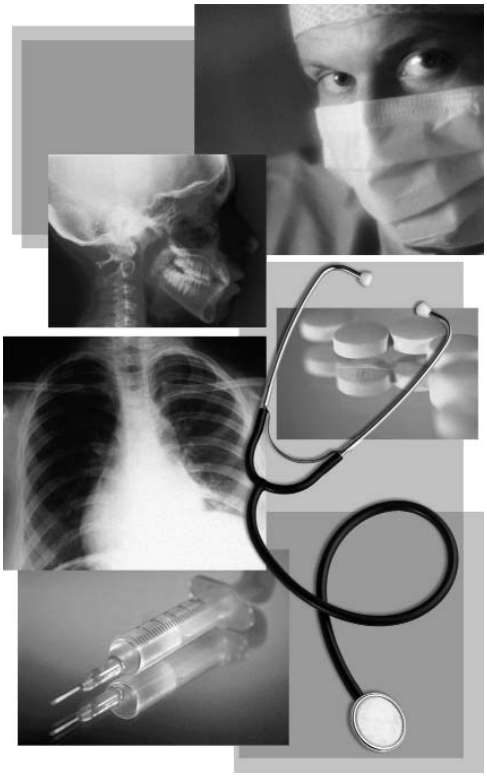
Table III.B1 on page 16 shows the increases in the allowed charges per fee-for-service enrollee for DME, laboratory services and other carrier services. Based on the increases in Table III.B1, Table III.B2 (not included here) shows the corresponding estimates of the average incurred reimbursement for 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. These changes have been made in an effort to slow the rate of growth in SMI expenditures. A fee schedule was established for tests performed in laboratories in hospital out-patient 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 per- iod 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 2002 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 slow down in the number of Medicare beneficiaries choosing to enroll in managed care plans, and in 2001 and 2002 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 (see section II.A for more details). Table III.B6 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 managed care enrollment is expected 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 grow somewhat.

"Hypertext versions of the 2002 Social Security and Medicare Trustees Reports as well as " A Summary of the 2002 Annual Reports" are available on the Internet at the following addresses:

Social Security (OASDI):
http://www.ssa.gov/OACT/TR/TR02/index.html

Medicare (HI and SMI):
http://www.hcfa.gov/pubforms/tr/

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)

	Physician Fee Schedule								
			Increase Due to Price Changes						
Calendar Year	MEI	MPA[1]	Net Increase in allowed fees[2]	Residual Factors	Total Increase	CPI	DME	Lab	Other Carrier
Aged									
1997	2.0	-1.4	0.6	3.6	4.3	2.3	12.0	-5.2	14.9
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	9.9
2000	2.4	3.0	5.8	3.7	9.8	3.5	10.5	6.8	15.5
2001	2.0	3.0	5.7	2.2	8.0	2.8	11.1	5.3	13.8
2002	2.6	-7.0	-4.1	3.4	-0.9	1.3	6.9	3.2	10.9
2003	1.6	-7.0	-5.6	4.2	-1.6	2.5	5.6	3.3	10.3
2004	2.4	-7.0	-5.0	4.6	-0.6	2.8	6.3	5.1	10.8
2005	1.7	-4.7	-2.3	3.8	1.4	2.9	6.1	5.3	10.2
2006	2.1	-2.2	-0.1	3.2	3.1	3.0	6.2	5.5	9.7
2007	1.9	-0.5	1.4	2.7	4.1	3.0	6.3	5.6	8.9
2008	1.6	0.2	1.8	2.5	4.3	3.0	6.3	5.6	8.5
2009	1.6	-0.3	1.3	2.6	3.9	3.0	6.3	5.6	8.5
2010	1.5	-1.3	0.2	2.9	3.1	3.0	6.4	5.6	8.5
2011	1.5	-1.6	0.0	2.5	2.5	3.0	6.4	5.6	8.5
Disabled (excluding ERSD)									
1997	2.0	-1.4	0.6	1.5	2.1	2.3	14.7	-4.5	7.9
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	3.5	2.2	2.7	3.0	11.1
2000	2.4	3.0	5.8	4.2	10.3	3.5	12.3	5.0	12.8
2001	2.0	3.0	5.7	2.1	7.9	2.8	11.5	6.3	16.2
2002	2.6	-7.0	-4.1	3.7	-0.5	1.3	7.1	3.6	11.0
2003	1.6	-7.0	-5.6	4.2	-1.7	2.5	5.6	3.2	10.1
2004	2.4	-7.0	-5.0	4.5	-0.6	2.8	6.3	5.1	10.6
2005	1.7	-4.7	-2.3	3.7	1.3	2.9	6.0	5.3	10.1
2006	2.1	-2.2	-0.1	3.2	3.0	3.0	6.2	5.5	9.6
2007	1.9	-0.5	1.4	2.7	4.1	3.0	6.3	5.6	8.9
2008	1.6	0.2	1.8	2.5	4.3	3.0	6.3	5.6	8.4
2009	1.6	-0.3	1.3	2.6	3.9	3.0	6.3	5.6	8.4
2010	1.5	-1.3	0.2	2.9	3.1	3.0	6.3	5.6	8.5
2011	1.5	-1.6	0.0	2.5	2.5	3.0	6.4	5.6	8.5

[1] Medicare performance adjustment
[2] Reflects the growh in the MEI, the performance adjustment as well as any legislative impacts
[3] 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[1]	Outpatient Lab	Other Intermediary
Aged				
1997	7.9	0.7	8.7	12.5
1998	-0.7	3024.0[2,3]	4.1	-1.5
1999	8.0	-25.4[2,3]	12.6	-20.9
2000	-3.6	-14.6[3]	6.9	17.7
2001	1.2	24.1[3]	4.0	17.6
2002	2.1	20.9[3]	3.3	6.1
2003	5.9	4.8[3]	3.3	-12.6
2004	5.5	8.6	5.1	5.8
2005	8.6	5.3	5.3	5.4
2006	7.8	5.5	5.5	5.2
2007	7.8	5.0	5.6	5.0
2008	7.8	4.6	5.6	4.9
2009	7.8	3.8	5.6	4.9
2010	7.8	4.2	5.6	4.8
2011	7.4	4.4	5.6	4.8
Disabled (excluding ERSD)				
1997	6.7	—	4.3	19.4
1998	-1.1	—[2,3]	1.8	3.9
1999	4.8	-25.2[2,3]	13.1	-15.3
2000	-0.1	-10.1[3]	9.6	-11.0
2001	4.1	24.2[3]	13.0	0.3
2002	3.4	19.4[3]	3.6	7.2
2003	5.8	4.2[3]	3.2	-28.1
2004	5.4	8.2	5.1	7.0
2005	8.5	5.1	5.3	7.0
2006	7.7	5.2	5.5	7.0
2007	7.7	5.2	5.6	7.0
2008	7.7	5.2	5.6	7.0
2009	7.8	4.5	5.6	7.0
2010	7.8	4.6	5.6	7.0
2011	7.4	5.1	5.6	7.0

[1] 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.

[2] 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.

[3] 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.

Pension Council Minutes

Marriott Hotel, San Francisco

June 27, 2002

Attendees: Paul Angelo, Marilyn Oliver, Eric Freden, John Kalnberg, Ian Genno, Tom Lowman, Zenaida Samaniego, John Wade, Sarah Wright, Judy Anderson, Lois Chinnock, Neil Parmenter.

Welcome

Paul Angelo opened the meeting at 8:30 AM PDT by welcoming members and visitors and asking for any changes to the agenda. Paul wanted to add a discussion of Don Segal's idea of having someone from the Pension Section Council attend the Academy's Pension Committee meetings; this new business appears under "9b" below.

Minutes

Eric Freden presented the minutes from the March 10, 2002 meeting and the April 12 and May 10, 2002 conference calls. The minutes were approved.

Treasurer's Report

John Kalnberg presented the Treasurer's report. We should have about $162,000 by the end of the year including spending $15,000 for the Pension Basics Course. Our balance remains somewhere in the neighborhood of two times annual dues. We should be able to spend $50,000 - $60,000 on research. Membership and revenue is stable or increasing slightly. There have been lower postage and mailing costs up until now due to fewer Forums being mailed, but we will be sending out at least two Forums in the near future, possibly three. We should take advantage of this situation and publish all we can. Eric moved the report be accepted, and Ian seconded the motion. The Treasurer's report was approved.

Practice Area Report

Judy Anderson reported on the task force report on practice areas and sections. The report was accepted at a recent board meeting.

Judy recruited members of the practice oversight group (POG) for the Mathew Greenwald research project to survey retirement plan preferences.

The recruits from the PSC include Eric, Zenaida and Paul.

Moody's end-of-month Aa rates are on line. They agreed to a click-on agreement to satisfy their concerns over the proprietary nature of the information. This not a secure web site at this time. The cost is $7,450 per year. This price is set through March, 2003.

Tom led a discussion of the results of the open call for research.

After the discussion, the council turned to funding of the research projects. Projects not listed below were rejected for funding. The votes were as follows:

The council agreed to fund $5,000 (out of $45,000 total) for the Urban Institute project on selection of joint survivor options.

A late proposal had been submitted regarding discrimination testing. The proposal was declined.

John Kalnberg moved and Eric seconded a motion to fund the Moshe Milevsky project 50%, up to $30,000.

Tom moved and John Kalnberg seconded a motion to fund the Linda Smith Brothers project 50%, up to $7,500.

The Council discussed how to make the collection of proposals for research projects more routine. If we send out a request for proposals every March, including publicizing it at the EA meeting, we could review the proposals every year at the June meeting.

Judy reported on various SOA activities and projects:

- Look for publication of Factors Affecting Retirement Mortality. RFP for phase two will follow.

- There is a new Post-retirement Needs & Risks SOA committee; they will be doing a project on annuitization and another on definitions of retirement.

- The Retirement Implications of Demographic and Family Change Symposium held at this Spring Meeting appears to have been a success. It will be the basis for the first on line monograph that the SOA puts out.

- Another on-line monograph coming soon will be based on the cash balance papers presented at the last Spring Meeting.

- There is a task force looking at the issue of how financial and economic models interact with pension valuation models; the task force will be looking at education and research needs in this area.

- A long-running project on mortality projections should be published soon, at least online.

- A turnover rates study is nearly final; new data has been collected in anticipation of a new study of both turnover and mortality.

- The Pension Web page is up and we should check it out; there is a sister web page for the social security committee, which still needs work; Council members are encouraged to help with the web page with content or other suggestions.

Update on Statistics for Benefits Actuaries

Marilyn Oliver has a new draft of the proposed statistics to forward to Eric, John and Judy for review. Her first impression is that the bond information is still weak, but she'd like input from the review committee mentioned above. The cost of the project may grow from $10,000 past $12,000 to as much as $19,000 due to efforts to expand the content to make it more useful. We should change the budget for this project to at least $15,000. Judy mentioned there are technical issues she will need to coordinate to get the Society to sign the long-term contract and get the information up on the Web.

Spring Meeting Review

Zenaida Samaniego reported we were guaranteed six transcriptions for the *Record*. Additional transcriptions cost $500 each. These go beyond just the tapes of the sessions; as the tapes are transcribed and edited by an actuary participant. This year an editor will also edit the transcriptions.

In looking at our six free transcriptions, we noticed that one of the negotiation sessions was included, but the other two were not. We also thought we should drop the Late Breaking Developments session but add the session on Lump Sums. We'll need $1000 allocated to provide for these two additional transcriptions.

Seminars, Web Cast – E&O Session

Tom Lowman reports that Larry Johansen (New York State Teachers) and Ron Seeling (California Public Employees' Retirement System) will appear at the Public Plans seminar. The seminar will cover a broad range of public sector problems, especially funding problems.

The Errors and Omissions seminar will be a webcast and Tom Lowman will be the moderator. Lauren Bloom, staff liaison for the Academy's Council on Professionalism will also participate. Another participant is involved with insurance coverages for E&O, and we are trying to find a trustee. The subject is the concept of the limitation of liability, and the time frame is September.

Marilyn and John discussed issues with the proposed forecast seminar. The problem is this process is software dependent and the firms use proprietary software. There was a discussion of the value of teaching the mathematics of forecasting. The market for the seminar may be the project manager, the person who considers the reasons to do the forecasts, who sets the assumptions and who presents the results in a way that is meaningful to the client. Marilyn and John will go ahead on this basis.

Paul mentioned that he, and Judy and Sandy had a conference call on the Multiemployer plans seminar.

Economic Assumptions is still a pending idea. This topic is on hold because of the combined AAA/SOA POG looking at this issue.

Global Consulting with Multinational Employers may be a topic that should be started but not put together in a rush. Instead, it can be done early next year, such as February. Judy, Ian and Sandy will talk about speakers before our next conference call.

9a. Task Force on Practice Areas/Sections Discussion

Neil and Judy led the discussion of this topic. The Board received a report and endorsed conceptually a two-phase initiative.

Phase one will last a couple of years or so and is intended to get the sections and the practice areas working together in a more coordinated way. This will be an expansion of the current system but there will be some budgetary changes for the practice area. We will work more closely with the practice areas, especially research. A group will be appointed by the Board to move this initiative forward.

Phase two will be section driven, which will mean little for us since we already have a practice area with similar goals and we work closely with them. Other sections are not so fortunate.

There were suggestions that the pension section schedule a joint meeting with the practice area or with the practice advancement committee as possible ways to begin the integration process.

It was suggested that this issue be on the September meeting agenda especially since the new members will be dealing with these changes during their term.

9b. Liaison Between Academy Pension Committee and the Pension Section

Don Segal of the Academy Pension Committee asked Paul to bring up the idea of a liaison from the Pension Section to the Academy Pension Committee. The liaison would be to get ideas for independent research that should be done based on the kinds of issues the Pension Committee deals with or to provide them access to existing research without us getting directly involved with trying to influence public policy.

After discussion regarding the roles of various committees of the Academy and the Society, and the role of the Practice Advancement Committee, we agreed that Judy would report back to us on the next Pension Committee meeting as a standing agenda item.

10. Web Page Development/Online Course

John Kalnberg reports that the online experience study course is in the final stages of being put together. It should be ready by our meeting in September.

Lois reported that the upcoming Pension Section News would describe the new pricing for taking online courses for credit.

11. Section Council Election

Lois reports six people are running for Pension Section Council. She described the online voting methods.

Paul raised a policy question as to whether we should send out a blast email reminding people to vote and mentioning the names of candidates that are members of the Pension Section, assuming this approach does not violate any Society rules. After discussion, Paul asked for a vote to get the sense of the group. There were four votes for this idea, one against the idea, three undecided, and one absent (a member had left to catch a plane). Paul will draft an e-mail and Lois will check with SOA rules to be sure this is not contrary to any policy.

12. New Business

The next call was scheduled for July 31, 10 a.m.CDT. The August call was scheduled on the July call. John Kalnberg moved to adjourn. Marilyn seconded. The meeting was adjourned about 2 p.m.

Congratulations

The following are newly elected members of the Pension Section Council. They will each serve a 3–year term.

Tonya B. Manning
AON Consulting
Winston-Salem, NC

Kenneth Kent
Mercer Human Resource Consulting
Washington, DC

Michael L. Pisula
dpb&z, Inc
Pittsburgh, PA

Thank You

2001-2002 outgoing members

Paul Angelo
The Segal Company
San Francisco, CA

Thomas B. Lowman
Bolton Offutt Donovan, Inc
Baltimore, MD

John F. Wade
NRECA
Arlington, VA

Society of Actuaries Webcasts

Continuing Professional Education Notice

by Sandy Neuenkirchen

Have you been looking for a way to participate in seminars and virtually eliminate your travel costs? The SOA has what you have been looking for, webcasts. Webcasts allow us to conduct live presentations to members in real time in any geographical location with all these benefits:

Effective: holding seminars with more people at one time anywhere in the world

Economical: conducting our marketing announcements electronically and eliminating printing and mailing costs, eliminating travel and hotel cost, and transferring seminar materials through e-mails eliminating printing and distributing hard copies

Interactive: utilizing polling and question & answer sessions to increase attention and participation in the program

Brief Description

Utilizing the web-based graphical presentations on the internet with a teleconference allows for a multimedia, distance presentation. Usually three to four presenters participate in the real-time information transfer and interaction with the participants. As mentioned, webcasts have the ability to reach a large number of people in a one-way presentation format, yet still allowing for interactivity via question and answer sessions and real-time participant polling. Questions can be submitted electronically or live based on time constrictions and the speakers can create online polling where results can be tabulated immediately and shared with all participants.

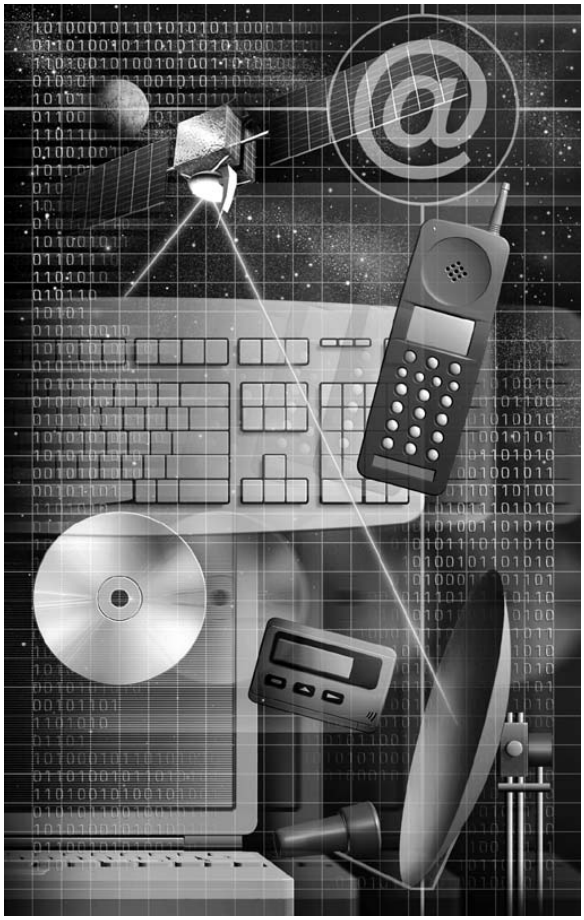
Other benefits for conducting webcasts include:

- Participants can call in from anywhere
- Lower Cost for the Attendee
- Development time less than traditional face-to-face program
- Minimal time commitment from attendees (webcasts vary from 60 – 120 minutes)
- Conducted with a small number attendees is not financially constraining (per minute/per participant price)

Tailored Presentations - Education Follow-up Opportunity

Attendees have the opportunity to tailor the program by submitting questions prior to the webcast. Questions are submitted to a SOA e-mail address and then forwarded to all speakers.

To continue the educational exchange and answer any questions that the speakers do not have the opportunity to answer, a discussion forum, on the SOA website, is available for approximately 10 business days. We receive commitment from the speakers prior to the



webcast in order to successfully answer all questions submitted.

Topics

If you have an idea for a webcast, contact your section council or practice area. Possible ideas include practical, "how-to" programs, briefings on the latest trends, updates on new laws and regulations and programs detailing new ideas for dealing with industry problems.

Webcast History

NAIC Health Reserves Guidance Manual (10/9/01) 135 Registered, 90 minutes

Pension Asset Smoothing in a Rough Market (2/27/2002) 173 Registered, 120 minutes

New AOMR Requirements – Burden Or Opportunity? (9/12/02) 80 Registered, 90 minutes

Dealing with Errors and Omissions by Pension Actuaries (9/23/02) 87 Registered, 120 minutes

International Accounting Standards (10/30/02) Event not completed at time of article, 120 minutes

Registration is completed by site; there maybe a conference room full of people actually participating.

Upcoming Webcast

Considerations for International Expansion on December 3, 2002 (co-sponsored with the Financial Reporting and International Section) from 1:00 – 3:00 p.m. (US/Central Time) with two replays of the webcast following.

For more information, please contact Sandy Neuenkirchen at (847) 706-3536 or sneuenkirchen@soa.org.

SOCIETY OF ACTUARIES

475 North Martingale Road • Suite 800
Schaumburg, Illinois 60173
Web: www.soa.org