

Conference of
Consulting Actuaries™

The Consulting Actuary

The Journal of the Conference of Consulting Actuaries

The Proceedings Issue

Volume XXV, Number 1

February 2013

The Consulting Actuary

Published by
The Conference of Consulting Actuaries

Patricia A. Rotello | President
John J. Schubert | President-Elect
Rita K. DeGraaf | Executive Director

Douglas C. Borton | Editor

Letters, comments and contributions to *The Consulting Actuary* are welcome. All contributions are the property of the Conference of Consulting Actuaries. The Conference reserves the right to use either excerpts from the contribution or the contribution in its entirety.

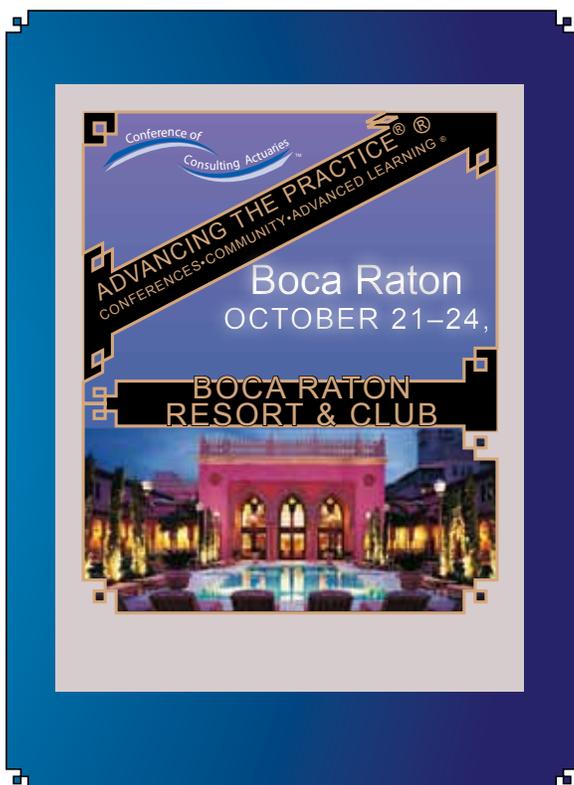
These works reflect the views of the authors and do not necessarily represent the position of the Conference. Neither the Conference nor its officers, members or staff assume responsibility or liability for the accuracy of information contained herein, nor the appropriateness of its use with specific clients. Each actuary is advised to make an independent judgment regarding the content and use of this information.

Authors' names will be used unless otherwise requested. Correspondence may be submitted anonymously; however, it is helpful to include your name even if you indicate that you do not want it to be used. Please address correspondence to:

The Consulting Actuary
Conference of Consulting Actuaries
3880 Salem Lake Drive, Ste. H
Long Grove, IL 60047-5292

© 2013 Conference of Consulting Actuaries
All Rights Reserved

2012 CCA Annual Meeting Recap



Over 550 actuaries and guests attended the 2012 CCA Annual Meeting from Sunday, October 21 to Wednesday, October 24, at the Boca Raton Resort & Club in Boca Raton, Florida.

Continuing education sessions covered timely and relevant topics to keep consulting actuaries up-to-date and well-informed on issues impacting specific areas of interest to consulting actuaries.

There were several different dialogue sessions during which IRS representative, PBGC representative and ASB members, respectively, offered insights for participant questions.

Equally important, participants enjoyed the opportunity to network with colleagues, exchange ideas, and catch up with long-time friends.

The Annual Meeting of the Conference of Consulting Actuaries is the only meeting designed to address the day-to-day issues facing consulting actuaries. You will not want to miss the 2013 Annual Meeting. Be sure to mark your calendar now for October 20-23, 2013 at the JW Marriott San Antonio Hill Country Resort & Spa – San Antonio, Texas.

2012 CCA Annual Meeting Business Section

The Conference's business section with the Treasurer's report, conference awards, election of new directors and other announcements precedes the opening session.

2012 Treasurer's Report

S. Aquil Ahmed delivered the Treasurer's report. Mr. Ahmed reported that The Conference of Consulting Actuaries remains in a strong financial position, and that the Conference's Board of Directors voted to approve a budget with no dues increase for 2013.

2012 Most Valuable Volunteer

Paul Angelo received the 2012 Most Valuable Volunteer Award, presented by CCA President Dale Yamamoto. This is awarded to a volunteer for contributions made to the Conference of Consulting Actuaries, or the actuarial consulting profession in general, during the past 12 to 24 months.

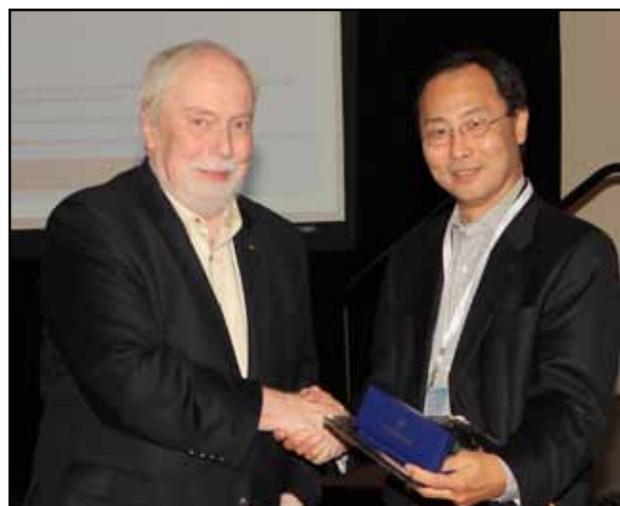


Mr. Angelo has been a speaker at our Annual and Enrolled Actuaries meetings on numerous occasions for over ten years. He has also served on the Joint Program Committee for the Enrolled Actuaries meeting, Chair of the Public Plans Steering Committee and on the Annual Meeting Committee.

Paul Angelo receiving the 2012 Most Valuable Volunteer award from CCA President Dale Yamamoto.

2012 Lifetime Achievement Award

Curtis E. Huntington is honored with the Lifetime Achievement Award and he received a standing ovation from the actuaries in attendance, many of whom personally expressed their gratitude to him throughout the meeting. CCA's Lifetime Achievement honor is awarded to a volunteer for contributions made to the Conference of Consulting Actuaries, or the actuarial consulting profession in general, during his/her professional career. Professor Huntington continues to be a strong force within the actuarial profession. From serving on The Actuarial Foundation Board and the AERF (Actuarial Education and Research Fund which later merged with the Foundation), and establishing a Huntington fund at the AERF, to teaching to many actuaries currently practicing, to continuing his teachings of the profession both within the US and internationally, Professor Huntington gives considerably of his time through support of and leadership to many individuals and groups in or related to the actuarial profession, including the IAA, Academy, CCA, ABCD, SOA and ASPPA.



Curtis Huntington receiving the 2012 Lifetime Achievement Award from CCA President Dale Yamamoto.



2012 John Hanson Memorial Prize

James Pierlot and Faisal Siddiqi are recognized as authors of the paper selected for the 2012 John Hanson Memorial Prize, entitled "Legal for Life: Why Canadians Need a Lifetime Retirement Saving Limit." The prize is awarded for the best paper on an employee benefits topic. Mr. Pierlot and Mr. Siddiqi address the issue of whether, in the current environment of low interest rates, an aging population and increasing longevity, workers can prepare for retirement when they have less time to save and must save more.

James Pierlot and Faisal Siddiqi, 2012 Hanson Prize honorees, with Bob Rietz who presented the award.

Click here for more information about the John Hanson Memorial Prize:
<http://www.cactuaries.org/communities/member/awards-hanson.cfm>

2012 Wynn Kent Public Communications Award

Jim Toole is the 2012 honoree for this prize established by family and members of the Conference Board in memory of Irwin I. "Wynn" Kent (Conference President 1989-1990) and his contributions to financial risk and the profession's work product. The Wynn Kent Public Communications Award is given to members of the actuarial profession who have contributed to the public awareness of the work of the actuarial profession and the value of actuarial science in meeting the financial security of society in the fields of life, health, casualty, pensions and other related areas. Mr. Toole is honored in recognition of using his actuarial skills to assist Forsyth County in identifying gaps in health equity in the community, increasing public awareness of gaps, working to bridge and close those gaps and communicating with the community about health disparities, public health efforts and shared responsibilities.



Jim Toole receiving the 2012 Wynn Kent Public Communications Award, presented by Bob Rietz.

Conference 2013 Award Nominations

Most Valuable Volunteer Award

This is awarded to a volunteer for contributions made to the Conference of Consulting Actuaries, or the actuarial consulting profession in general, during the past 12 to 24 months. The award is announced at the Conference's Annual Meeting, where the recipient is given a plaque, a small gift, and waiver of registration fees for that meeting. Although nominations are accepted throughout the year, nominations made by June 1 of each year would be considered for presentation at the upcoming Annual Meeting.

Submit your nominations for the Conference Most Valuable Volunteer at:

<http://www.cactuaries.org/communities/member/awards-mvv.cfm>

Lifetime Achievement Award

This is awarded for volunteer contributions made to the Conference of Consulting Actuaries, or the actuarial consulting profession in general, during his/her professional career. The award is also announced at the Conference's Annual Meeting, where the recipient is given a plaque, a small gift, and waiver of registration fees for that meeting. Although nominations are accepted throughout the year, nominations made by June 1 of each year would be considered for presentation at the upcoming Annual Meeting.

Submit your nominations for Lifetime Achievement award at:

<http://www.cactuaries.org/communities/member/awards-lifetime.cfm>

Wynn Kent Public Communication Award

The intent of this award is to recognize members of the actuarial profession who have contributed to the public's understanding of financial risk and to encourage more actuaries to engage in these activities. Activities recognized by the Award include, but are not limited to: literature, speeches, work with the media, and volunteering and representing the profession in areas outside the actuarial profession. The award is also announced at the Conference's Annual Meeting, where the recipient is given a plaque, a cash award, and waiver of registration fees for that meeting.

Click on the link for more details about how to submit a nomination for the Wynn Kent Public Communication Award:

http://www.actuarialfoundation.org/research_edu/wynn-kent-submission-form.html

John Hanson Memorial Prize

When merited, up to three outstanding papers on employee benefits topics may be awarded the John Hanson Memorial Prize. Authors need not apply to be considered for the award, and Conference membership is not a requirement for consideration. Hanson Prize recipients receive a cash award and waived registration at the CCA Annual Meeting, where their paper is republished, and they are awarded a recognition plaque.

To submit a paper for consideration for 2013 visit:

http://www.actuarialfoundation.org/programs/actuarial/john_hanson_submission_form.shtml

CCA Welcomes New Directors to the Board

CCA Welcomes New Directors to the Board

CCA welcomes to the Board for three-year terms new members Rebekah D. Bayram and Ellen L. Kleinstuber, and returning Board members Nadine Orloff, Robert J. Reiskytl, John T. Stokesbury and Thomas A. Swain. P. J. Eric Stallard joins the Board filling a two-year unexpired term, and Bruce A. Richards joins the Board to complete a one-year unexpired term.

Special thanks and appreciation go to retiring board members Lawrence J. Sher, Barbara J. Lautzenheiser, Marn Rivelle and Lawrence A. Johansen for the time and commitment they dedicated to the Conference through their Board service.

Address by Dale Yamamoto, CCA President 2011-2012

PRESIDENT DALE YAMAMOTO: Good morning. Hasn't this been a great meeting? Let's give a hand to John and the annual meeting planning committee for putting together yet another meeting to remember.

Anyone watch the debate on Monday? Some of you jokingly asked if we invited them to our meeting. We actually did when we heard the debates were going to be held here in town. Unfortunately, both candidates sent notes back to us declining. I really think they missed an opportunity to get some free actuarial consulting advice.

I entitled this message, "Stuff Happens." I was going to use the other noun that begins with the same letter but something that I have learned over the last year as President is that I need to be more politically correct. And, I am also going to use this time come out of the closet.... I'll let those words sink in a bit before I explain.

Anyway, wasn't this a great way to spend three days? I guess it could have been better if we weren't stuck inside most of the time but if you weren't, think about what you would have missed. You would have missed acknowledging one of the actuarial legends of our time—Curtis Huntington and you would have missed Jim Toole's encouraging words to use your talents in your local area. You would have missed learning some new things and refreshing your memories of old things. You would have missed connecting with old friends and meeting new ones. And, you would have missed me messing up by forgetting one of our past presidents—Ken Kent. But it dawned on me at the Monday evening event as I was talking to Tom Finnegan that I also missed him! But he didn't make a big deal about it. In fact, he never mentioned it. Of course he was carrying two Budweisers with him at the time too. Tom is the President-elect of ACOPA so after this session, Ken/Tom, you should get together and have a couple drinks and celebrate for being among the unknowns or misfits or whatever you two decide to call yourselves.

Back to the closet thing. How many of you wanted to be an actuary when you were in junior high school? Honestly? Anyone want to be a fireman, policeman, actor, dancer, rock star? I just picked up the book, "No Easy Day," about the raid on Osama Bin Laden and in the preface, the author says that he wanted to be a Navy SEAL since junior high school. That reminded me that it was about that time, when I was in junior high school, that I wanted the same thing. It's one of those things that you don't mention in public because it does create some negative thoughts among a group of people. It's kind of like never discussing religion, sex and politics. Wanting to belong to such an elite group was not something you talked about. But, I figure given all the popular press about the Navy SEALs after the Bin Laden incident and other rescues that have put them in the headlines, I figured it's now safe to come out of the closet.

So, why talk about this at an actuarial meeting? Number one, it's the last time I'm going to talk about it publicly because I doubt I will ever have another forum like this.

Address by Dale Yamamoto, CCA President 2011-2012
cont.

And number two, as I think about my actuarial career and the last year, I find many similarities between my childhood dream career and the one I ultimately ended up.

First a little history. The Navy SEALs weren't officially formed until the early 1960s so when I was so absorbed with it in junior high, there wasn't a lot of information about them. The key thing that attracted me to them was that everything that I did read about them said they were the "best of the best." As I relate that to the actuarial profession, I think actuaries are also the best of the best. The reason the SEALs are the best is that they go through an extremely rigorous selection process to prove they belong. So, I relate getting through the actuarial exams to be much like Navy SEALs selection. Many start the process and only a few finish.

Back in junior high and high school, almost everything I did was focused on becoming a SEAL. My dad loved to hunt so I honed my shooting skills tromping through farm fields for pheasants. We didn't have a lot of money so my dad always told me not to miss! I studied martial arts—primarily Judo—but also karate, aikido and kendo. I spent the summers in swimming pools taking as many Red Cross courses as possible and got my swim instructors certificate. I even ordered materials to make my own firecrackers so I could start learning about explosives. Fortunately, I have all fingers accounted for. I taught self-defense at the Air Force training base near our home. My first airplane flight was a trip from Spokane, WA to Seattle for my Navy physical. It was there that they told me that I wasn't qualified because my eyesight was too poor. The same reason why my dad was turned down by the army in World War II.

So, like most of us, I accidentally discovered the actuarial profession and focused on that. I went "east" to college at the University of Nebraska. Hey, when you're on the west coast, Nebraska is east! In my early career I had actuaries in my life that were volunteering for the profession. Not unlike those who volunteer for the Navy. At Nebraska there was Steve Kellison and my summer job in Lincoln, it was Barbara Lautzenheiser (who is just coming off the Conference board), and in my first full-time job in Seattle it was Gary Corbett. All three were presidents of at least one of the actuarial organizations. Again, not unlike the SEALs who want to emulate the leaders that they see in their organization, I also found myself volunteering.

Fast forward to this last year. Part of the job of President is to participate in the Council of US Presidents or CUSP. This group was formed to better coordinate the operations all of the US actuarial organizations. I started the year at our last meeting by saying that I wanted to improve the coordination between the Conference and our sister organizations. There were bumps in the road along the way but there was some increased collaboration this past year. We finished up the details of the new joint discipline process agreement this past year that will be effective this coming early in 2013. We also established a task force to consider how we might better coordinate with each other. This group produced a paper with recommendations for further collaboration that I hope CUSP takes the time to act on their suggestions. Again, this is similar to collaborative task forces where the SEALs and the Army Delta Force operators work together for a common goal. Two groups that are very separate but have common interests.

The SEALs work in relatively small teams. Each member has a specific task but they all know how to do each other's job. The staff of the CCA is a good example of that. This summer one of the staff was out for an extended period of time because of an accident. There are only six staff members in the office and they all pitched in to keep the operation moving when that happened because, like a SEAL team, they know how to do each other's jobs. John mentioned in the opening session that our staff does a phenomenal job so I also personally encourage you to just say thanks to any of the staff you see on the way out. And finally, from what I understand, remember they didn't let me in because I can't see, the SEAL teams work hard, play hard and enjoy working with each other. I evidenced that during these last three days and especially on Monday night!

The title of the book, "No Easy Day," is a take on the SEALs motto, "the only easy day was yesterday." That's one thing that is only partially true in this case because the reality of how many things work, there is turnover in leadership, and now is the time for me to turn over the reins of the CCA leadership to Pat Rotello. I doubt she wanted to be a Navy SEAL when she was young but she has gone through the actuarial selection process and over the last years has proven to be a great leader. So, for her, "the only easy day was yesterday." For me, "every day will be easy now."

Address by Patricia Rotello, CCA President 2012-2013

PRESIDENT PATRICIA ROTELLO: Thank you, Dale, I am honored to take on the role of CCA President for the coming year. To be honest, I am also a bit nervous as I already have two full time jobs – as a mother and a consultant. The CCA is an organization with which I've been involved since my very first days as an actuary. As a brand new actuarial analyst at Kwasha Lipton, one of my first non-billable activities was organizing packages to be sent to the Board when the head of my actuarial group, Dave Reade, was on the Board and ultimately became President of the Conference. I'll admit I didn't become a member until many years later, but it didn't take me long to learn more about the CCA.

I attended my first CCA meeting shortly after becoming an ASA, and quickly realized if I was going to be attending professional development meetings in my future, this was the place to be. I am a pension actuary by background who also does account management, and so these days I attend sessions in the international and healthcare tracks more often than the pension track. As a member of the Annual Meeting Committee for years, I view the evolution of our session topics as very indicative of our organization's mission and strength – a focus on the needs of our members.

As I look to the coming year, I have to reflect on the past year and all that we have accomplished as an organization and all that I have learned – and for this, I want to thank Dale. Dale is certainly an industry leader in the healthcare consulting arena, and in the past year I have had the benefit of working closely with him and see his general leadership skills in action. He has led our organization and our Board in what I can characterize as "Dale" style – tactful, decisive, thoughtful, respectful, inclusive, sometimes funny and always calm. We have a running joke about that Midwestern calmness and politeness that Dale exudes, which I, a native New Yorker, will never have.

In addition to the normal CCA activities, our activities this past year, under Dale's direction, included –

- Working with the other US actuarial organizations, as Dale mentioned we expect to have the final approval in November with an early 2013 effective date for the joint discipline process. This has been a few years in the making and was no easy task. With any luck, our next effort will be aligning continuing education requirements.
- We embarked on a strategic review of our organization to examine the challenges facing us and how we can better bring value to our members. As a part of this continuing process, you will be receiving a short survey from us via email in about two weeks. We really want and need your input to shape how we can help you as a professional and as a business person.
- We've worked within the International Association of Actuaries with the other US organizations to ensure the voice and needs of US actuaries are considered. As a country we have the most developed set of actuarial standards. There are many countries around the globe where no

such standards exist, and thus they are clamoring for the establishment of a consistent set of standards on a variety of actuarial topics. Our self-interest is to ensure that the IAA does not supersede what we view as its level of authority and impose any standards or directives that would conflict with those already in existence in our country.

To say the least, it's been an interesting year and one in which again I am thankful for the opportunity to have worked with Dale. On behalf of the CCA Board, staff and members, I want to present Dale with this plaque as a symbol of our gratitude.

I won't take up a lot more of your time, as I stand between you and our final session. There are, however, a few parting thoughts I would like to share with you:

- You've likely heard a lot over the past three days about ways you could volunteer in order to grow as a professional and to aid our profession. Joe Kelly talked about opportunities to volunteer with the Actuarial Foundation. Jim Toole spoke about getting involved in your local community. The CCA is always looking for volunteers to get involved in a variety of areas, so if you are interested, please let us know.
- In several of the sessions I attended over the past three days, there has been discussion about the need for financial education – not just in the US but around the globe. Our speakers in the Lifetime Income session on Monday discussed the need for and importance of sound financial education. In the emerging markets session yesterday morning, our speakers from both

Address by Patricia Rotello, CCA President 2012-2013
cont.

Armenia and Brazil commented on how this was needed in their countries as well. As we contemplate the future of the retirement actuary, I challenge each of you to think about this and what we need to do as a profession to develop a role for the retirement actuary in addressing this very important future crisis. I use “retirement” actuary loosely here to include both pension and retiree health actuaries.

- Finally, I mentioned our survey earlier and I want to reiterate how important it is for us to hear from you – our members and non-members alike -

about areas where we could provide new networking or learning opportunities for you.

I hope you have enjoyed your time at this meeting. I want to thank John Schubert, Scott Hittner, all of the members of our Annual Meeting Committee, and the CCA staff for all of their hard work. I want to thank all of our speakers, moderators, and recorders for contributing to a successful meeting, and lastly, I want to thank all of you for your attendance and support.

Hopefully we’ll see many of you again next year at our meeting in San Antonio. Safe travels.

Session Summaries from the 2012 Annual Meeting

Would you like to be a recorder at the 2013 Annual Meeting?

Recorder duties include writing a brief description of specific sessions, collecting continuing education forms, and other duties as requested by the moderator.

New actuaries are especially encouraged to consider serving in this capacity as it is an excellent way to network into other continuing education opportunities, gain exposure within the profession, and potentially participate in speaking opportunities.

A special thank you to our recorders who provided the following summaries.

Danielle Appelbaum, Buck Consultants
Dorene Conlon, Deloitte Consulting, LLC
Colleen O’Malley Driscoll – The Segal Co.
Melissa M. Dubay, Towers Watson
Valerie Hintzen, Towers Watson
Amanda Holland, Deloitte Consulting, LLC
Kevin House, Towers Watson
Robert W.E. Newton, Towers Watson
Jesse B. Nichols, Towers Watson

Vaibhavi Patel – Aon Hewitt
Irina Pogrebivsky, Towers Watson
Una Raghavan, Towers Watson
Francis X. Reagan, Towers Watson
Mike Ringuette, Towers Watson
Tanya Rizzuto, Towers Watson
Casey Shork, Deloitte
Richard Tash, OptumInsight
Andrew V. Wilkinson, OneAmerica

Session 1 Again With The Gray Book

Speakers:

Bruce A. Cadenhead, Mercer
Eric A. Keener, Aon Hewitt
Maria M. Sarli, Towers Watson

Session Coordinator / Recorder:

Francis X. Reagan, Towers Watson

The speakers cover both the Blue Book and Gray Book released earlier this year.

Blue Book highlights:

Q&A 2: After a flurry of activity with plan sponsors refilling PBGC Schedule A's recharacterizing plan year contributions in years past to reduce PBGC variable premiums, the PBGC stated they would no longer process these requests. Part of this process involved refilling Schedule SBs as well. IRS Notice 2012-61 was the first time the IRS formally stated their "long-standing" position that you cannot recharacterize contributions already reported on Schedule SB. So both organizations do now have policies which effectively stop this practice.

Q&A 3: For plans that are at-risk, the \$700 per participant + 4% load becomes part of the vested benefit funding target for variable premium purposes even though it isn't a benefit liability of the plan.

Q&A 14: Be careful when deciding whether certain unvested death benefits need to be included in the premium funding target or not. It isn't always intuitive.

Q&A 19: The Blue Book did not acknowledge the PBGC's new Section 4062(e) enforcement approach which takes into account the credit-worthiness of the sponsor. Stay tuned until next year's Blue Book for Q&As about this.

Gray Book highlights:

Overall, there are lots of questions about the interaction of MAP-21 when applied to existing guidance. Expect plenty of MAP-21 questions in next year's Gray Book.

Q&A 2: It can be onerous to use disabled life mortality tables for funding valuations due to restrictions on their use. There is a potential "gotcha" here, because you cannot use those tables for ERISA 4010 filings or 4044 allocations.

Q&A 5: Continue to follow Revenue Proc. 2000-41 for filing method changes. The IRS favors long term strategic rationale in applications to change methods rather than for short term budgeting considerations.

Q&A 8: The moral of the story is that if you are running a short plan year, describe the asset method change very carefully to avoid having to ask for IRS approval. Delays obtaining approval can really cause problems for you and the plan sponsor in operating the plan. There is still a lot of missing IRS guidance and slow response times for several IRS approvals which can force you to do something on an old basis in the meantime, or your question generates additional questions before ruling.

Q&A 14: Asset method changes are handled differently between spinoffs and mergers. Combining cash flows for the plans is the preferred approach versus treating the merged in plan as a cash inflow to the trust.

Q&A 15: With respect to standing credit balance elections, there are pros and cons to their use and you need to be careful of problems such as triggering a 4010 filing or replacing Carry Over Balances with Pre-Funding Balances. One strategy would be to have a standing election in place each year and revoke it after each September 15th, after which you would make any further balance adjustments.

Q&A 24: Be sure to test benefits, rights, and features in situations in which rank & file are in a DB plan and have a lump sum option while higher paid are in a DC plan.

Q&A 41: In an M&A mid-year spinoff situation, actual fund earnings is the only acceptable way to adjust the asset amount spun-off. Don't bother negotiating a reasonable interest rate to apply to delays in an asset transfer.

Session 3 Late Breaking Developments

Speakers:

Ellen L. Kleinstuber, The Savitz Organization
 Tonya B. Manning, Internal Revenue Service
 Sandra G. Rolitsky, Deloitte Consulting LLP
 Carolyn E. Zimmerman, Internal Revenue Service

Session Coordinator/Recorder:

Andrew V. Wilkinson, OneAmerica

A number of items were covered by the speakers – many that were highly technical and detailed. This summary is not intended to cover completely all of the information presented.

Moving Ahead for Progress in the 21st Century (MAP-21) (Zimmerman/Manning):

Clearly most pension actuaries had been living and breathing MAP-21 for the last few months. The key provision of the legislation provides:

1. Funding relief based on 25 year average interest rates
2. Additional information, annual report to participants under ERISA 101(f)
3. Expansion, transfer excess assets under §420
4. Increased PBC premiums

The funding stabilization formula creates an interest rate corridor that helps minimize fluctuations caused by interest rate swings (especially the low one currently being experienced). Over time, that corridor widens to reduce the relief provided during periods of low interest rates. Plans that use the full yield curve are not subject to this relief, but have an opt-out provision during the first year MAP-21 applies. The MAP-21 rates do not apply to several other key interest rates including deductible limits under §404(o), lump sum payments, PBGC variable rate premiums, and financial reporting basis.

The effective date is for plan years beginning in 2012, which has caused considerable focus on this during the last few months. A plan can elect to defer until 2013 for all purposes or §436 purposed only. The impact of the MAP 21 relief on segment interest rates is as follows (IRS Notice 2012-55):

Rates of January 2012	Unadjusted	MAP-21
1st Segment	1.98%	5.54%
2nd Segment	5.07%	6.85%
3rd Segment	6.19%	7.52%

While the 2012 plan year rates will not change, the IRS is looking at possibly adjusting the historical rates it uses for 2013 and beyond. “The IRS is aware of the need for 2013 rates on a timely basis.”

Next, there was a review of IRS Notice 2012-61 which relates to AFTAP, both using MAP-21 and non MAP21 plans, and the timing of the certification, application (prospectively or retroactively) and the ability to reclaim funding balances. An example was offered to show how elections to reclaim reductions in funding balances would work. Additional items addressed in the IRS notice include application to hybrid plans (no final regulations will be effective before 1/1/2014), interest credits, Schedule SB reporting, deadlines. There remain a number of unanswered questions, some of which were pointed out in the presentation.

MAP-21 also expands Actuarial Funding Notices on certain underfunded plans with over 50 participants. The notices must show funding target percentage, funding shortfall, and MRC on both with and without MAP-21 basis for the current plan year and the two prior plan years. Additional language is also required.

PBGC Premium Increase: (Kleinstuber). The flat-rate premium (per participant regardless of funding status), increases from \$35 in 2012 to \$49 in 2014, with an inflation adjustment thereafter. The variable-rate premium (which applies to the plan’s unfunded balances [BOY]) doubles from .9% to 1.8% by 2015 with an inflation adjustment beginning in 2013. This will significantly raise the premium for underfunded plans. The increases may encourage well funded plans to offer lump sum windows. It should be noted that the unfunded balance is not calculated on the MAP-21 basis.

ERISA 101(j) Notices (Zimmerman):

Requirements regarding notice to participants when the plan becomes subject to funding-based benefit restricts, as well as when they are lifted were covered.

Developments in Administrative and ERISA Matters (Rolitsky):

A number of items were covered:

- 1) 8955-SSA – Eliminates the signature requirement on Form 5558 Request for extension
- 2) Determination Letters – Schedule Q Eliminated, restrictions on Form 5307
- 3) ERISA Developments - 408(b) Fee Disclosures - Indirect compensation refers to compensation that is received from any source other than the

plan, the plan sponsor, the covered service provider, or an affiliate and must be disclosed. Non-compliant service providers are subject to prohibited transaction rules and penalties. This mainly impacts defined contribution plans.

Interim Mortality Improvement Scale BB (Kleinstuber):

Generally, auditors expect a forecast of mortality improvement beyond the disclosure date unless there is a convincing argument for no future improvement. No real push for using BB.

IRS Focus Items (Rolitsky):

1. Definition of Governmental plans – IRS is formulating regulations under §414(d). Some plans that have always considered themselves government plans may not meet the definition - “quasi” governmental for example. Transition relief will be necessary.
2. Definition of Normal Retirement Age in Governmental Plans - Effective date of NRA regulations for governmental plans is postponed until 2015
3. PPA Audit Issues
 - a. Annual funding notices and elections – late, undated, or unspecified dollar amounts.
 - b. Actuarial increases not being applied for late retirement benefits.
 - c. Asset valuation – done differently from minimum funding versus funding based limits
 - d. Late quarterly contributions

Lifetime Income Guidance (Zimmerman):

Very few retirees elect immediate or longevity annuities. The reasons include irrevocability, illiquidity, and the financial security of insurance company, lack of understanding, price, and complexity. IRS issued small four pieces of guidance in February 2012 addressing this issue:

1. Rev Rul 2012-3: Addresses how QJSA and QPSA rules apply to profit sharing plans offering annuities.
2. Proposed QLAC Regulations: Defines qualified longevity annuity contracts and excludes their value from the MRD rules.
3. Rev Rul 2012-4: Clarifies DC to DB rollovers to provide additional DB benefits.
4. Proposed Regulation § 417(e): Attempting to encourage employers to offer partial lump sums.

Lump Sum Windows (Kleinstuber): Numerous employers have implemented, or are considering offering a onetime lump sum option – most commonly to deferred vested participants. The reasons include lower costs (relative to purchasing annuities), reduce PBGC premiums, simplify plan administration, and improve risk management. There are a number of considerations when designing and implementing the window, including 436 restrictions, beneficial accounting treatment in 2012, anti-selection, and administrative issues.

2013 Regulatory Limits: The recently released limits for Retirement Plan compensation and contributions were presented. Most had either no or modest increases.

Session 4 Retirement Ready – Or Not?

Moderator:

Robert J. Reiskytl, Aon Hewitt

Speakers:

Grace K. Lattyak, Aon Hewitt

Andrew J. Peterson, Society of Actuaries

Session Coordinator/Recorder:

Melissa M. Dubay, Towers Watson

In this time of a rapidly changing US retirement system, will employees have adequate income to retire? The speakers discussed the definition and measurement of income needs in retirement and the outcome of informative surveys on retirement income from employees' and employers' perspectives.

Background

An employee's personal responsibility for retirement security is increasing as fewer employers offer traditional (defined benefit) pension plans and retiree health plans. As more and more companies move to savings (defined contribution) plans, individual employees are increasingly responsible for their retirement income and the majority is concerned about their ability to retire with adequate income and the sustainability of their income. The areas of biggest concern are inflation and rising health care costs, with 74% of pre-retirees being somewhat or very concerned that they will not have enough money for healthcare in retirement.¹

Employers recognize that employees are unprepared for retirement, but are more focused on the cost and competitiveness of retirement benefits and less paternalistic in the view of their responsibility.

Defining and Measuring Retirement Needs

The two most common ways to measure retirement income is determining the amount needed to maintain (a) a basic subsistence level, or (b) the pre-retirement standard of living. Many assumptions are needed to project future experience, including: longevity, investment returns, public policy, health care, inflation and taxation. Note that most studies and rules of thumb are more useful for aggregate estimates on a population's adequacy than for individual financial planning. Often, studies are not available for some of the populations most at risk: those below the poverty line, and the part-time workforce (or those with long breaks from the workforce).

These measurements are compared to gross replacement rate targets (i.e. Rules of Thumb). Based on a Society of Actuaries research paper ² on replacement rates, the Rules of Thumb are grossly inadequate due to the complexity and diversity between individuals. For example, the amount needed varies significantly by income level and age due to medical trend, with lower earners needing a much higher percentage of pay due to medical costs, relative to income.

Adequacy studies compare the projected total value of retirement resources to retirement needs. Retirement needs are defined as pay at retirement adjusted for lower taxes, change in expenditures, increases in medical costs, and elimination of savings for retirement. Retirement income can be measured as a percent of pay or as a multiple of pay. A replacement ratio values the annual amount needed in retirement (in the first year of retirement) relative to pay at retirement, while a multiple of pay reflects the present value of the income needed through retirement. The multiple of pay approach reflects the value of inflation, while the percent of pay does not.

How Are Employees Doing?

2012 Retirement Income Adequacy at Large Companies - The Real Deal (Aon Hewitt)

Highlights:

- Average shortfall of 2.2 times pay between needs in retirement and projected private retirement income.
- Forty-six percent of full-career workers are nearly on track to retire at age 65; 20% have projected shortfalls of greater than six times pay.
- Non-contributors are most at risk with a projected shortfall of 10.8 times pay.

- Females are more at risk due to saving less than males and longer life expectancy.
- DC-only employees are projected to have a larger shortfall due to lower employer-provided benefits.

Suggested Methods of Improving Adequacy:

- Later retirement increases the savings period and decreases for which the period income is needed; precludes need for pre-Medicare medical costs.
- Escalation of savings rates; in addition to more savings, needs decreased due to pre-retirement standard of living being reduced. Survey results projected with auto-escalation resulted in significant improvements.
- Recommended savings rate of 15% (total employee plus employer) beginning at age 25 for adequacy.

Retiree and Employee Attitudes Toward Retirement

Summary of SOA Post-Retirement Risks and Needs Committee Bi-annual Survey in 2011 (Society of Actuaries)

Highlights:

- There is a large gap between when retirees expect to retire and actually retire; 40% of retirees retired before they expected.
- Thirty percent of employees feel that retirement doesn't apply to them, with 45% of them feeling financially unable to retire.
- Less than half of workers plan on stopping work "all at once."
- People do not plan long enough, with 48% of retirees and 32% of pre-retirees planning <10 years.
- People underestimate population life expectancy but they do a slightly better job estimating personal life expectancy.

Long-term findings:

- Misperceptions still exist after 20+ years of experience with 401(k) plans.
- It is unclear if the economic downturn will lead to better management/planning.
- Longer-term risk management is very difficult for individuals.
- Education is important but cannot be the primary strategy; there are limits to what it can accomplish.

¹ According to the Society of Actuaries, 2011 Risks and Process of Retirement Survey

² See: MacDonald, B-J., and K. D. Moore. 2011 "Moving Beyond the Limitations of Traditional Replacement Rates." Society of Actuaries. <http://www.soa.org/research/research-projects/pension/research-moving-beyond.aspx>

Session 7

EGWPs – The True Story

Moderator:

Thomas S. Tomczyk, Buck Consultants

Speakers:

Geoffrey Kuhn, Aon Hewitt

Troy Michael Filipek, Milliman Inc.

Session Coordinator/Recorder:

Danielle Appelbaum, Buck Consultants

This session is interactive, with audience questions throughout the presentation. The speakers provide an overview of employer retiree pharmacy benefit options, discuss recent regulatory guidance and walk through an employer case study. After a summary of the main points of the presentation, a listing of the questions and answers are provided below.

Overview of Prescription Drug Options

Comparisons are drawn between Retiree Drug Subsidy (RDS) plans and Employer Group Waiver Plans (EGWP) with and without a secondary wrap plan. RDS plans have historically been favored by employers since they were the “path of least resistance.” The RDS will be taxable beginning in 2013 to help fund the improvements put forth in the Affordable Care Act (ACA), including improvements to Part D. These improvements include a 50% Pharma discount on brand drugs during the coverage gap (funded by pharmaceutical companies) as well as a gradual increase in Plan cost sharing so that by 2020, enrollees are paying 25% of drugs in the coverage gap (consistent with drugs after the deductible). Two items of note regarding the Pharma discount: you must be enrolled in a Part D Plan to receive the discount, and the discount accrues toward TrOOP. The employer impact is that EGWP value is increasing (and will continue to increase through 2020), while the RDS value decreases for taxable entities. As a result, employers are considering plan design changes and implementing EGWP approaches (usually in conjunction with a wrap plan) to capture the savings available under Part D.

Recent Regulatory Guidance

CMS-4157-FC was initially interpreted as no longer needing wrap plans to maximize the Pharma discount and federal reinsurance. After further discussions with CMS, the current interpretation is that no benefits beyond basic Part D are allowed through EGWPs beginning in 2014. Thus, wrap plans are effectively mandated going forward, with a 1-year lag for the effective date likely to be allowed by CMS given the late guidance. We are awaiting guidance from CMS to confirm this interpretation and allow the waiver until 2014.

Case Study and Considerations

In the second half of the session, the speakers included an overview of the savings and implementation process for an EGWP product. The savings drivers include the 50% Pharma discount on brand drugs in the coverage gap (sensitive to the distribution of claims), direct risk-adjusted capitation payments (albeit decreasing in recent years), and federal reinsurance payments. These savings are partially offset by increased administrative costs due to the additional claim adjudication and other work done by the insurer or PBM. It is important to keep in mind that subsidies are mechanically different than RDS. EGWP subsidies are plan assets that directly offset the costs of the plan. Plan sponsors must determine to what extent the generated revenue will be shared with retirees through premium or contribution subsidies. Other considerations when adopting an EGWP include the timing differences of EGWP revenue compared to RDS, plan design adjustments that may be needed (e.g., mandatory generics and mandatory mail programs are not allowed in EGWP), different administrative processes, and the need for comprehensive communication and education programs so retirees are aware of what is changing.

Question & Answer Listing

The speakers answered the following audience questions:

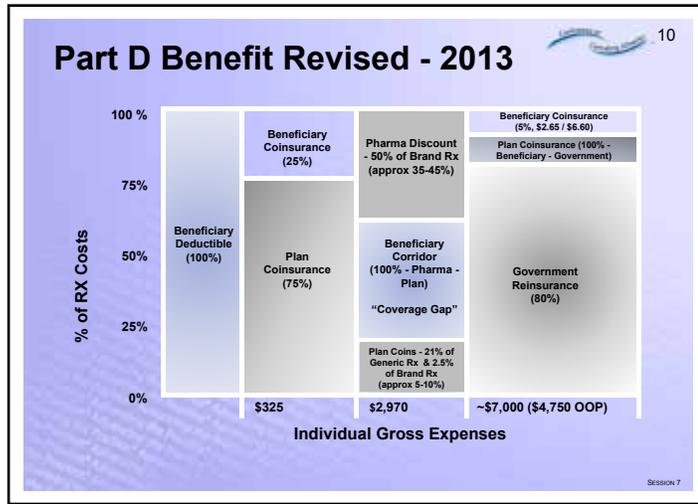
General Questions:

QUESTION: If a client had been using RDS, they would only recognize RDS for 1 year?

ANSWER: GASB yes, FASB no – recognize present value of entire future stream under FASB for RDS and under both GASB / FASB under an EGWP.

QUESTION: In coverage gap, 50% discount in gap Pharma and government subsidies?

ANSWER: 50% is Pharma only; other government subsidies make up the remaining 25% to total of 75% covered.



QUESTION: If you are high income, you will not receive the subsidy?

ANSWER: If you are high income, the Pharma discount applies but the direct capitation is lowered. If you are low income, you continue to get the same low cost sharing of usually \$1-3 copays that was in place pre-ACA and thus, the Pharma discount does not apply to low income beneficiaries.

QUESTION: Is it true you can continue to ignore the closing of the donut hole in Part D Attestations?

ANSWER: Yes, when doing creditable coverage testing and Part D Attestations, you can use the 2010 standard benefit with 2013 parameters.

QUESTION: Is there an expiration of the Pharma discount?

ANSWER: TBD; 10 year deal at \$80B, but president and others expect this to continue on for perpetuity

QUESTION: From real world perspective, how do they identify the amount that Pharma has to pay? Does it flow through Part D?

ANSWER: CMS administers it with the help of vendors; Initially they were taking subsidies and paying them out; going forward, CMS will be removed from the process

(just identify amount payable) and subsidies will be paid directly from Pharma to plan; on member's card at pharmacy, claim will auto-adjudicate to know how much enrollee pays.

QUESTION: For last bullet on page 9, how does that work?

ANSWER: If not in Part D, there is no Pharma discount. So ER plan outside of Part D doesn't get anything (though also usually don't have coverage gap)

QUESTION: Why is the government allowing this? Why would they let the Pharma discount apply first?

ANSWER: They're likely not highly concerned because it's not their money; it is Pharma's money. Pharma has been raising concerns behind the scenes on Capitol Hill.

QUESTION: Should we assume it should continue forever?

ANSWER: Yes. CMS says if a client offers an EGWP benefit, it can only be the basic. Starting in 2014, if you offer enhanced benefits, they must be provided outside of Part D. The Wrap would need to cover the enhancements beyond the basic Part D benefits.

QUESTION: Does the Pharma discount come before rebates?

ANSWER: Yes, it applies to the ingredient cost, which is before rebates

QUESTION: Since this is still a group plan, does the communication come from the employer or CMS?

ANSWER: It would come from the carrier, based on standard CMS rules. This differs from an RDS plan where communication came directly from employer.

QUESTION: Due to formulary restrictions, do you see plans where the EGWP includes formulary but WRAP has additional formulary restrictions?

ANSWER: Varies by carrier and PBM; large PBMs usually willing to customize formularies between plans. Easier to add to the Wrap benefits, but more difficult to limit benefits (like add prior authorization, etc.).

QUESTION: Earlier you suggested that Rx companies may feel they have been tricked. With the greater percentage of employers switching to EGWP, do you anticipate pressure from CMS to let Pharma companies out of this loop hole (for 50% Pharma discount to perpetuity)?

ANSWER: Pharma likely didn't anticipate the effect of Wrap plans. Expect Pharma will lobby in DC. CMS will be in a tough spot. May be used as an incentive to switch to individual plans which will continue to have Rx discount if removed or reduced through group plans.

QUESTION: Does the enhanced EGWP provide greater subsidies due to the richer benefits?

ANSWER: No; in fact likely decreased overall since takes longer to reach the catastrophic reinsurance pools. Direct subsidies will stay the same.

QUESTION: You mentioned the direct subsidy, can you talk to the factors that increase the limit in RDS going forward? Is it the average Part D premium?

ANSWER: Employers (ERs) are struggling with RDS. Subsidies are driven by average claims, which have gone down substantially for the past 2 years with brand drugs losing patent. ERs would not expect that amount to decrease. Based on individual market forces, EGWP direct subsidies have also decreased (whereas RDS is tied to specific claims).

QUESTION: What do most ERs do with the EGWP subsidies? What's the best practice?

ANSWER: Most ERs try to carve out the subsidies and keep themselves; instead of different premium/cost value for contribution purposes. Use the gross premium to set retiree costs. Capitation and reinsurance are most often kept by the employer under an EGWP. There are different views on EGWP Pharma discounts – some share and others keep.

QUESTION: Back to CMS guidance, retirees can only get basic coverage in Part D. What challenge is CMS solving by changing this guidance?

ANSWER: CMS is removing themselves from the oversight rule with the enhanced benefits. Since plans do not file CMS bids (there are no Part D EGWP bids), CMS wants to let PBMs and carriers handle through the wrap. However, doesn't seem very impactful.

Example of EGWP + Wrap Benefit 13

- \$100 brand name drug
- Member in coverage gap
- \$20 copay

	RDS	Pure EGWP *	EGWP + Wrap
Total Drug Cost	\$100	\$100	\$100
Primary Plan	\$80	\$80	\$2.50
Secondary Plan	NA	NA	\$27.50
Pharma	NA	\$10	\$50
Member	\$20	\$10	\$20

* CMS regulations dictate no coverage beyond defined standard allowed in EGWPs beginning 1/1/2014

SESSION 7

QUESTION: How is the \$2.50 calculated?

ANSWER: Based on brand coinsurance which is 2.50% in the coverage gap beginning in 2013.

QUESTION: This would change when you get close to the OOP max? Example of drugs when total spent is close to OOP.

ANSWER: PBMs have different approaches; “ping pong approach” where in the gap, out of the gap, never get to catastrophic; other approaches get you to out of the gap; definitely affects the Pharma discount that is paid and how claims adjudicated

QUESTION: Why even show the middle column? Does it exist?

ANSWER: It currently exists (2010 through 2013); Alleged waiver until 2014; Out of play effective 2014 based on recent CMS guidance.

Savings Example 21

Post-65 Retiree PMPM Gross Cost Analysis of RDS and EGWP + Wrap Strategies
Per Member Per Month Basis; Without Regard to Retiree Contributions

	2013		2020	
	RDS	EGWP	RDS	EGWP
Prescription Drug Plan Cost Components (PMPM)				
A. Gross Rx Plan Cost				
1. Gross Rx Plan Cost Net of AWP Discounts	\$ 309	\$ 309	\$ 445	\$ 445
2. 50% Discount on Brand Drugs in the Coverage Gap	N/A	(\$ 38)	N/A	(\$ 55)
3. Gross Rx Plan Cost Net of Pharma Discounts (1 + 2)	N/A	\$ 271	N/A	\$ 390
B. Member Cost Sharing	(\$ 58)	(\$ 55)	(\$ 83)	(\$ 79)
C. Gross Rx Plan Cost Net of Member Cost Sharing (A + B)	\$ 251	\$ 216	\$ 362	\$ 311
D. Administrative Fees	\$ 2	\$ 10	\$ 3	\$ 12
E. Projected Rebates	(\$ 31)	(\$ 28)	(\$ 44)	(\$ 41)
F. Net Rx Plan Premium Equivalent Cost (C + D + E)	\$ 222	\$ 198	\$ 321	\$ 282
Medicare Part D Subsidy Payments				
G. RDS	(\$ 50)	N/A	(\$ 72)	N/A
H. PDP/EGWP Direct Capitation Payment	N/A	(\$ 43)	N/A	(\$ 78)
I. PDP/EGWP Federal Reinsurance Payment	N/A	(\$ 20)	N/A	(\$ 28)
J. Total Subsidy Payments (G + H)	(\$ 50)	(\$ 63)	(\$ 72)	(\$ 106)
H. Net Pre-Tax Rx Program Cost (F + J)	\$ 172	\$ 135	\$ 249	\$ 176
I. Change Due to EGWP		(\$ 37)		(\$ 73)
J. Percent Savings		-22%		-29%

SESSION 7

QUESTION: RDS is back loaded based on when you file for reimbursement, but capitation like H is immediate. So they shifted when you get the dollar amounts.

ANSWER: Yes, timing can differ. RDS depends on when you apply. Rx discount quarterly, capitation payments monthly. So the timing of discounts and subsidies may differ.

QUESTION: Rx discount quarterly?

ANSWER: point of sale for customer; quarterly for plan

QUESTION: What types of funding arrangements do you see with the 2 plans? Both fully insured?

ANSWER: Not usually, Wrap typically self-insured. Sometimes wrap is fully insured for small plans.

QUESTION: Walk through why direct capitation subsidy is increasing?

ANSWER: Part D becomes better benefit so Government reimbursement for offering that benefit increases over time. However, recently, the direct subsidy has been decreasing based on market forces and brands losing patent.

25

Retiree Contribution Development

	Current RDS Strategy (No Sharing)	EGWP + Wrap Strategy		
		No Sharing	Share Pharma Discount Net of New PBM Deal	Share All EGWP Revenue
Premium Equivalent Rate Development				
Gross Paid Claims	270	270	270	270
Member Cost-Sharing (e.g., copays)	(75)	(75)	(75)	(75)
Net Rx Paid Claims	195	195	195	195
Retiree Drug Subsidy/CMS Revenue	—	N/A	N/A	(60)
50% Pharma Discount	N/A	—	(35)	(35)
Administrative Fees	5	5	10	10
Net Rx Premium Equivalent	200	200	170	110
→ Basis for Retiree Contributions				
Premium Sharing				
Retiree Premium Share (40%)	(80)	(80)	(68)	(44)
Employer Premium Share	120	120	102	66
Net Employer Cost				
Retiree Drug Subsidy	(50)	N/A	N/A	N/A
Federal Capitation	N/A	(50)	(50)	—
Federal Reinsurance	N/A	(10)	(10)	—
50% Pharma Discount	N/A	(35)	—	—
Impact on Administrative Fees	N/A	5	—	—
Net Employer Cost	70	30	42	66
} Part D Offsets				
<small>True net EGWP Cost: \$205 - \$95 = \$110; retiree contribution cannot be more than this amount...a retiree share percentage greater than 55% under "No Sharing" would violate maximum CMS premium requirement</small>				

Session 9 Working Around the Globe – Best Practices for Retirement

Speakers:

Wifredo J. Gaitan, Aon Hewitt
 Stephen Barry, ING Employee Benefits
 Susan M. Fleming, Coca-Cola Company

Coordinator/Recorder:

Vaibhavi Patel, Aon Hewitt

Internationally mobile employees can lose pension benefits as they transfer from their home countries to various other countries for assignments. Speakers discuss challenges of providing pension benefits to mobile employees as well as strategies geared to reducing the loss in pension benefits, including transitioning from Defined Benefits plans to Defined Contribution plans.

Loss of Pension Benefits for Internationally Mobile Employees over a Full Career

The speakers kicked off with an introduction of various categories of mobile employees. The main categories of mobile employees are:

- Local Nationals; employee who has been hired and working in his/her country.
- Expatriates; A US citizen hired in the US and deployed to work in another country for an extended basis:
 - o Term from 1-3 years.
 - o May have multiple assignments in his/her career.
- Third Country National (TCN); Non-US citizen hired in a country other than the USA who is deployed to work in another country for an extended basis.
- Inpatriates; A non-US citizen hired and working at a foreign subsidiary of the US parent who is assigned to work in the US for a temporary period of not less than one year.
- Global Nomad: employee deployed from country to country, essentially with no home country.

The discussion focused mostly on loss of pension benefits for Global Nomads. These employees tend to lose pension benefits due to various reasons such as;

- Loss in link/coordination of social security benefits between countries where they transfer.
- Loss in aggregate supplementary pension plan income due to break in service, contribution features, lack of pension plans in a particular country, lack of consistency in inflation indexation, etc.

QUESTION: Are rebates shown on this slide?
 ANSWER: No, rebates aren't factored in. They are removed to simplify.

QUESTION: In fully insured environment, are you allowed to split the items at the bottom to not share?
 ANSWER: More difficult since you do not see the flow of funds.

QUESTION: Has a retiree group ever challenged that the RDS/EGWP subsidies should be shared with them?
 ANSWER: I've seen this come up in union discussions (i.e.: is it ours vs. the company's?); that's why unions are slower to implement these types of plans. Unions have been fairly receptive to this plan change – mostly an administrative change, but your retiree benefits are the same (your copays and formularies are fundamentally the same). Employers have taken the stance that we don't need to negotiate this since we aren't changing the benefits. What's tricky is how to split the savings at the end.



CONTINUING EDUCATION

- Pool local investment environment for DC plans;
- Currency fluctuations; and
- Adverse taxation features.

Typical Approaches to Mitigate Loss of Pension Benefits for Global Nomads

The discussion moved to the best approach for providing pension benefits for Global Nomads. The discussion focused on offering a specialized solution for these employees that focused on designing an International Retirement Plan.

The typical plan designs tend to be defined benefit with offsets of pension accruals earned in the various countries of assignment (umbrella plan), a top-hat defined contribution plan (in addition to the local pension plan) or hybrid plans that tend to be cash-balance in nature.

The typical features to keep in mind and discuss when incorporating and designing these pension plans are:

- Oversight board; critical to keep in mind to ensure the plan is meeting the original purpose.
- Corporate guidelines on eligibility. It is important to determine the employee nationality (US vs. Non-US), position level, host country social and tax systems and duration of assignments.
- Benefit levels; should the benefit be fixed benefit or fixed contributions that are provided at the global or regional levels? Is the purpose of the benefit to match a global standard or a US program? Should the plan require employee contributions?
- Funding; should the plan be funded via an offshore trust or offshore insurance? Offshore Trust arrangements tend to have a high set-up cost, whereas offshore insurance arrangements typically do not. Book reserve plans can also be considered where an accrual is made in the books to recognize the promise to pay in the future.

The overall trends for these kinds of pension plans were discussed next. Funded plans tend to be DC in nature and more vendors are entering the market that are offering administration and funding solutions for such plans. Globally mobile employees (especially executives), are getting more savvy in asking for a pension benefit as part of the total rewards package when they are asked to move from assignment within various countries.

Case Study – The Coca-Cola Company

Using a case study example, the speakers next discussed the challenges and solutions of how the Coca-Cola Company approached providing a retirement solution for

their globally mobile employees. The case study illustrated how the Company transitioned from providing a traditional final average pay defined benefit pension plan with offsets to providing a top-up cash balance pension plan to their employees.

The traditional defined benefit plan was difficult for participants to understand as well as an administrative burden. The Company went through the same plan design discussions regarding the features for the new defined contribution plan.

Special transition benefits were offered to active non-grandfathered employees who had 45 age and service points.

The speakers concluded by discussing the overall feedback from the employees at the Company who saw the transition to a DC pension plan as generally positive.

CCA Annual Meeting

October 20-23, 2013

JW Marriott San Antonio Hill Country
Resort and Spa - San Antonio, TX



Session 10 Executive Compensation

Moderator:

Phillip Merdinger, Mercer

Speakers:

John Lowell, P-Solve Cassidy

Michael Melbinger, Winston & Strawn LLP

Session Coordinator / Recorder:

Tanya Rizzuto, Towers Watson

Protecting Plan Fiduciaries, Board Members and Others from Personal Liability under ERISA

Part of executive compensation work involves protecting plan fiduciaries from personal liability, and clearly identifying roles so the Board of Directors and other executives aren't inadvertently fiduciaries. Compensation committee charters giving responsibility and liability for benefit plans to the committee, or identifying the plan administrator as "the company," can unnecessarily expose committee members and executive officers to liability. In recent cases, courts are finding fiduciary breaches for non-qualified plans (not just qualified plans) regarding the safety/surety of promised benefit amounts.

Fiduciary responsibility can be delegated internally (e.g., to a committee), to an outsider, or to plan participants. The delegation must be crystal clear & documented. Here is a five-step process to ensure the appropriate fiduciaries discharge their fiduciary duties/responsibilities and are protected from liability:

1. Centralize and concentrate the fiduciary duties in the hands of a few qualified individuals (e.g., a committee).
2. Establish policies and procedures to help ensure that fiduciaries adhere to their fiduciary duties.
3. Train the internal fiduciaries to comply with the established procedures and their duties.
4. Protect internal fiduciaries with liability insurance and indemnification.
5. Narrow plan provisions that provide for broad fiduciary oversight or overlapping delegations of authority (e.g., use the term "benefit committee" rather than "company").

In re Unisys is a good example of a situation where a plan was set up well with respect to fiduciaries and is an easy-to-read case.

Improved Protection of Non-Qualified Plan Benefits

Non-qualified deferred compensation plans can help

participants defer taxes and save for retirement. However, they are not immediately taxable because they are subject to claims of the company's creditors in the case of insolvency. A rabbi trust doesn't protect against bankruptcy. There is lots of case law about when creditors can/cannot access rabbi trust money.

A QSERP (Qualified Supplemental Executive Retirement Plans) may make sense if the non-qualified plan promises an excess benefit, and through non-discrimination cross-testing there is sufficient room in the qualified plan to transfer some liability to executives. With MAP-21, plans look better funded, so this may be a good time to implement a QSERP for some sponsors.

Advantages to a QSERP:

- Removes the benefit from being subject to IRC Section 409A.
- Completely secures the benefit (in light of bankruptcy and/or change in control).
- Benefit is exempt from FICA taxes.
- Sponsor gets immediate tax deduction when funded.
- Plan assets grow tax-free.
- Benefits are paid from a large trust, not company assets or a small rabbi trust, reducing cash flow volatility.
- Qualified plans have better optics than SERPs.
- Easier to manage risk in a qualified plan than in a SERP.

Compensation Committee Adviser Provisions of the Dodd-Frank Act

This is essentially Sarbanes-Oxley rules for the compensation committee. This is a new law, so there's been no enforcement yet. Independence requirements under the rule include:

- The Compensation Committee, in its sole discretion, may retain and obtain the advice of independent advisers.
- The Committee may only select a compensation consultant, legal counsel or other adviser after taking into consideration six factors identified by the SEC.
- The Company must provide for appropriate funding, as determined by the Compensation Committee, for payment of reasonable compensation to any adviser.

The rule does not require independent advisers. The six factors should be considered together; no one factor should be viewed as a determinative factor of independence. A Compensation Committee may select

any compensation adviser it prefers, including one that is not independent, after considering the six independence factors outlined in the final rule. Committees should undertake this assessment before year-end 2012, in time for any changes in the relationship or disclosure in the 2013 proxy statement. The rule does not require company to describe or disclose the Compensation Committee's process for selecting compensation advisers.

Compensation Risk Assessments

The SEC published rules in December 2009 requiring every public company to:

- Evaluate whether any of its compensation plans or practices, including non-executive officer compensation plans and practices, create risks that are reasonably likely to have a material adverse effect on the company.
- Disclose the results of that evaluation and any steps the company has taken to manage or mitigate those risk-taking incentives, only if the policies and practices create risks that are reasonably likely to have a material adverse effect on the company.

A company is not required to make an affirmative statement that it has determined that the risks arising from its compensation policies and practices are not reasonably likely to have a material adverse effect on the company. Many companies are not doing this internally and the SEC has pointed out that they are not seeing compliance with this. Note - many things we don't typically think of as compensation are compensation for SEC purposes. The report should be included in the proxy statement.

The Next Round of Dodd-Frank provisions

Only 6 of 13 executive compensation provisions have become effective so far!

Pay Ratio Disclosure (Dodd-Frank Act Section 953(b) requires a company to disclose:

- The median of the annual total compensation of all employees except the CEO (including employees outside the U.S.);
- The annual total compensation of the CEO; and
- The ratio of the amount described in paragraph (A) to the amount described in paragraph (B).

The company must calculate annual compensation using the rules for the Total Annual Compensation figure in the Summary Compensation Table. Companies are also required to disclose in the proxy statement "information that shows the relationship between executive compensation actually paid and the financial performance

of the issuer." Financial performance and executive compensation haven't been defined.

Many companies are including "realized" or "realizable" pay. These terms have no consistent definition, so the SEC doesn't really like them. Companies should disclose what these numbers represent. ISS (institutional shareholder services) recently issued a policy statement that they will review realized/realizable pay, so companies will need to start reporting this.

Clawbacks - it will be very hard to figure out the amount paid in excess of what should have been paid. Dodd-Frank creates somewhat of a cycle, as more rewards → more whistleblowing → more investigations → more restatements... The SEC is reporting 10 whistleblower complaints per day.

2013 Tax Increases

- The new Medicare tax of 0.9% on taxable income over \$200,000 (single)/\$250,000 (married). How will this be administered?
- OASDI tax has been 4.2% of pay instead of 6.2% for the last 2 years; it will revert to 6.2%.
- UIMCT - There will be a new 3.8% tax on the lesser of (i) "net investment income" or (ii) the excess of modified adjusted gross income over a \$200,000 threshold.
- Bush tax cuts are set to expire.

Many DB SERPs haven't reported FICA. They are strongly incentivized to pay FICA in 2012 because of all the tax increases coming.

Session 11

Healthcare Around the Globe – Are There Lessons to be Learned?

Speakers:

Wifredo J. Gaitan, Aon Hewitt
 Stephen Barry, ING Employee Benefits
 Douglas J. Carey, Deloitte Consulting LLP

Coordinator/Recorder:

Vaibhavi Patel, Aon Hewitt

The speakers included presenting key features of selected healthcare systems around the world. The objectives included discussing country statistics, groups covered, benefits provided, financing and delivery of benefits and

the key challenges faced. The selected countries covered were Switzerland, United Kingdom, France and Colombia.

Switzerland

Coverage: Switzerland provides universal healthcare coverage which is a statutory national health insurance system with compulsory coverage for all Swiss residents and dependents. Individuals are allowed to seek treatment only within their canton of residency and only to hospitals receiving reimbursements for providing basic treatment. The main categories of coverage are Sickness, Maternity and Accident insurance.

Health Insurance Cost: Premiums vary based on geography and not gender/risk profiles. Government provides direct cash subsidies to people if health insurance equals more than 8 percent of personal income, and about 35% to 40 % of households get some form of subsidy.

In Switzerland, insurers are not allowed to make a profit off this basic insurance, but can on supplemental plans. It was discussed how 99% of the 7.8 million Swiss residents are covered by compulsory basic insurance and enjoy one of the longest healthy life expectancies in the world. Access to healthcare is not an issue for the Swiss.

Some of the key challenges of the current health care system discussed are:

- High Cost; healthcare expenditures are the third-highest in the world (as a % of GDP in 2010) and premiums have increased an average of 5% per year.
- Poor Transparency; benefits included in the package have increased by over a third since 1985 and too many insurance plans currently exist.
- Aging Population; Increases the healthcare burden on the government.

It was discussed that only around 25% of the individuals own supplemental health care which is arranged on an individual basis.

United Kingdom

Coverage: Government owned National Health System (NHS) provides free health services to all UK citizens.

Health Insurance Funding; The UK system is funded mainly by general taxation and national insurance contributions. The majority of financing comes from business and personal taxes.

Only around 10% of the UK population has private insurance. The UK system provides affordable care for

all and is relatively cost efficient from an administration perspective as well as coordination of health provision.

Some of the key challenges of the current health care system discussed are:

- Talent shortages: UK is facing an increasing shortage of nurses and doctors.
- Access to health care: Capacity limitations and long waiting times at NHS hospitals are driving patients for overseas medical care where surgery prices tend to be 20 to 50% lower in some countries compared to the UK.

Supplementary health care plans are highly prevalent among executives (95%) and other employees (60%). The intent of Private Health Insurance (PHI) is to reduce waiting time and get faster access to health care. Private dental and vision coverage is also becoming more popular due to reduced provision by the NHS. Employers tend to offer PHI via flexible benefit arrangements.

France

Coverage: France provides social health insurance which is compulsory. The insurers that cover the benefit tend to be agencies that participate in negotiations with the state on the funding of healthcare in France. Healthcare expenses are reimbursed according to a schedule of fees set by the state. The fee schedules are applied to medical procedures and the balance is borne by the individual.

Health Insurance Cost: Contributions to the social health insurance are charged as a percentage of income whereby total cost is 20% of wages. Employers pay 12.8% and contribution from employee is 0.75%. A social tax of 7.5% contributes most of the tax to cover healthcare benefits.

Some of the key challenges of the current health care system discussed are:

- High Cost/medical inflation: medical costs for the population continue to increase.
- Aging Population: Increases the healthcare burden on the government.

Supplemental health plans tend to be employer sponsored plans with the intent to cover expenses not covered by social security. Employees typically pay 40%-60% of the annual premium. Coverage tends to also be provided to retirees, disabled or terminated employees but with a greater percent of cost sharing due to higher risk. Deductibles tend to be based on coverage.

The discussion then focused on an example of how the social health care system reimburses for a typical medical service.

Colombia

Coverage: Employers are obligated by law to contribute. Plans are administered by an “Empresa Promotora de Salud” (EPS) and each employee selects an EPS. “Plan Obligatorio Salud” (POS) provides a basic basket of medical coverage. Work related accidents and sickness are insured through “Administradora de Riesgos Profesionales” (ARP). The ARP system provides subsidies for the unemployed and the poor. All EPS’s reimburse expenses at the same level and cover basic medical and dental procedures.

Health Insurance Cost; Benefits are financed 2/3 by the employer and 1/3 by the employee. Aggregate contributions to the EPS are 12.5% of the income and paid to the EPS directly.

Some of the key challenges of the current health care system discussed are:

- High Cost/medical inflation; medical costs for the population continue to increase.
- High administration costs; Healthcare benefits administration costs continue to increase.
- Limited benefits offered by the EPS leave employee to seek additional coverage.

Supplemental health plans are not common even though some multinationals tend to provide this benefit. These plans are mostly insured with the employee typically paying between 20% to 40% of the annual premium. Retiree medical is shared cost of 50%. The trend appears to be that these plans will be increasing in demand. The public plans will likely not be able to keep up with increasing medical inflation and costs leaving the supplemental plans to fill in the gap.

The speakers concluded by a chart that demonstrated the health care spent in the above four countries with a comparison to the US. This led to a discussion about the various healthcare systems in the world.

Session 12

Talking to the Auditors/Defending Your Work

Speakers:

Judith Venturino, KPMG LLP
Dennis Polisner, KPMG LLP
James Burke, The Savitz Organization

Coordinator/Recorder:

Colleen O’Malley Driscoll, The Segal Company

Background

In the wake of Sarbanes-Oxley, the calls and emails from actuaries employed by accounting firms and even by accountants have multiplied. Reasonableness checking and layers of scrutiny are now applied to actuarial opinions on obligations for both retirement and postretirement health plans. Although an actuary’s principal may undervalue these conversations, they are a necessary step in the valuation process.

Session 12 aimed to explain the actuarial review inherent in the audit process. In addition to explanation, Session 12 shed light on the key components of an actuarial valuation that typically require supporting documentation, even approval from the auditors. A case study was examined that allowed the speakers to don their everyday roles of signing and reviewing actuary and audit partner.

Summary

The speakers led off with an agenda that highlighted the reasons why actuarial opinions receive the scrutiny they now bear. Some of these reasons are:

- Balance sheet impact of present values for benefit promises, either pension or postretirement health;
- Amounts recorded in Accumulated Other Comprehensive Income;
- Projected cash flows;
- Plan Assets.

Explanation of the heightened importance of these items was provided. Further description of the requirements of the audit process, including the need for the audit partner to rely on the reviewing actuary as a subject matter expert, was given. Description of the testing of a client’s internal controls, the sufficiency of the client’s audit evidence and the need to understand the client’s operations, were identified. These descriptions were provided to help explain the paradigm of the reviewing actuary and the drivers of his/her work.

In response to a statement made by Ms Venturino, audit partner at KPMG and lead speaker, additional description

of the role of Reviewing Actuary was given. The audit partner and the reviewing actuary are allies in the goal to appropriately disclose their review of the client's operations. The reviewing actuary has specific knowledge that the audit partner does not possess. This knowledge base is used to query the work of the signing actuary to assess reasonableness of the signing actuary's results and appropriate choice of assumptions. Reference was made to two articles of suggested reading: 1) "Using the Work of a Specialist," AICPA SAS No. 73 and 2) American Academy of Actuaries' Practice Note: "Working with Pension Plan Auditors."

Key assumptions such as discount rate selection, choice of expected return on plan assets and the need to include provision for future mortality improvement were reviewed. Actuarial Standard of Practice No. 35 and the need to consider future mortality improvement were discussed. Speakers aired their views on how best to support the signing actuary's choice of mortality assumption. An audience member asked about projection scale BB and the likely timeline for its common inclusion in mortality projection choices.

Methods of choosing discount rates were debated as well as an implied requirement to be consistent in the selection of the method for setting the discount rate or expected investment return. Examples such as the use, period over period, of the same bond universe for the yield curve and the consistent use of the method to set the expected investment return were given.

Questions were raised by the audience related to the need to understand materiality and trivial. "Bright lines," ranges of reasonableness and definitions of materiality were all aired. Audience members contributed real-life examples to the presentation outline which spurred discussion among both the speakers and the audience. Speakers again endorsed the need to develop supporting documentation in one's work papers to answer a reviewing actuary's questions on choice of assumptions. Anticipating the questions arising from a review of the actuarial opinion and which can be answered by a work paper analysis were proffered as a proactive way to move the audit process forward. Audience members solicited opinions from the speakers on sufficient documentation in one's work papers. Discussion followed on these queries.

A case study was introduced. Omissions in actuarial disclosures, changes in assumption selection and other anomalies were all included in the case study. These irregularities provoked animated discussion between the audience and speakers. Following review of the

case study, suggested best practices were put forth by the speakers. Discussion followed on the best way to incorporate these suggestions into the actuarial valuation work process.

Conclusion

The tutorial on audit processes and their impact on the actuarial opinion was the foundation of the presentation. Debate, signaling resistance to the need for additional supporting documentation in response to queries from the reviewing actuary, shifted the presentation from an educational review of past practice towards discussion of best practices for the future. As actuaries continue to sign opinions and then benefit from other actuaries reviewing those opinions, actuarial practice can only improve.

Session 13 Future Mortality Improvements

Moderator:

Tammy Shelton, Towers Watson

Speakers:

Dr. Jay Olshansky, University of Illinois at Chicago
Robin B. Simon, Buck Consultants
William E. Roberts, Towers Watson

Session Coordinator /Recorder:

Kevin House, Towers Watson

The speakers gave 3 perspectives on future mortality improvements:

- SOA Retirement Plans Experience Committee
- Robin Simon's analysis using Buck's data
- Jay Olshansky's research

Retirement Plans Experience Committee (RPEC) of the SOA – Mortality Study Update

The RPEC has been studying mortality data to assess future recommendations for mortality assumptions for pension plans. In the course of this study the RPEC found that the prevalent mortality improvement scale of AA may not sufficiently project mortality improvement and have developed interim scale BB as an alternative for actuaries to consider while RPEC finalizes the study.

Various data analyses were used to compare actual experience to what the AA scale would have predicted. It showed that age alone is not a good predictor of mortality

improvements. RPEC developed BB leveraging:

- Data patterns observed thus far in the study;
- UK studies and techniques;
- 2 dimensional table analysis (age and calendar year).

Robin Simon's Analysis

Buck's experience data show mortality improvement that has generally been higher than what AA or BB predict, further confirming the tenants of ASOP 35 (an actuary must consider mortality improvement before and after the measurement date of the liabilities). Buck's recent surveys show that most actuaries currently use a variant of RP-2000 and static mortality improvements.

Actuaries should be cautious when assessing mortality experience against a table with mortality improvement projected beyond the measurement date because that table is suggesting there be mortality gains in the near term because mortality improvements have been layered in beyond the period being assessed. To take advantage of experience in smaller plans in assessing the appropriate tables to use, some simple credibility factors can be used to weight the experience. Below are a couple simple formulas leveraging credibility theory that to weight the experience and adjust a published table:

Adjustment Factor (AF) = actual deaths/expected deaths
Credibility Factor (CF) = Min (1, (expected deaths / 1000)^(1/2))
New qx = qx (from appropriate published table) x [CF x AF + (1 - CF)]

Beyond experience adjustments actuaries are reminded that they can vary their mortality assumptions by work collar, income level, industry, etc.

Jay Olshansky Discussion

Mortality improvement cannot continue at the rates that we saw the last century as many in the actuarial and scientific community are suggesting. Many scientists focus on the tails and are missing the bigger trends and issues. For years forecasters have under and over-estimated longevity improvement. There is empirical evidence pointing in the direction of higher life expectancy for some and lower for others. The education gap appears to be driving large relative differences in mortality improvement. Those with less than 12 years of education have seen their rates decrease, and those with higher education have seen their rates improve. Education level is correlated with many other socio-economic conditions that also may impact mortality rates, but it is clear that there appears to be a high correlation of education to mortality improvement.

The level of obesity change from 1990 to 2010 is alarming. The proportion of people that are considered obese has nearly doubled during that time. Even more alarming is the level of obesity among children. We have not seen anything like this in our history so we can't really assess how future longevity will be impacted by this obesity epidemic. It is fairly clear that we can't simply take the mortality experience from the past and extrapolate it on the current population because of how different the populations are from an obesity stand point. There are data suggesting that the spike in obesity is not solely due to eating more and moving less, but perhaps other contributing factors such as newer medicines and vaccines. Evolving socio-economic and technological changes do not necessarily lead towards perpetual mortality improvement.

Session 15 Medicare Advantage and PDPs

Speakers:

David M. Tuomala, OptumInsight
 JoAnn Bogolin, Optum
 Troy Michael Filipek, Milliman Inc.

Session Coordinator / Recorder:

Richard Tash, OptumInsight

The speakers address seven key aspects of Medicare Advantage and PDPs. The leader provides an overview, and audience participation with questions and comments follows.

Impact of STARS

Rate plans based on quality, developed from 33 HEDIS (Healthcare Effectiveness Data and Information Set) measures.

Scores 1-5 with 5 being the best; CMS (Centers for Medicare and Medicaid Services), revenue based on STARS rating.

Beginning 2015, the CMS demonstration that allows plans with 3.0 or greater STARS to receive a bonus to the benchmarks ends and only plans with 4.0+ STARS will receive a bonus applied to the benchmark.

The measures plans are subject to are moving targets. For example, CMS released guidance on the amount of time plan representatives have to answer the phone when

beneficiaries call. This round of STAR results showed that CMS expected a much better time than the guidance indicated to score well.

Are STAR ratings a 0-sum game?

No, everyone could get a 5 but it is a moving target, therefore 2013 targets won't remain for 2014. What is advantage to set a minimum for performance standards? CMS minimum requirement in the regulations for plans to use as standards. They have strict guidelines. Use a blind audit.

What is the lag; 11/13? CAHPS (Consumer Assessment of Healthcare Providers and Systems) on HEDIS; administrative reports, clinical reports. Part D is nearly baked for 2015 right now, 2014 STAR determined. CAHPS next year.

Three to four years to correct systematic issues? Found out what they need to do to increase score in short term. No retrospective "true up."

How do STARS impact enrollment data? Medicare compare shows a note on plans as being low quality. Medicare beneficiaries tend to be loyal to their doctors, but it may impact new enrollment. Also, 5 STAR products can enroll retirees year round. Members can leave low STAR plans for higher plans during the year but cannot leave high STAR plans.

Do carriers market to plan STAR rating?

CMS rate book by county. Member risk score x rate book = CMS revenue. Bonus given for STAR rating. Beginning 2015, only 4 and 5 STAR plans will get a bonus.

CMS has taken 25% historically of savings. The remaining rebate is used to purchase additional benefits. With ACA, CMS will take 30% from 5 STAR plans and 50% from 2.5 STAR plans. The amounts retained by the plan are used to enrich benefits. Originally, rebates were only intended for 4 and 5 STAR plans, so ACA is moving to the original intent. Cuts put into ACA are offset by this program.

With the cuts in rebates, even 5 STAR plans will not get back to the original rebate levels but 5 STAR plans will be closer than others. What is needed by plans to contain costs:

- Squeeze administrative and better claim management.
- Integrated carriers get closer to 5 STAR ratings than non-integrated plans.
- United/Humana are non-integrated plans that are catching up.

Do Medicare Advantage trends lead to increases in premiums faster than non-Medicare Advantage plans and therefore do not need to add extra trend?

Correct. Miami Dade County has the highest reimbursement and \$0 premium plans. Companies may need to file plans at a loss to compete.

How does one find out the 4 and 5 STAR plans? Publicly available, link provided by speakers.

1. CMS Benchmark Changes

How does the government save money? Over 6 years, the rate book will be bringing each county to within 95-115% of FFS medical expense. Some companies will need to take off 5-10 points to be better than FFS. Risk put back on plans; 95% before risk adjustment number. Depends on the inefficiency of the market whether companies can make it work using a percent of FFS.

By 2017, the benchmarks for all counties will be at FFS target. IME paid thru rate book but will phase out and CMS will pay IME directly to facilities.

Revenue – CMS adjusts for coding differences. Everyone's risk score will reduce 3.4% since MA risk scores are less than the average member risk score.

In 2013 CMS initiated sequestration. This will reduce payments to plans by 2%. For FFS contracts, some of this may be passed to providers but wouldn't apply to capitations or case rates.

2. ACA Reform Initiatives

CMS implementing an excise tax / insurer fee (since ACA needs to pay for itself). For commercial business represents ~\$1 pmpm (per member per month). For Medicare, this represents ~\$16-20 pmpm. This is ~2% of 2013 premium and includes CMS revenue. Accrues for 2014 and used to pay for ACA provisions. Some exemptions include:

- very small premium.
- Government reductions.
- Non-profit reductions.

The excise tax will be a continuing expense, not temporary.

Beginning 2014, carriers must meet 85% medical loss ratio. Penalties are worse than for commercial since after 3 years of not meeting 85% MLR, carrier can have enrollment limited. After 5 years of not meeting 85% MLR, carrier can be kicked out.

Year over year premium and benefit change cannot be greater than \$36 pmpm.

Medicare advantage has implemented more of ACA than other blocks. CMS is not backing off. Regardless of who wins Presidency, changes are permanent.

Sequestration cuts in FFS Medicare Physician contracts. This is nearly a wash on the Medical side if contracts with providers are tied to the Medicare payment schedules.

Part D close of donut hole. Not substantial, see more change in Employer market. 5-6 million retirees are expected to move to a PDP plan from RDS.

CMS is more hands off with employer market and more safeguards are implemented with individual.

3. **Dual Eligible Integration**

ACA: Calls for coordination of care between Medicare and Medicaid. Plans need to cover dual eligible for 100% Medicaid including LTC and Institutional. Depending on the type of enrollment that the states decide, dual eligible beneficiaries could be automatically enrolled into the program and removed from existing D-SNP programs.

Currently, D-SNP plans can be run very well, profitable by MA organization.

Even if dual eligible members have a choice of whether or not to join the integration program or remain in a D-SNP, it is difficult for plans to project experience going forward, not knowing who will remain in their program. Carriers need to apply and be accepted into dual integration program. Determined at the state level, since care is fragmented. This should better coordinate care between programs.

Best equipped plans are currently doing Medicaid. CMS needs to make a profit from this program. It is too difficult for carriers to set up a program

so program is being pushed back 1 year or may test in select counties.

4. **Senior Market Competitive Product Differentiation**

In a market with 2 plans for a carrier, they need to have a \$20 actuarial value difference on benefits. This includes Part D with formulary. CMS tests this for you based on the actuarial value. Limits how competitive to make yourself in a market.

The test doesn't cover out of network benefits, so companies can game with change to out of network plan. With increased generics, Part D plans, enhanced plans can evaluate to less than the standard plan which makes no sense.

Special need plans (SNP) plans allow for differentiation by population.

Chronic SNPs (C-SNP) covers retirees with specific conditions such as diabetes or COPD.

Institutional SNP – e.g., SNF plan. These allow a carrier to segment and target specific populations.

Medicare Supplement plans: Where Medicare Advantage doesn't make sense (e.g., Chicago) then companies may be better to offer Medicare Supplemental Insurance. Companies need a Medicare Supplement strategy to offer other plans and keep members.

Do you see a shift to Medicare Supplemental Insurance? New retirees like Medicare Advantage since they are used to coordinated care. Depends on county, or market and demographics, whether Medicare Supplement works.

Medicare Advantage with ~\$100 premium are chasing Medicare Supplement plans. Medicare Advantage is expected to increase. New enrollees like add-on benefits such as gym memberships.

5. **Managing Cost of Care**

How to mitigate trends, e.g., claim costs may increase 5% but revenue increases 1%.

May revert to contracts like in 1990's and move risk back to providers.

Attention to STAR rating getting to 4 or 5 STARS plus chase risk score. Use chart reviews to increase in mid-year sweep which can result in double digit increases. Companies chase the revenue.

It is possible that 2010 and 2011 were showing suppressed medical costs due to the recession, yielding lower trends. Plans are noticing an uptick in expense in 2012. It is possible that there is pent up demand, 2012 has higher claim costs than in the past.

Many STARS measures are geared toward effectively managing care, by measuring how many members have had mammograms and if diabetics have their A1C tested.

PDP plans not directly impacted by STAR ratings but drug adherence is important. CMS is struggling with how to get plans to adhere to Part D program.

PDP: Currently risk score based on medical diagnoses, PDP can't influence risk score.

CMS is looking for good ideas to increase adherence. Part D targeting plans that don't take medications at coverage gap, people stop taking drugs.

Other Topics

ICD-10 change: How to absorb costs into premiums. How do you measure trend, with year-over-year claims on different ICD schedules?

Part D is getting very competitive, consolidation occurring with United, Humana, Big PBM's and fewer providers. Plans that own a mail order provider is important, scale is important.

Humana had very low Part D premiums to market their Medicare Advantage plan. Smaller carriers are being squeezed.

ACA: would this make Medicare Advantage obsolete in certain markets? What is impact from ACO? Provider owned plans are good candidates such as ACOs. Should providers take unnecessary risk.

Session 20 Retirement of the Future and Improving Plan Design

Speakers:

Donald E. Fuerst – American Academy of Actuaries
Andrew J. Peterson – Society of Actuaries

Session Coordinator/Recorder:

Robert W.E. Newton , Towers Watson

This speakers reviewed work that has been completed to provide an objective framework through which policy makers might evaluate current and future retirement systems and improve plan design. It specifically focused on key outcomes from the Society of Actuaries "Retirement 20/20" initiative which started in 2006 and the follow-on joint initiative called "Retirement for the AGES" by the American Academy of Actuaries & Society of Actuaries. The speakers closed with principles for improving plans.

Retirement 20/20

In discussing this initiative, the speakers indicated that in reaction to the shortcomings of both traditional defined benefit plans and defined contribution plans, Retirement 20/20 was started to find solutions that meet the economic and demographic needs for the 21st century in North America. While some would have preferred a focus solely on the preservation of the DB system, it became clear that in order to arrive at a credible, objective and politically neutral conclusion, there should be no constraints. In essence, the work began with a clean sheet of paper, not with a specific goal of preserving DB plans.

Initially, Retirement 20/20 focused on the needs, risks and roles of stakeholders – Society, Individuals, Employers and Markets. The goal was to offer designs that improve outcomes for all stakeholders.

The speakers highlighted a key learning - retirement systems need a degree of insurance to protect society and individuals. Here they discussed how DB plans generally offer elements of insurance and defaults while current DC plans tend to offer investment flexibility and choice.

The speakers discussed the role of choice. They felt choice created a good environment for innovation pointing specifically to the innovation in the delivery of DC plan benefits (e.g., record keeping improvements, flexibility in investment choices and auto enrollment). They acknowledge that choice creates risks and so comes at a cost. This element of risk implies a need to offer choices with care and the need for strong defaults to guide participants.

In thinking through behavior, the speakers discussed how Retirement 20/20 concluded that societal “signaling” influences choice of individuals – whether in positive or negative ways. For example, offering normal, early and late retirement dates will signal to participants what are “appropriate” retirement choices.

They indicated that today the retirement systems balance is tipping in favor of choice and investment and away from default and insurance. They questioned whether this produces an optimal outcome for stakeholders.

Retirement for the AGES

Retirement for the AGES is a project that identifies key principles from the Retirement 20/20 work using AGES as an acronym to highlight those principles. The speakers discussed the component parts of the acronym as follows: Alignment, Good Governance, Efficiency and Sustainability. The AGES dimensions act as a basis for a scorecard that can be used to evaluate the effectiveness of a retirement system and “measure” improved plans. The speakers noted that adequacy was not included in the framework because it represents a very subjective quality.

It was noted that alignment deals with assignment of roles to best utilize the skills of stakeholders (sponsors, individuals, and society). For example a good framework would place the responsibility for investment management with entities that have the skill knowledge and experience to meet those roles.

They discussed that good governance is reflected in a system that avoids conflict of interest and political motives, minimizes moral hazard and the risk of litigation and uses self-adjusting features. They pointed to an example where a plan’s normal retirement age might be tied to life expectancy – so needed changes are made based on objective criteria.

It was pointed out that an efficient system maximizes retirement income while avoiding excessive risks by pooling (e.g. using large groups to share risk), hedging (e.g., deep deferred annuity to hedge long life) and risk mitigation (e.g., reduce risky assets as retirement nears).

Finally, a sustainable system allocates cost fairly across current groups and between generations. It would be able to withstand financial shocks (high inflation, recessions) and be self-adjusting to respond to changing circumstances.

Principles for Improving Plans

The speakers closed with the 6 principles for improving plans:

1. Focus on retirement income rather than accumulation.
2. Set up strong defaults that emphasize retirement income.
3. Provide better risk-hedging investment mixes.
4. Build variability into retirement income.
5. Encourage fewer larger plans.
6. Increase standardization among plans.

Session 27

Plan Termination: Preparing for the Big Day

Speakers:

Ross Krinsky, Fidelity Investments
Gloria Lesmeister, Buck Consultants
Paul Sepe, Towers Watson

Session Coordinator / Recorder:

Mike Ringuette, Towers Watson

Project Management and Timeline

There are many steps in the termination process, many with formal deadlines and many which are interdependent. Coordination of all of the activities to ensure proper execution is critical. A sample timeline is included in the presentation material. Key issues include the following:

- 204(h) notices must be provided at least 45 days in advance of freezing benefits
- What is the “date of plan termination”? It is a prescribed date in the plan termination process, around which required filings are due (but is not tied to the distribution of plan assets):
 - o 60 – 90 days after Notice of Intent to Terminate is sent
 - o 180 days before Notice of Plan Benefits is due
- If the sponsor decides to file Form 5310 to request an IRS determination letter (most common approach), keep in mind that it may take a year or two to get the letter from the IRS, which will create uncertainty around the date when the plan can actually be “terminated,” when election packages can be sent to participants, etc.

IRS Filings

Discussion and audience questions occurred regarding the advantages and disadvantages of requesting a determination letter from the IRS. Issues discussed included the following:

- The advantage of getting the letter is the security of knowing that the IRS has reviewed the document and is unlikely to come back later and ask for a change to the plan.
- The disadvantage is that the determination letter process takes time. The IRS targets a 16 to 18 month process, but often it takes longer.
- What are the risks associated with not requesting a determination letter? The risk is that the IRS may find something in the plan that needs to be fixed, after benefits have been paid and annuities have been purchased.
 - o There may be less risk if the plan had already recently received a determination letter, particularly if that letter was issued after the plan was frozen
 - o Plan legal counsel should be involved in the decision
- What if the sponsor is getting ready to terminate, and the regular cycle for the plan is coming up next January? Need to discuss with ERISA counsel.

Don't forget the Form 6088 (top 25 participants by compensation).

- Common follow-up question is on calculation of the highest lump sum and if it was tested for 415 limits

PBGC Forms

Most of the discussion focused on missing participants. Plan sponsors must make a reasonable attempt to find missing participants (i.e. conduct an address search).

Participant Communications

Several required notices were listed in the presentation material. Discussion focused on the following:

- Notice of Intent to Terminate – Any union representing plan participants will get this notice, too. Best to give the union advance notice that the formal notice is coming. If the union is surprised, this could slow down the process.
- Notice of Plan Benefits – This is often the focal point for the plan sponsor, and typically involves an intense data cleaning exercise. Participants in different situations may need different information to be included in their notice. This also provides participants the opportunity to dispute their data

and make sure it is corrected. One benefit of the data clean-up is that it helps improve the data for the annuity purchase process.

- Participant Election Forms – Typically provided 90 to 180 days before the distribution date. If the sponsor has requested a determination letter but has not received one within this time frame, it is possible that they will need to send new election forms to participants after they receive the determination letter.

Annuity Purchases

Many plan sponsors offer lump sums first to terminated vested and active participants (sometimes retirees, too). Typically, the lump sum offer is on a "window basis." If a permanent lump sum feature is added to the plan, this will impact annuity pricing for the people who do not elect a lump sum at termination.

There are approximately 7 insurance companies actively in the annuity market. Some companies will not consider taking on cash balance plans and immature plans (e.g. 50% or more of the covered population is active and terminated vested).

Sponsors must be able to demonstrate that they have gone through a process to make sure they are selecting a safe provider (DOL Bulletin 95-1).

Typical annuity purchase interest rates are roughly equal to AAA bond yield rates. Features such as early retirement subsidies and lump sums could result in more conservative pricing.

The annuity purchase process is typically a two stage process:

- Provide carriers information to prepare an initial round of pricing as of a certain date. This initial bid may be used to winnow down the carriers that will make it to the final part of the process. Gives the sponsor opportunity to ask the carriers questions. It is best to share as much information with the carriers as possible about the plan and the covered population, to ensure accurate bids.
- Request a final pricing as of the closing date. Some sponsors negotiate further after this asking for a "best and final offer." This typically occurs within 24 – 48 hours before the actual settlement date.

Data Clean-Up

Sponsors will want to make the data as clean as possible for the annuity purchase process. Common areas of focus include the following:

- Death audits – Includes checking to see if the spouse has predeceased the retiree, for retirees with joint and survivor benefits.
- QDROs – make sure Alternate Payee information is up to date.
- Terminated vesteds – conduct address search and try to obtain spousal data.
- Missing participants – PBGC requires some due diligence. Even with a rigorous search, participants may “come out of the woodwork” later. However, if too many participants do, the insurers may require a re-pricing. Social media may be a helpful tool to find people.

Managing Assets

Sponsors need to consider whether or not to immunize. Further, it may take time to liquidate certain investments (e.g. real estate and hedge funds). Also need to consider how to address old group annuity contracts. In-kind asset transfers (typically for transactions of \$1B or more) may help reduce the proposed annuity price.

Lump Sums

Many sponsors offer a temporary window for participants to elect a lump sum (in some cases, such as GM, even for existing retirees). Considerations include the following:

- Typical window periods are 30 – 60 days.
- The window can be closed prior to the annuity purchase.
- Need to determine how to address issues such as participant death between the time the lump sum is offered and the time it is scheduled to be paid.
- The window may result in anti-selection that can impact annuity purchase pricing later. Note that the greatest amount of anti-selection may occur at older ages where the expected remaining life time is relatively short.
- Many participants are well-versed in the difference between the PBGC guaranty that applies to an on-going plan and the state insurance company guaranty that applies to annuities. Some participants may feel compelled to take the lump sum because they do not trust the state insurance guaranty.
- Some sponsors choose to get a private letter ruling for their window. Others do not. The sponsor needs to consult with their plan legal counsel.
- Some sponsors condition lump sum on rolling it over to the 401(k) plan.
- Try to keep the election forms as simple and “user-friendly” as possible.

Items to Manage After Termination

The PBGC requires records to be kept for at least 6 years, and sometimes they ask for data after 6 years. Important to determine who the keeper of the data will be. Also, eligibility service will need to be tracked for retirement eligibility purposes. Finally, if missing participants emerge, determine who they will need to work with for help.

Session 29 Through the Looking Glass: A Multi-Perspective View of Retirement Plan Risk

Moderator:

Kathleen P. Lamb, Mercer

Speakers:

Craig P. Rosenthal, Mercer
Royce S. Kosoff, Towers Watson
Kai Petersen, Buck Global Investment Advisors

Session Coordinator / Recorder:

Valerie L. Hintzen, Towers Watson

In this session the speakers focus on three different perspectives on retirement plan risk:

- Quantifying the Non-Financial Risks
- Retirement Risk Management
- Pension Investment Risk

Non-Financial Risks

Retirement plan risk is top of mind for many plan sponsors, although usually from a financial perspective. Workforce risks are also important. Employers have jobs to offer, but not enough of the right people to hire. Retirement benefits are valued highly by recent hires (currently ranks 2nd after pay) and can be used to help manage workforce risk.

Some drivers of workforce risk are external, like the makeup of the labor market; internal, such the make-up of the current population and whether there will be a retirement bubble; and process related, retirement plans and whether they are available to help with workforce planning needs. Demographic shifts, operating pressures, and market/economic pressures drive workforce risks, which become business risks. For example, high demand for certain skills can lead to a loss of experienced employees, leading to slower growth or higher labor costs. Tenure values can drive workforce needs. For companies where a strong, stable workforce is key to business growth,

tenure is highly valued. Where there is an emphasis on hiring new employees with currently needed skills, tenure is not highly valued.

It is important to talk to clients about what particular workforce risks are important to them, including tenure. Retirement plans can be used to optimize workforce composition and tenure. To achieve the desired workforce outcomes, the consultant should review certain analytics:

- Quantify risk management exposure – who is eligible to retire in the near future and what is the talent make-up of that group.
- Identify factors affecting the retirement decision – e.g., investment performance, access to retiree medical benefits.
- Quantify impact of earlier or later than expected retirement – talent gaps, client relationships, unwanted turnover of new generation.

There are other less predictable factors that influence retirement decisions, which cannot all be quantified. It is important to have these discussions with your clients.

Retirement Risk Management

How to manage retirement plan liability risk is a hot topic with employers, in different stages of their “Journey Plan”. Some have an ongoing benefit strategy and are managing active liability and long term plan cost, while others are managing legacy benefits and heading toward an exit strategy to reduce overall risk exposure. There are many paths to managing plan risk and they are multi-dimensional, including both asset and benefit strategy components. Sponsors will need to consider the balance between funding and investment strategy for the sponsor’s time horizon and decide what tactics to use. More plan sponsors are considering bulk lump sums to settle DB plan liability. They are also considering annuity purchases, as GM did and Verizon recently announced.

It is important for companies to plan for and monitor triggers for action in the journey plan, rather than having to be reactive and miss opportunities. MAP-21 allows plan sponsors to delay funding pension plans, but since interest rates continue to go down and PBGC costs are increasing, annuity purchases and lump sum offerings continue to look attractive.

Pension Investment Risk

Key principals regarding successful pension risk management involve:

- Liability driven approach – measuring performance in the context of the liability.

- Taking “smart” risk – getting adequate compensation for the risk taken, seeking new sources of return and diversification, and capturing improvements in funded status.
- Better employer and employee investment risk sharing – reducing sponsor risk, increasing employee reward opportunities, and reducing volatility through pension designs.

Asset allocations should be dependent on the plan sponsor’s financial strength, the funded status of the plan, and the plan sponsor’s ability to use surplus. Stochastic forecasting is a good tool for assessing likelihood of reaching certain triggers for changing asset allocation. Because of MAP-21, we now have more opportunity to consult on cash flow risk, since there are fewer rules and limits on pension plan funding.

Session 31 What’s up with ACOs?

Speakers:

Scott Rabin, Buck Consultants
Gnana Kumar Kanisan, Deloitte Consulting, LLC

Session Coordinator/Recorder:

Amanda Holland, Deloitte Consulting, LLC

What is the issue?

Health care costs are out of control, with health insurance premiums rising much faster than workers’ earnings and overall inflation. The current system is broken due to several drivers such as:

1. Increased demand from the aging population and access through the health care reform law.
2. Financial incentives are not aligned as care is provided on a fee for service basis without incenting coordination of care or basing reimbursement strictly on outcomes (i.e., more care does not mean better quality).
3. Shortage of physicians is growing, especially primary care physicians (PCPs).

Given the current environment and the regulatory reforms driving the industry to a “new normal,” maintaining the status quo is unsustainable. There is a shift to focus on quality outcomes, care coordination, data and reporting, and payment models. Regulations have called for the establishment of accountable care organizations (ACOs) to specifically focus on this.

Accountable care uses performance risk to drive clinical integration in order to create value. Some of the structural flaws to overcome in the current system include fragmented delivery, limited competition, lack of transparency, and limited accountability. Additional considerations include the involvement of more PCPs in the process and the alignment of incentives as well as the need for the use of big data to focus on outcomes as doctors and hospitals become more accountable. It should be noted that the term “ACO” (accountable care organization) is just an acronym for the Medicare shared savings program, but the goal for high quality, cost effective care spans across the entire health care spectrum and not just Medicare.

How can Payers and Providers respond?

Health care organizations are pursuing different “on ramps” for accountable care models. Some of these vehicles include Medical Homes, Bundled Payments, Care Warranties, Value Based Payments/Pay for Performance/Pay for Quality, Self-Insured Employee ACO, Medicare Advantage, and the CMS ACO program. Some of these are substantial transformation efforts as they evolve established ways of delivering care.

To date, most executed ACOs have largely been CMS driven under the Medicare shared savings program and the Pioneer ACOs.

How can Consumers and Employers respond?

In order to better engage consumers, they need to have the ability, willingness and initiative to actively manage their own health care to understand quality and cost of care. Additionally, the connection between consumers and providers must improve as well as pricing transparency.

Employers are beginning to contract directly with ACOs for specific healthcare services or programs. Eventually, once the system is capable and the market is ready, employers will contract directly with health care providers for all health care services. The ACO would provide integrated care management directly through its own accountable delivery system.

In summary, the health care world is changing and all sides of the market place are heading in the same direction to what will hopefully be a better system of improved quality and more controlled costs.

Session 34 Financial Analysis for the Consulting Actuary

Speakers:

Thomas A. Swain, Bryan Pendleton Swats & McAllister LLC;
Randy Zeek, IMMUCOR, Inc.

Session Coordinator / Recorder:

Casey Shork, Deloitte

The speakers at the session examined balance sheet and income statement and discussed common financial measurements and the footnote disclosures. Through discussion, the speakers demonstrated how these tools give financial analysts insight and standards of comparison to better understand the financial health of an organization as well as the financial and other risks that may affect organization.

Q: Where does Pension and OPEB accounting disclosure fit on the balance sheet and income statement?

A:

- Disclosure reconciliations get reflected on balance sheet, with some sections flowing through Net Liability and Equity (retained earnings).
- Annual expense gets reflected in income statement. However it is not a separate line item – it gets folded into other line items.
- Other Comprehensive Income (OCI) gets reflected in income statement as well.

Q: What are the typical components of OCI?

A: In addition to pension/OPEB, the OCI includes foreign currency transaction adjustments, change in fair value of securities available for sale (until sold) and unrealized portions of hedge qualified for cash flows.

Q: With lower discount rates, companies are reporting much larger liabilities on their balances sheets. How do financial analysts interpret this liability (which can go up or down based on market conditions) in their analysis of a company?

A:

- It highlights the risk associated with plan.
- Financial manager view – trying to minimize uncertainty and take some risk away.
- It all boils down to cash, as cash is easy to report and comprehend.

Q: The lower interest rates are generally good for the company, except when you deal with Pension/OPEB plans. Can pension/OPEB plans be used as a hedge?

A: Yes, if you are a borrower, but value of asset in the plan doesn't have direct impact on Balance Sheet because of unrecognized (gain)/loss.

Q: What are the rules surrounding management's presentation of company risk factors, including pension and OPEB obligations?

A:

- It's subjective to who your audience is.
- Disclose the least possible amount of information.
- Have to disclose anything that has material or adverse effect. Materiality is not defined, it's up to management to decide.

Q: There's been a rise of mid-year remeasurements reflecting only change in discount rate. What do you think could be the cause?

A: Companies are now second-guessing themselves, they don't want to miss disclosing anything that might have significant impact.

Q: What are the financial, accounting, risk management motivations for such recent trends as Immediate recognition of gains/losses (AT&T, Honeywell, Verizon); Lump sum windows; liability driven investing?

A:

- Immediate recognition of gains/losses – this is good example of financial engineering – it doesn't change cash flows and operations and won't gather much publicity as long as this action is not due to fraud. The company would implement this if they think that worst is over.
- Lump Sum windows – good way to reduce PBGC costs.
- LDI – proven to reduce balance sheet risk, but will increase expense in the long run. Most likely will go away with IAS conversion.

Q: What are the ramifications when your accounting expense budget estimate is followed by a higher actual accounting expense?

A: You will need to explain what changed and why (assumptions vs. actual). Company will also need to "fill the whole" if estimate fell short. Education about assumptions is the key.

Session 35 Recent Developments in Hybrid Plans

Moderator:

Scott Hittner, October Three

Speakers:

Brian Donohue, October Three

Jon Joss, Fidelity Investments

Mike Pollack, Towers Watson

Session Coordinator / Recorder:

Irina Pogrebivsky, Towers Watson

Last major set of regulations related to hybrid plans were issued in 2010. They were split between final and proposed. There is still a great deal of uncertainty. Session included the following topics: (a) current state of regulations; (b) wish list for the next batch of regulations; (c) valuation issues related to hybrid plans; (d) current activity in hybrid plan design.

The moderator noted at the beginning that the "hybrid plan" under discussion was mostly the cash balance plan. Although there are other lump sum plans like Stable Value and PEP plans, regulations related to these plans are not likely in the near future.

Current state of regulations

The speakers first focused on the existing final regulations related to hybrid plans and areas that have been clarified:

- Definition of accrued benefit = lump sum benefit;
- Vesting (e.g., vesting in multiple formula plans);
- Conversion basis;
- Age discrimination is not an issue if interest crediting and accumulated balance guidance is followed. This includes limits on interest credits (not above market rates) and accumulated balance floor.

There have been numerous discussions between IRS and employers about the next round of regulations. It is expected that the next round of regulations will be split between final and proposed. We expect that final regulations will focus on whipsaw and market rate issues and proposed rules will focus on transition issues and maybe "other" hybrid plans.

Whipsaw and Market rates

Whipsaw wish list is to confirm that final regulations were not intended to reinstate whipsaw or eliminate early retirement subsidies in account balance plans. Very optimistic that IRS will confirm that whipsaw was

eliminated. The intent of IRS is to provide same level of protection to account balance as exists for accrued benefits but not to impose whipsaw. IRS may impose limits on amount of subsidies in hybrid plans but if they do, it is hoped that there would be a generous transition.

Market rate wish list includes: (a) use of safe harbors - better to use safe harbor and process to demonstrate that you meet safe harbor rather than a finite list. There are thousands of rates available in the market and using a specific list is unnecessarily limiting; (b) disregarding minimums in applying market rate test - IRS currently integrates minimum into the definition of market rate but seems more consistent with congressional intent to determine market rate independently and then apply minimum; (c) allow for use of rational retirement portfolios in definition of market rates - IRS is considering allowing target date funds as a market index; (d) update 96-8 rates to approximate 3rd segment rates rather than outdated 30-year treasuries - IRS seems open to this suggestion but expressed concerns about the resources and time it could take to address; (e) increase existing minimum/maximum rate provisions - optimistic that IRS will make some adjustments.

Another item on the wish list is to change current approach of using current interest rate to project account balance for backloading and nondiscrimination. It is not clear if IRS will move on this point even though using current rates could result in illogical and unpredictable results. One of the speakers pointed out that using current interest rates (when they are very high) could lead to abuse and make discriminatory plans nondiscriminatory.

Transition

IRS has indicated they that they understand the complexity involved and the need for lead time to implement changes. It is expected that they will provide for substantial transition timing (hopefully at least 12 months).

Valuation issues related to cash balance plans

Speaker analyzed the economics behind cash balance plan designs and then reviewed whether valuation process is consistent with the economics. First he discussed the economics of cash balance plans with fixed or bond-based interest credits. The speaker's view was that these plans are unhedgeable (or hedge is too expensive) which creates a risky liability for companies. In addition, he used a net return analysis over a 30 year period (asset return - interest credit) to argue that for participants, these designs do not provide significantly more downside protection relative to equity based indices but limit the upside

potential. His next point was that even though equity-based cash balance plan designs may be more beneficial, the valuation accounting rules do not reflect the realities of an equity-based interest crediting approach and disadvantage the plan. For fixed interest crediting plans, the valuation methodology of projecting and discounting is reasonable since credits are definitely determinable and even if based on bond yields is close enough over a long-term horizon. However, an equity-based index approximates a DC plan much closer than a DB plan and should be valued on the same basis (i.e. no future projection: cost = current year's pay credit). Overall, the speaker feels that current valuation rules (accounting and funding) inflate the cost for employers relative to actual pay credit. The speaker's final point was that cumulative guarantees in equity-based cash balance plans are not very expensive to employers. They are most relevant in the short term when account balances are very small. Over the longer term, they don't provide as much downside protection and therefore are not very costly.

Current Activity

In terms of current activity, there is not much movement due to delay in issuance of final regulations. There was some concern that employers are tired of waiting and are moving to DC plans instead.

Session 37 Compliance from the Plan Sponsor Perspective

Speakers:

Edward K. Warner, Buck Consultants
Grace C. Caress, WellPoint, Inc.
Scott Japko, The Savitz Organization
Erin A. Kartheiser, Winston & Strawn, LLP

Session Coordinator / Recorder:

Dorene A. Conlon, Deloitte Consulting LLP

While sponsors of defined benefit plans are faced with the burden of maintaining a pension plan, the speakers remind us of the risks associated with managing a pension plan. From the plan sponsor's perspective, these risks can be categorized as 1) operational, 2) compliance, 3) financial, and 4) technological. Speakers with varying backgrounds provide real-life experiences of plan risks.

The Worry List

Representing the client side, Grace Caress takes us through the endless “worry items” and provides practical approaches to dealing with many challenges related to recurring plan audits, mergers & acquisitions, participant claims and other matters. Wearing multiple hats as plan administrator, we hear the spectrum of compliance issues such as dealing with amateur auditors, fickle or unpredictable IRS agents, and plan participants who make irrational claims (e.g. not being able to locate their spouse for purpose of consent), have ludicrous expectations of benefits, or misinterpret plan information. From a financial perspective, the added obligation of monitoring monthly benefit payments against the cost components of expense so as not to trigger settlement requirements can be another hidden burden for plan administrators. Internally, we hear about the stresses of administering the plan such as organizing committee and consultant meetings in order to make important and informed decisions whilst upholding fiduciary responsibilities and managing internal controls, especially when making the operations more efficient with technology -- which has helped reduce the number of staff needed to administer the plans.

e-Communications

Grace Caress notes that in regard to “going green” by offering participants the ability to receive electronic communication, her company is experiencing low traction. In general, the retirement industry has been slow to take advantage of electronic communication, which may not be surprising when we consider the DOL and IRS rules of permissible use. Scott Japko focuses on the use of electronic communication, highlighting the differences in DOL and IRS rules under Reg. §2520.104b-1(c) and Treas. Reg. §1.401(a)-21, respectively. Stressing the need to highlight the importance of information that is being communicated electronically and other requirements, it seems the more difficult part of providing notices electronically is determining who is eligible to receive them automatically and who requires advanced consent. Field Assistance Bulletins have provided practitioners more guidance on acceptable methods when communicating information electronically, promoting good faith compliance.

In more recent developments, the DOL has sought public opinion regarding electronic disclosure policy. With approximately 77% of households with access to the internet, the DOL has recognized this fact and has become more forward thinking, making reference to Linked In, Facebook, and Twitter, and seeking commentary from employers and other groups on how to advance their requirements in the electronic world.

In December 2011, the DOL published Technical Release 2011-03R, which discusses the permissible ways to deliver the DC fee disclosure materials electronically. As a result, the guidance created a bi-furcated process (e.g., it is acceptable for plan level information to be included with benefit statements, which follows FAB 2006-03; but this was not the case for investment related disclosures). In March 2012, several retirement industry groups urged DOL to reconsider these rules.

Benefit Websites

Overall, there are risks and trade-offs for e-communication services to be considered. In regard to benefit website authentication, certain clients are starting to use passwords and tokens to increase security strength. Recalling the evolution of accessing websites, IDs and passwords used to be provided. But now more people are in control of account IDs and passwords which creates risk due to a lack of uniqueness. Currently, the benefits industry is following the broader technology – to authenticate you must have an ID and token and/or recognition of device. Looking forward to enhanced security, introducing more education around stronger passwords and/or changing passwords more frequently as well as biometric identifiers (e.g., facial recognition, hand print, signature patterns, keystrokes) may be involved. Reference is made to the Linked-in password breach article where the most common password was found to be “12345” (top 10). In 2009 the most common password was “iloveyou” and “princess” and in 2011, it was “letmein” and “trustnoone.”

In addition to all the technological controls, employers should disclose on the website the reliability of the information presented on the website, the privacy and data security policies, how the information collected on the website will be used, whether it will be shared with other parties, how will it be protected, and, if any modeling is being done, it should be disclosed that it is an estimate.

Pension Payroll Controls

Looking behind the scenes with respect to pension payments, it is incredibly important when making distributions to require segregation of duties and quality assurance controls. Other best practices include taking extra care in determining lump sum and off-cycle payments, performing audits frequently, reviewing returned mail and un-cashed checks, and reserving the right to reverse direct deposits in case overpayments need to be recouped.

Qualified Domestic Relations Orders (QDROs)

If all requirements of a QDRO are met, you may split a benefit in a qualified plan once the QDRO is entered by the court. Review of specifics of what constitutes an appropriate QDRO is discussed. Typically, benefits are split based on a percentage that will be paid out at retirement, and may include early retirement subsidies, future accruals, contingent approvals, benefits upon death especially of the alternate payee, and other technical related items. As such, the importance of involving an actuary to determine whether a QDRO can be appropriately split is emphasized. From an administrative standpoint, actuaries should be asked as to whether the described split of benefits is understandable and/or doable and in accordance with the terms of the plan. Generally, the QDRO may provide anything that is not contrary to the terms of the plan. Usually an alternate payee can elect any form of payment that the plan offers, except a joint and survivor with a subsequent spouse.

A question is asked regarding whether a DRO/QDRO can be enforced after death. While the speaker has not seen this happen, it is understood that it is allowed and court cases have dealt with this situation, so it should not be dismissed. Further warning is given around freezing accounts upon receiving notice of a participant's marital split and the grey areas of receiving other forms of notice other than a DRO/QDRO (e.g. phone call, email, or letter).

Tips on managing the QDRO process is discussed including external plan procedures, checklists, model QDROs, and internal review procedures – describing who will handle and coordinate with legal and actuarial consultants. An audience member contributes experience related to benefits that are split in future years which may not represent the intent of the QDRO in the first place, so an actuary's input can be very valuable in identifying issues upfront. He adds a best practice of performing "what-if" calculations as part of the process at the time the QDRO is submitted and keeping it on file rather than waiting years later when interpretation may change. The speaker adds that benefits defined by dollar amounts (DC plan) can be an issue if account decreases.

Other miscellaneous reminders are provided such as 1) alternate payee should receive SPDs, SMMs and other required notices 2) expenses of reviewing or administering a QDRO can be charged to the plan as well as to a participant's account and 3) lawyer's fees cannot be taken out of benefits.

Minimum Required Distributions (MRDs)

Participants are required to commence pension benefits no later than the April 1st of the calendar year immediately following the later of the calendar year of 1) attainment of age 70½ or 2) retirement (unless a 5% owner, who must begin by the April 1st of the calendar year immediately following the calendar year of attainment of age 70½). Such participants who do not commence timely are subject to a very large tax penalty. Audience member recalls old regulation clause at the end of §1.401(a)(9)-2 where if something is due to an error in administration which is not part of a series of pervasive errors, then the excise tax may be waived.

In general, errors related to minimum required distributions can be self-corrected. In response to a question related to what should be done when a participant cannot be located, the speaker suggests the use of a 3rd party vendor to provide a "close out" letter as evidence and adds that other documentation such as a notarized "missing spouse" form with information on last date seen, relatives, etc. can also help protect the plan.

Required Communications

Review and reference to documents that must be provided to participants and required timing including Summary Plan Description, Summary of Material Modification, and other notices such as safe harbor plans, benefit restrictions, QJSA, suspension of benefits, and suspension of tax. A suggestion is made by the speakers to maintain helpful checklists to ensure completeness. A question is raised in regard to whether benefit restriction notices need be provided to new participants and alternate payees in subsequent years if the restrictions remain in effect. Individuals in the session agree that guidance does not address this but speaker suggests that the safest route is to provide it every year.

Prudent Fiduciaries – Plan Fee Case

Fiduciaries are required to maintain and enforce a prudent process, which includes ensuring that fees are reasonable when paid from the trust. In the case of *George v. Kraft Foods Global, Inc.*, the plaintiff argued that plan sponsor should have solicited competitive bids periodically rather than rely on the advice of the consultant who claimed they were reasonable. Defendant argued that the law does not require solicitation of bids. Summary judgment to the defendant was granted by the district court. The 7th circuit disagreed and believed the fiduciaries were not necessarily prudent by relying on ongoing consultant's bid.

Session 38
State Exchanges

Speakers:

Edward M. Pudlowski, Buck Consultants, a Xerox Company
Alan J. Silver, Towers Watson
Olga T. Jacobs, UnitedHealthCare

Session Coordinator /Recorder:

Richard Tash, OptumInsight

The audience questions in follow up to the presentation prompt interesting and relevant comments from speakers.

Olga Jacobs – Individual Exchange

If a plan year is say Dec 1, 2014, when does it need to comply with HC Reform? Employer mandate – some provisions are 1st plan year after effective date. Exchange is a hard deadline. When does risk adjustment become effective? Don't know, waiting for government regulations in this case.

From UnitedHealth perspective – will they need to be prepared for rules for 50 separate Health Benefit Exchanges (HBE)? There may be relatively few differences in HBEs with many states choosing the government exchange. This could be a big deal for national plans with expected increased administrative costs.

If a state chooses a Federal model, does the state --have to reimburse for setting up an HBE? Fed will charge, either to the state or through HBE policies. States are looking for methods to pay for HBE; who pays and how?

What are the advantages and disadvantages for a State creating its own HBE versus a Federal model?

- Federal government is giving dollars to build the exchange.
- Politics; some states don't want to comply or have anything to do with HC Reform.
- Certain states see this as a Federal based program and should set up exchanges. Other states want control of the HBE for their state.

Will UHC offer products within the HBE only?

- Consultants are helping to develop exchanges.
- Some employers are developing their own HBE.
- If a company offers a product in the HBE, they must also offer the same outside.

Where do consumers go to purchase and compare plans on the HBE?

- go to the Individual HBE for carriers in the HBE.
- can compare through brokers and EC Health Compare outside the HBE.
- depends on the individual's circumstance whether they choose being in or outside HBE; mostly in Individual HBE.
- Individuals with employer plans have more choices.
- government premium and cost sharing subsidy is only available in the HBE.

Will small group certification of premium go away in the HBE?

- speakers did not see that going away.
- some states taking certification off the books. There are rate values required under HBE and certification may be a duplication.

What is the rationale of narrow networks and must they apply to all metallic plans in an area? When consumer does shopping, differences should only be due to plan design and not network differences. Therefore, comparisons need to be based on same network.

Quality Health Plan certification is beyond rates, look at network, accreditation, benefit plans, community providers, etc.

Is "actuarial value" defined? HHS is building an actuarial value (AV) calculator that all carriers will be required to use. Also, a separate minimum value calculator will be required for employers of over 50 employees.

HHS has different assumptions for 3 different geographic areas. A beta-test model is developed but no one in room participated or reviewed. Not sure if there will be 1 model with different assumptions or 3 different models. There is a possibility of having different continuance table, based on which model choice.

What is the role of broker going forward? Will commissions be excluded from MLR? There may still be a role for brokers. They continue to spreadsheet options.

Pricing within the HBE carries with significant block premium. Premiums within and outside the HBE are the same for same benefits. New players are getting into the HBE without having existing members. Could this result in a price disparity between existing and new carriers? New carriers may price more aggressively than existing carriers and hoping low pricing will get offset by the 3-Rs and they will be able to get the better risks.

With subsidy set to the 2nd lowest silver plan may cause membership disruption.

Multiple carriers with identical plan design may have a large premium differential.

Alan Silver – Employer Exchange – SHOP

Will there be a subsidy if a Federal Exchange is created? Only state exchanges can provide a subsidy and not on Fed exchange.

If an employer of 20 has a defined contribution plan, then employees are eligible to go to the Individual exchange.

Large employers may be eligible for HBE beginning 2017. Each state makes own rules regarding eligibility of HBE.

Are employer sponsored HSA funds considered in the actuarial value, i.e., increases the actuarial value of the plan? Yes.

Can a carrier in the HBE that offers say a silver and gold plan play with the admin and profit for different metallic plans to be creative with premium? Not sure. Will need to monitor. Rates in the HBE will be available in 2013 but need to consider now. Is it better for carriers to overprice their plans then give back excess of MLR rather than underprice for which they cannot recover?

Massachusetts Exchange was not designed for everyone to be included. It was geared towards people who don't have coverage. This is different than HBE which was designed for everyone and therefore is a different structure than the MA Plan.

Will members on COBRA choose the exchange when group rates are higher than the HBE. Yes, may improve group's experience since COBRA tends to have higher claims.

Is subsidy based on 2013 tax return or 2014? Uses 2014 tax return. An advanced tax credit may be taken but may need to pay it back. Can take a portion of the tax credit. Guidance states that tax return from prior 2 years of return are averaged and then tried up.

How will carriers approach a new market; aggressive or conservative?

- Same as for employers, cautious.
- Uninsured new groups that haven't previously had insurance may become targets.

- As a trusted advisor to employers, carriers may move into HBE so employer will pick their plan.
- For some states, if a carrier does not participate in 2014 then they cannot participate in 2015 or for some period of years afterward.
- Can a carrier exit in 2015 if experience too bad? Must go through a decertification process.

Session 53 Construction and Interpretation of the Yield Curve

Speakers:

Douglas K. German, Buck Consultants
Robert S. Byrne Jr., Towers Watson

Session Coordinator / Recorder:

Jesse B. Nichols, Towers Watson

The speakers provided a comparison of various yield curve construction techniques, along with commentary on the models and their effects.

Key Concepts of Yield Curve Construction

Always use all available information:

- Don't throw away individual bonds.
- Individual bond issuers can provide varying characteristics and risk classes, including the US Treasury.
- Databases and "whisper" prices can provide price estimates for bonds not trading in a given month.
- Extremely long-duration bonds (e.g. 80-year Coca-Cola bond) are not traded every month, but can provide valuable information in the months they are traded.

Decide in advance the criteria that define a "best-fit" yield curve.

Avoid singular-direction bias in the resulting yield curve.

Advantages of a Quartic Spline Methodology (Robert Byrne)

Directly mapping data to a yield curve may result in an over-fitted yield curve with illogical results:

- Erratically-shaped yield curve with numerous peaks and valleys.
- Credit spreads (excess in yield to maturity of a corporate bond over a similar Treasury bond) implied to be negative, resulting in arbitrage opportunities.

Primary measure of directly fitted yield curve is Accuracy Error – difference between the expected bond yield derived from the yield curve and the actual bond yield.

This ignores two additional measures of yield curves:

- Horizon Error – weighted average move in forward rate from one half-year period to the next; yield curves with sharp changes in one-year forward rates result in a high Horizon Error.
- Slope Error – weighted average deviation in the third forward rate from the expected straight-line extrapolation using the first and second forward rates; yield curves with numerous changes in the rate of increase/decrease of yields result in a high Slope Error.

By smoothing credit spreads between bonds, a yield curve can be constructed that smoothly flows throughout the curve period while maintaining a logical relationship to the Treasury curve.

- Smoothing results from bond-weighting based on penalties added to the accuracy error.
- As compared to an unenhanced (directly-fitted) curve, use of a quartic spline model resulted in a modest increase to the curve's accuracy error (generally a 0.1 basis point increase) while providing significant decreases in the horizon and slope errors.
- Unenhanced curves will generally result in smooth par and spot rate curves; the differences usually arise when comparing the forward curves.

Considerations for Constructing and Evaluating Yield Curves (Douglas German)

Constructing yield curves:

- What database(s) should be used – Estimated prices are available via databases for bonds that are not currently traded; Outside of the US and UK, databases are few and far between.
- Which bonds should be used – US GAAP's "high quality" Corporate; SEC's S&P AA- / Moody's Aa (common switch due to numerous bonds "lost" because of downgrades); Exclude bonds on credit watch, collateralized bonds, or callable bonds (with or without "make-whole" provision)?
- Which prices should be used – Bid, Ask, or Mid.

- How do you classify data as "bad data", and what do you do with it – Creating predetermined filters can cause problems as markets change; alternatives include using judgment on bad data or including all data.
- How do you transform the data – Use option-adjusted spreads; Bootstrapping spot rates; Fitting a spot curve; Weighting by market cap (should not have much of an impact in a highly efficient market).
- What type of curve should you fit – Bootstrapped spot rates; Cubic splines (e.g. Treasury PPA curves); Nelson-Siegel variations.
- How do you fit the curve – Defining goodness-of-fit; Grouping data for bootstrapping and for filters; Choosing number and location of spline points; Choosing number of parameters (i.e. Nelson-Siegel offers 4, 5 & 6 parameter versions).
- What do you do after the data runs out – Freeze the last spot rate, forward rate, or a recent average; Extrapolate the fitted curve.
- Should there be more than one curve – Above median curves excluding 50% of the lowest-yielding bond data within duration groupings; Alternatives could exclude 75% or more, but must have sufficient cash flow to cover expected payments and must produce discount rates acceptable to auditors.
- How often should you reconsider the variables above – Bond markets are dynamic, and there are too many arbitrary decisions to put the process on autopilot.

Evaluating Spot Curves:

The "best fit" depends on the variable being minimized in the initial calculations. Because the resulting curves do not reproduce all the data, you must decide where to introduce compromises:

- Minimize the overall price error
- Using least squares based on equal weighting, or weighted by market cap.
- Abundance of short-duration bonds overemphasizes short-bond fit at the expense of long bonds.
- Optimal solution may be a family of curves for different plans based on plan duration, but timing constraints limit the number of curves that can realistically be produced.

Session 58**Pan-European Pensions****Moderator:** Gareth Wyn Jones, Mercer**Speakers:**

Paul Kelly, Towers Watson

Norman A. Dreger, Mercer

Session Coordinator / Recorder:

Casey Shork, Deloitte

The speakers at the session discussed the recent developments in the market for Pan-European pensions, with a focus on the regulatory environment and the practical issues surrounding implementation.

Pan European Pension Plans (PEPP) Framework:

- EU members must allow employer and individuals in various “host” (where “out of country” participant is located) countries to sponsor / participate in plans located in other “home” (where plan is located) members states.
- The “home” plan must respect the “host countries” social and labor laws.
- The plan must be “fully funded at all times” in accordance with local funding rules, which makes cross border DB plans potentially less attractive.
- Assets are taxed on “host” country basis.
- One funding valuation is done for “host” country, but multiple accounting valuations are done for each “home” country.

Main “host” locations are Belgium, Ireland, Luxembourg, Netherlands and UK.

Advantages of Pan European Pension Plans:

- Move away from risky Eurozone crisis prone countries
- Employer cost savings due to lesser funding requirements
- Mobile workforce is taken care of
- Lower DC fund charges for employees
- Better governance
- More effective solutions for small countries
- Pooling of deficit/surplus;

PEPP structure is a realistic DC plans solution for both internationally mobile and local employees. Surprisingly also being used for DB plans (despite “fully funded at all times” issue). It is much easier to make business case for DB rather than DC.

Issues with PEPP:

- Issues with regulators – limited experience; bureaucratic hurdles (actual and perceived) in being a trailblazer.
- Issues with providers – mainly insurance companies; invest enough to look like they are in the game, but not enough to develop truly a market changing product.
- Non-diversification of political risks – Ireland, Greece; how do you diversify this risk?
- Availability of other options – possible to achieve same objectives through other means (Global DC plan management, Global Provider Selections, Asset Pooling, Global Custodian, Financing pension benefits using a Captive, etc.).
- Perceived lack of need of additional pension vehicles – using Germany as example – Germany currently has 5 different pension vehicles; do they need another one?
- Difficulties in providing the financial business case.
- Lack of substantial other cases: The simple question “why aren’t other companies doing this” is always asked.

Current developments:

- “Solvency II” directive is being driven by France Insurance Lobby which would potentially increase capital requirements for pension funds.
- Voting system is similar to US electoral votes system, with each EU country having certain number of votes – need 74.8% of votes to pass (258 votes out of 345).
- Majority of EU countries don’t have pension plans or don’t care and most likely to vote “yes”.
- UK is dead set against directive, since directive excludes book reserve promises widely popular in UK; Germany and Netherlands are also aligning with UK, but combined votes from these countries won’t be enough to block “Solvency II”.
- If “Solvency II” is passed, a lot of UK pension plans might end up being wound up.

Session 59 Social Media Networking

Moderator:

Thomas S. Terry, TTerry Consulting LLC

Speakers:

Brian M. Septon, October Three LLC

Cameron Winklevoss, Winklevoss Technologies LLC

Tyler Winklevoss, Winklevoss Technologies LLC

Session Coordinator / Recorder:

Una Raghavan, Towers Watson

Introduction

What started as a simple way to connect with others, social media has evolved dramatically over the last few years. The old idea that "Facebook was only for college kids" has changed completely.

Background of Speakers

Brian Septon and Cameron and Tyler Winklevoss are experts and pioneers in social media, and in this session they summarized their vision of social networking.

Brian's introduction to Social Media began while he was studying Computer Science at the University of Illinois. He created a web-profile which led to a career in Social Media. He wanted to find a way to create business connections with colleagues, and friends of friends.

Cameron and Tyler Winklevoss were juniors in Harvard and discovered that because of a hectic academic and sport schedule, they did not have a lot of time to meet other people outside of their circle of friends, so that sparked the idea of a social internet network. They founded HarvardConnection (later known as ConnectU) along with their friend Divya Narendra. The network was exclusive to those with an ".edu" email address, which was the proxy for the identity of those who joined.

The Winklevoss brothers later formed Winklevoss Capital, and are now investors in SumZero, which is a social networking company aimed at professional investors. SumZero was founded by Divya Narendra, their Harvard classmate. SumZero focuses on early-stage start up financial companies, and brings together investors to share trading ideas and research. There are around 30,000 members who are all experts in their field. A strict application process is required for membership into this network. The network is self-policing and helps members build a personal brand. Memberships are revoked if members are not thought to be adding value. Today,

SumZero is based in English but in future years, more languages will be available and it will become more widely used by the global population. The Winklevoss twins believe that many industries can benefit from networks of this nature.

The Evolution of Social Media

Social media has completely evolved, from a college network to something far greater. For example, now recruiters use social media to do research on potential candidates, and social media facilitates research on anything from companies to CEOs. The legal profession is a profession which very effectively uses social media. Upon searching for a lawyer, one is likely to find a biography with a picture attached. Lawyers also use social media to publish papers of research.

Internet blogs have also evolved. Blogs are valuable tools for discussions, new ideas, insights and will live forever. They are almost seen as a way of validating ones existence.

Social Networking & Actuaries

While actuaries have been known to have many great credentials, communication is not one of them. But if actuaries cannot communicate effectively, then how can their voices be heard? The Winklevoss brothers believe that social media can be a means to offer actuaries a strategy, and well thought out way to have a voice. Social media can be a tool for marketing and branding what an actuary is and for advertising research papers and actuarial books etc. This will help bring actuaries to the main stream.

For social media to be used to its fullest advantage, individuals should spend 5-10 minutes a day keeping up with connections. It is not required that someone be connected to every social media channel, but should at least tuned into a few. Actuaries could use social media as a means to establish themselves as experts and to become the actuary with the biggest social following!

The Future of Social Networking

In future years, the Winklevoss brothers see social media as a means to have information broadcast earlier, for example, in the actuarial world, earlier publication of 3-segment rates. They also predict an increase in smaller, interest specific, expert networks. The founder of FourSquare, believes that social media will see an increase of games with business applications. Facebook has the social side of the market covered. AOL chat-rooms had a similar function back when they began.

In terms of data sensitivity, there are some tips that should be followed. Operate social media as if it will be published and permanent. Be aware of pit falls and use secure passwords. The next generation of users will be more savvy with personal information than the generation before.

How does Social Media apply to the bigger firms? The best way is to look for a human element. Is there a CEO or founder who is interesting enough to have a following,

such as Steve Jobs for Apple? Bloggers can become bigger than the blogs they write, but they also need a personal element, a rock-star with a human component. The rock-star will not be evident from the beginning, it will take time and a lot of work but they have the potential to grow exponentially once they are discovered.

Social Media can be very anti-social! How does one keep up with all feeds? Little by little...every day.

Brian McGee Found to Materially Violate Code of Conduct

The Conference of Consulting Actuaries ("CCA") received a report from the Actuarial Board for Counseling and Discipline ("ABCD") that concluded CCA member Brian McGee materially violated Precepts 1 and 3 of the Code of Professional Conduct ("Code of Conduct") and recommended a three-year suspension. Pursuant to Article X of the CCA bylaws, the CCA President appointed a disciplinary committee to review the ABCD report and record. The Disciplinary Committee held a hearing on June 28, 2012 with Mr. McGee attending by phone. After careful deliberation, the Disciplinary Committee concluded that Mr. McGee materially violated Precepts 1, 2, and 3 of the Code of Conduct and decided that the discipline should be a two-year suspension from the CCA.

The purpose of this article is to inform CCA members of the decision regarding Mr. McGee and to provide an overview of the conduct leading to the violation of Precepts 1, 2, and 3.

PRECEPT 1. An Actuary shall act honestly, with integrity and competence, and in a manner to fulfill the profession's responsibility to the public and to uphold the reputation of the actuarial profession.

ANNOTATION 1-1. An Actuary shall perform Actuarial Services with skill and care.

ANNOTATION 1-2. An Actuary shall not provide Actuarial Services for any Principal if the Actuary has reason to believe that such services may be used to violate or evade the Law or in a manner that would be detrimental to the reputation of the actuarial profession.

ANNOTATION 1-3. An Actuary shall not use a relationship with a third party or with a present or prospective Principal to attempt to obtain illegal or materially improper treatment from one such party on behalf of the other party.

ANNOTATION 1-4. An Actuary shall not engage in any professional conduct involving dishonesty, fraud, deceit, or misrepresentation or commit any act that reflects adversely on the actuarial profession.

Precept 1 Violation

The Disciplinary Committee found that Mr. McGee signed an actuarial valuation and co-signed an actuarial valuation which reflected coding errors that were known in the firm in which Mr. McGee worked before issuance of these reports. The coding errors caused liabilities to be understated by a significant amount. Mr. McGee knew of the coding errors before issuing these two reports but did not correct them or disclose them to the client. The Committee found that issuing these two reports without correcting or disclosing the errors constituted a material misrepresentation and that Mr. McGee materially violated Precept 1.

In finding a Precept 1 violation, the Committee focused in particular on Annotation 1-4, because it found that Mr. McGee knew of the coding errors before issuing the two reports in question but did not correct them or disclose them to the client. This behavior constituted engaging in professional conduct involving misrepresentation.

PRECEPT 2. An Actuary shall perform Actuarial Services only when the Actuary is qualified to do so on the basis of basic and continuing education and experience, and only when the Actuary satisfies applicable qualification standards.

ANNOTATION 2-1. It is the professional responsibility of an Actuary to observe applicable qualification standards that have been promulgated by a Recognized Actuarial Organization for the jurisdictions in which the Actuary renders Actuarial Services and to keep current regarding changes in these standards.

ANNOTATION 2-2. The absence of applicable qualification standards for a particular type of assignment or for the jurisdictions in which an Actuary renders Actuarial Services does not relieve the Actuary of the responsibility to perform such Actuarial Services only when qualified to do so in accordance with this Precept.

Precept 2 Violation

The Disciplinary Committee found that Mr. McGee violated Precept 2 because he was not qualified to perform relevant actuarial services on the basis of basic and continuing education and experience. Although testimony by Mr. McGee indicated that he felt that he had adequate health actuarial expertise to perform the work and sign the relevant actuarial reports, the Committee concluded that Mr. McGee was not appropriately qualified to sign the relevant actuarial reports. For example, although per capita claim costs were provided by the client, there was no review of the development of such costs. A qualified health actuary would have reviewed the per capita claim costs provided by the client in order to determine if appropriate claims data were used, trend rates used in the projection were reasonable and that no other adjustments were made in such rates that would not be appropriate for a retiree group benefit valuation. In addition, a qualified health actuary would have recognized that the relationship of pre-Medicare and post-Medicare costs would have changed over time (it was noted that the cost relationship was assumed to remain constant over a long period of time).

PRECEPT 3. An Actuary shall ensure that Actuarial Services performed by or under the direction of the Actuary satisfy applicable standards of practice.

ANNOTATION 3-1. It is the professional responsibility of an Actuary to observe applicable standards of practice that have been promulgated by a Recognized Actuarial Organization for the jurisdictions in which the Actuary renders Actuarial Services, and to keep current regarding changes in these standards.

ANNOTATION 3-2. Where a question arises with regard to the applicability of a standard of practice, or where no applicable standard exists, an Actuary shall utilize professional judgment, taking into account generally accepted actuarial principles and practices.

ANNOTATION 3-3. When an Actuary uses procedures that depart materially from those set forth in an applicable standard of practice, the Actuary must be prepared to justify the use of such procedures.

Precept 3 Violation

The Disciplinary Committee found that Mr. McGee violated Precept 3 because he provided actuarial services that did not meet all of the applicable actuarial standards of practice. The Committee concluded that the health care cost trend rates used did not violate Actuarial Standard of Practice No. 6. However, the Committee found that Mr. McGee violated Section 5.3 of Actuarial Standard of Practice 23, "Data Quality", which was in effect at the time of the services in question, because of his failure to:

- disclose reliance upon others as the source of premium calculations,
- disclose that such calculations were not appropriately reviewed for reasonableness, and
- disclose any resulting limitations in the use of the actuarial work product.

Conclusion

The Disciplinary Committee found that Mr. McGee materially violated Precepts 1, 2, and 3 of the Code of Conduct and that such violations warrant a two-year suspension from the CCA. The Committee imposed a two year suspension as compared to the three year suspension of membership recommended by the ABCD due to the cooperation, sincerity and contrition demonstrated by Mr. McGee.

Members: Subscribe for the Entire 2013 Series of CCA-Hosted Audiocasts



Now you can take advantage of significant savings on CCA-hosted audiocasts, including all currently scheduled and late breaking presentations. Register now and you can stay on top of the latest developments, the same way many of your peers do, with a subscription to CCA's audiocast series. As a CCA member (current dues must be paid before or at the same time as purchasing a subscription) your yearly subscription rate is only \$500. All participating Conference members receive a continuing education certificate at no additional charge.

Subscribe for the Entire 2013 Series of CCA-Hosted Audio/Webcasts

Exclusive CCA Member Savings As a member you save up to \$100 on each CCA-hosted audio/webcast, or subscribe to the full year for 50% off our next lowest rate. Nonmembers should consider joining CCA for just \$390 more to take advantage of these savings and benefit from all the other aspects of CCA membership.

Season Subscription: The cost of any previously purchased session is not applicable toward the purchase of a season subscription.

CCA Member - \$500
 Nonmember - \$1,200
 CCA Member and U.S. Federal Government Employee - \$250
 U.S. Federal Government Employee - \$300

Single Session Rates:

Individuals

Groups

Registrations received one week prior to the event are charged a \$50 late fee. Fees listed are applicable for participants in the U.S. only. Participants outside the U.S. will incur additional phone line charges payable by the participant.

CCA Member - \$125
 Nonmember - \$225
 CCA Member
 and U.S. Federal Government Employee - \$62.50
 U.S. Federal Government Employee - \$112.50

CCA Members - \$300
 Nonmembers - \$600
 U.S. Federal Government Employee - \$150

For more details visit the CCA website or review the document "[Audio/Webcast Options and Fees for 2013](#)".

<http://www.ccactuaries.org/opportunities/2013audiocasts.cfm>
 and http://www.ccactuaries.org/opportunities/cca_audiocast_policy_2013.pdf

Please note: No portion of these live audio/webcasts may be recorded by any third party. Registration for these events acknowledges that you are aware of and agree to uphold the "Code of Professional Conduct." Member rates are only applicable for those who have paid their 2013 membership dues. Cancellations received in writing more than one week prior to the seminar will be refunded the full fee minus a \$50 processing fee. Within one week, no refunds will be available.

Upcoming audio/webcasts hosted by the Conference of Consulting Actuaries

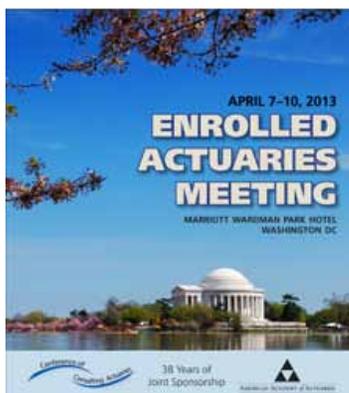
All sessions presented from 12:30 PM - 1:45 PM ET.

NAME	DATE
Issues in Plan Terminations	February 20
Post-Election Fallout: Impact on Pension & Healthcare	March 13
Accounting Update (IAS 19)	April 17
Professionalism: Assumptions	May 8
Multiemployer Update	May 22
Pension De-risking Programs Lessons Learned	June 12
Healthcare Exchanges	July 17
Emerging Practices / Non-traditional Projects	September 18
Executive Compensation	October 2
Liability Driven Investment (LDI) / Investment Issues	November 13
DOL / IRS Audits	December 4
Professionalism : Ethics (Special 100 Minute Session)	December 11

Register Now for the 2013 Enrolled Actuaries Meeting and Post-Meeting Seminars

April 7-10, 2013

Marriott Wardman Park Hotel
Washington, DC



The American Academy of Actuaries and the Conference of Consulting Actuaries host the thirty-eighth annual Enrolled Actuaries Meeting, April 7-10, at the Marriott Wardman Park Hotel in Washington, DC. The program features sessions in several formats, covering a wide range of topics and issues relevant to Enrolled Actuaries and other pension professionals. The meeting also includes an exhibit of products and services geared to Enrolled Actuaries.

Access the EA meeting website at: <http://www.cactuaries.org/ea2013>

The following seminars are scheduled immediately following the EA meeting:

Sunday, April 7
Professional Standards/Media Response Seminar

Wednesday - Thursday, April 10-11
Pension Symposium: Outlook for Private Sector Pension Funding

For more information on these seminars, please visit: <http://www.cactuaries.org/opportunities/ea2013>

CCA Welcomes New Members

The Conference congratulates and welcomes the following new members since our last issue.

Michelle M. Acciavatti, ACA
Michael Albino, FCA
Pamela Potts Anderson, FCA
Karen L. Anway, FCA
Joshua William Axene, FCA
Charles Thomas Axford, FCA
James Brahm, FCA
Truman Breithaupt, V, FCA
Robert Blaine Brickhouse, FCA
Geoff Bridges, FCA
Emojoy R.W. Brown, FCA
Mark Henry Buis, FCA
Kelly Cruise, FCA
Dorene Ann Conlon, FCA
Drew S. Davidoff, FCA
Lorraine Dorsa, FCA
Norman A. Dreger, FCA
Thomas Joseph Egan, Jr., FCA
Michael Elliston, FCA
Jonathan Evans, FCA
Richard Ryan Falls, FCA
Mark Gilje, ACA
John Gleba, FCA
Jennifer Gunckle, FCA
Donna Lynn Hamaker, FCA
David D. Harris, FCA
Jonathan Steven Hassen, FCA
Kevin Anthony House, FCA
Shawn C. Howell, FCA
Liaw Huang, FCA
Paul Janus, ACA

Mahasen S. Kunapuli, FCA
Chyna Kwok, FCA
Grace Katherine Lattyak, FCA
Michael Massa, FCA
Christopher Daniel Mast, FCA
Margaret G. McDonald, FCA
Nick Haralambos Meggos, FCA
Christopher L. Meta, FCA
Christopher A. Neal, FCA
Jesse Nichols, ACA
Viresh Parmar, ACA
Vaibhavi V. Patel, FCA
Craig F. Pedersen, FCA
Eric J. Pers, FCA
Thomas Edward Persichetti, FCA
Daniel Joseph Rakers, ACA
Paul T. Richmond, FCA
Marc Rochon, FCA
Maryann Scott, ACA
Paul Sepe, FCA
Paul N. Smalley, FCA
Megan Ann Torau, FCA
Frederick C. Toth, FCA
Lori Anne Valis, FCA
Laurie E. Vance, FCA
Michelle A. Vande Loo, FCA
Eddie L. Vaughn, FCA
Amy C. Viener, FCA
Catherine A. Wandro, FCA
Dana Lynn Woolfrey, FCA