

Session Summaries

CCA Annual Meeting 2025

October 26-29

Las Vegas, NV | The Cosmopolitan of Las Vegas

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CONSULTING ACTUARIES

Session 101

Penn and Exit: Making a Pension Plan Disappear

Speakers: Jeremy P. Olszewski – Fidelity Investments
 Rebecca Bak – Fidelity Investments
 Joseph C. Anzalone – Gallagher
 Kerri Dantos – Prudential

Session Host: Alexandra Hyten – Prudential

Plan Termination Process Overview

The process of plan termination can take up to two years and is quite arduous. This session will review the process in detail, including the timeline and steps that need to be taken.

Pre-Filing & Filings

Before the termination process starts, it is essential to get the Plan document in order. A plan amendment is needed with termination and appropriate freeze language. Plan sponsors should also ensure the plan is up to date with current law, and that it allows for the reversion of assets, if applicable. If the sponsor intends to offer a lump sum window, an amendment is needed to define the population and structure. It would also be helpful to clean up redundant or little-used optional forms and make simplifications where possible.

Data preparation should be done upfront, as this could significantly slow down the process. All data should be in an electronic format, and spousal or beneficiary data must be collected. Once the data is in order and the plan document is set, the plan termination process can begin.

There are three filings that are required early in the process for PBGC-covered plans: Notice of Intent to Terminate, Notice of Plan Benefits, and, for plans that will file for a determination letter, Notice to Interested Parties. The Notice of Intent to Terminate informs participants and other affected parties of the plan sponsor's intent to terminate and provides a timeline. The Notice of Plan Benefits (NOPB) provides participants with detailed information about their accrued benefits. The Notice of Interested Parties notifies interested parties of the plan sponsor's intent to seek IRS approval for termination. Filing with the IRS for a Determination letter is not required, but it provides plan sponsors with added comfort that the IRS has blessed the termination as described. The panel noted that recently, Determination letters have been coming back sooner than expected, sometimes within only 6-7 months, but there have been instances where it took over two years, making the timing very uncertain for sponsors.

Distribution Timing and Requirements

Distribution timing cannot begin until 60 days after the Pension Benefit Guaranty Corporation (PBGC) acknowledges receipt of Form 500. There are time restrictions for which all distributions need to be made, but the PBGC will accept extensions. If a request for a D-letter is filed, the sponsor has 120 days after the D-letter to make distributions, and there is risk involved in paying benefits out before IRS approval.

Lump Sum Window and Annuity Purchases

A lump sum window is typically only offered to active participants and terminated vested participants, because including retirees introduces more complexities. Offering a lump sum usually makes financial sense as it is often more cost-effective than an annuity, and election rates are usually high. A robust communication strategy is suggested to make things easier for participants and increase election rates. The lump sum calculations are generally based on 417(e) rates (but may use a basis that provides larger lump sums), and no distributions can be made until after the PBGC review period. Extra time should be allowed for correcting paperwork and finalizing lump sum elections before proceeding with annuity purchases.

Investment Considerations

In order to preserve the funded status during the termination process, the Liability-Driven Investment (LDI) strategy needs to match liabilities across the curve, not just simple duration matching. Investment-grade fixed income will generally move in tandem and be good for annuity purchases and paying out lump sums, but the best lump sum hedge is cash once rates are locked in. The portfolio should be adjusted at key event dates in the termination process.

Annuity Purchase Process

In a traditional plan termination, annuities will be purchased for anyone who does not take a lump sum via a group annuity contract after the lump sum window. The plan sponsor will send a request to insurers to gauge interest. There are over 20 insurers in the space, though not all will participate. Typically, there are two rounds of pricing, with the second round resulting in insurer selection. The premium then transfers, typically one week after insurer selection.

An alternative strategy involves a buy-in at the time a sponsor decides to terminate their plan. Due to the large gap in timing between the sponsor deciding to terminate and the actual payout, this could be seen as a more optimal process. There are three major risks that the plan sponsor takes with the traditional plan termination process that the buy-in mitigates: basis risk, lump sum risk, and insurer capacity risk. The advantage of a pension buy-in is that it is not a full settlement, and engagement can begin as soon as the decision to terminate is made. The contract matches the Projected Benefit Obligation (PBO) at all points in time and can be converted to a buy-out at the end of the termination process. The lump sum risk can be transferred to the insurer, or a buy-in can

be purchased for deferred lives expected to remain after the window. Engaging with insurers early on allows for locking in today's economics and reduces concerns about timing.

Final Distribution and Compliance Filings

All assets need to be distributed in satisfaction of benefit obligations, including paying monthly checks to all retirees, paying out all lump sums, and paying annuity premiums. Many insurers will accept payment of part of the premium as assets in kind rather than cash payment, which might result in a discounted premium for the plan due to potential transaction cost savings and less out-of-market risk for the insurer.

Surplus assets are subject to a 50% excise tax plus corporate tax, but there are options to reduce the excise tax from 50% to 20%. Many choose to transfer assets to a qualified replacement plan, such as a defined contribution plan in order to achieve the lower excise tax.

Final compliance filings include PBGC Form 501, which is the final form submitted to the PBGC indicating that all plan assets have been paid and the plan termination is complete. The PBGC audits all plans with more than 1,050 participants and randomly audits small plans, so sponsors should be prepared for that.

Session 104

Quit Gambling on What's Driving Healthcare Costs

Speakers: Michael Johnston, FCA, ASA, MAAA, Quantum Health

Todor Penev, FCA, FSA, MAAA, Aon

Moderator: Edward M. Pudlowski, FCA, ASA, MAAA, MorningStar Actuarial Consulting

Session Host: Nalene Langley, FSA, MAAA, Avalon Healthcare Solutions

Healthcare Cost Trends and Key Inflatoms

Overview

Industry surveys show that healthcare cost trends are rising year-over-year. Medical costs increase by 8–9.5%, prescription drug costs by 10–12%, and combined costs by 8.5–10%. These trends reflect a market running hotter than previously predicted.

Common Cost Drivers

Several key inflators contributing to rising healthcare costs:

- **Behavioral Health and Substance Abuse (BH/SA):** Utilization of mental health services doubled from 2018 to 2024, especially among Gen Z and Millennials. These groups have shown significantly higher physician visits and inpatient stays for mental health. Gen Z has almost 8 times the mental health utilization compared to Baby Boomers.
- **Facility Costs and Severity Coding:** Data reveals increased unit costs at top-billed facilities and a shift toward higher-severity emergency department coding. This trend suggests more aggressive coding practices in pursuit of higher reimbursement rates.
- **Specialty Medications:** New therapies, including cell treatments and GLP-1 drugs, have entered the market and driven up costs. Specialty medication utilization has grown at a 17.2% compound annual rate over three years.
- **Federal Law Changes and Technology Advances:** Regulatory shifts and new medical technologies contribute to higher severity coding and increased treatment costs.

GLP-1 Medications and Workforce Impact

GLP-1 medications (e.g., Wegovy, Ozempic, Mounjaro, Zepbound) impact workforce health and employer costs. These drugs treat obesity, diabetes, and related conditions, but they are expensive—ranging from \$900 to \$1,350 per month in 2024. Despite high costs, GLP-1s show promise in reducing hospitalizations and improving health outcomes.

Other Inflat

Regulatory changes aimed at reducing spending on Medicaid and ACA Markets could drive up costs in Group and Individual plans.

GLP-1 Analysis and Implications

Obesity and Economic Impact

Obesity affects nearly 40% of U.S. adults and is projected to reach 58% by 2035. It drives up healthcare costs, absenteeism, and comorbidities such as depression and cardiovascular disease. The global economic impact of obesity-related conditions is expected to reach \$4.3 trillion by 2035.

GLP-1 Clinical Expansion

GLP-1s are increasingly approved for conditions beyond diabetes and weight loss, including chronic kidney disease, sleep apnea, and cardiovascular events. Research explores their potential in treating Alzheimer's, substance use disorders, and more.

Employer Coverage and Adherence

Employers are split on covering weight-loss GLP-1s. Most do not plan to change coverage policies in 2025. Adherence to GLP-1 therapy has improved over the last year, with over half of users meeting the clinical standard of >80% Proportion of Days Covered (PDC).

Real-World Evidence and Cost Trends

GLP-1 users show higher initial costs but lower medical trend rates compared to controls. Inpatient utilization improves, and hospitalizations for major adverse cardiovascular events (MACE) decrease by 44%. Other conditions, such as pneumonia and substance use disorders, also show reduced incidence.

Mixed Diagnosis Impacts

GLP-1 users experience reduced diagnoses for several conditions (e.g., IBD, osteoporosis) but increased diagnoses for others (e.g., Disc/Joint disorder, mental health disorders, sleep-wake disorders). These trends align with emerging clinical literature and may reflect side effects or expanded treatment options. Post weight loss may make patients eligible for disc/joint surgeries that they were previously not eligible for.

Pricing Trends and Market Dynamics

GLP-1 prices may begin to decline due to competitive pressures and direct-to-consumer strategies. Net prices are significantly lower than list prices, and historical comparisons to blockbuster drugs like Viagra suggest potential for future affordability.

Session 105

Intersection of Price Transparency and Network Evaluation

Speakers: Ed Hausman – Deerhold

Aaron Jurgaitis – Optum

Meghan Rausch – Aon

Session Host: Robert G. Tate – Aon

Overview

This session explores the intersection of price transparency and network evaluation in the healthcare industry. It provides an in-depth look at the technical, regulatory, and practical aspects of utilizing price transparency data—particularly the Machine Readable Files (MRF) now mandated for payers and providers—and addresses the challenges and opportunities they present for actuaries, providers, and payers.

Processing Transparency Files

Price Transparency Machine Readable Files (MRFs) are complex and voluminous, containing rates for a wide range of services but lacking utilization data, patient information, or direct geographic anchoring. Understanding the structure and limitations of MRFs is essential, as they differ significantly from claims data and require supplementary files and technical expertise for meaningful analysis.

Working with MRFs presents several challenges, including technical barriers due to data size and complexity, and the need for specialized skills in data mapping and provider identification. Evaluating network performance or comparing reimbursement rates is not straightforward and often necessitates additional data sources beyond transparency files. Organizations must decide whether to conduct analyses in-house or use vendors, weighing their technical capabilities and access to supporting data. Transparency data is valuable, but it must be carefully interpreted and supplemented to provide actionable insights into healthcare pricing and provider performance.

Price Transparency Data for Provider Negotiations

Price transparency data enables comparative analysis of reimbursement rates across systems, payers, and markets. This comparative approach can provide an actuary's provider client with a clearer understanding of their market position, helping frame a more collaborative and data-driven negotiation strategy with payers.

Raw rate data is not enough though; effective analysis requires actuarial expertise to account for the nuances in contract structures, such as case rates, per diems, and percent-of-charge

arrangements, and to clean and interpret the MRF data. There are many variables and inconsistencies—such as mislabeling of billing classes or gaps in provider identifiers—that must be addressed to ensure accuracy.

Finally, it is important to articulate the value a provider delivers, in addition to focusing on rates. A specialty provider, such as a children's hospital, has expertise that can't be provided by generalist providers, so emphasizing that value in negotiations is critical.

Employer Uses of Price Transparency Data

Employers are increasingly leveraging price transparency data to contain rising healthcare costs and fulfill fiduciary responsibilities. By comparing real-time negotiated prices across providers and networks, they can identify significant cost variations, benchmark market rates, and implement strategies such as steerage to lower-cost, high-quality providers. These insights also support network evaluation, alternative plan designs, and direct contracting, ensuring members have access to cost and quality information for better decision-making.

Case studies reveal that negotiated rates for common procedures and service categories can vary dramatically between hospitals and carriers. For example, recent price increases for maternity services in a specific market show notable price differences across carriers. Also, rates for a common outpatient procedure, colonoscopies, show that there can be significant differences in negotiated prices by provider and setting. By using this data, employers can pinpoint opportunities to shift care to more affordable locations, renegotiate contracts, and explore alternative health plans, ultimately improving both the cost efficiency and quality of their health benefits.

Session 106

Actuaries and AI: From Awareness to Action

Speakers:

Rob Bacher, FCA, FSA, EA, CFA

David Driscoll, FCA, FSA, EA

Alicia Traviss, FCA, FSA, EA, MAAA

Session Moderator: Justin Hornburg, FCA, FSA, MAAA

Session Host: Logan Grime, ACA, ASA

Artificial intelligence continues to reshape the way actuaries approach their work, prompting both curiosity and caution within the profession. The session explores how actuaries are moving from awareness to practical action, highlighting insights from the CCA's 2025 member survey and follow-up focus groups. These initiatives aim to understand adoption levels, identify barriers, and build shared resources to help members integrate AI responsibly into actuarial practice.

The member survey conducted in January 2025 establishes an early baseline for how actuaries view and use AI. Results show that most respondents are still in the early stages of adoption, with many curious or experimenting but only a small group actively integrating AI into their workflows. A significant number report no current use, underscoring the broad range of experience within the community. Despite this, enthusiasm remains high, and actuaries recognize the need to keep pace with evolving technology.

Comfort levels around using AI in client work remain low. Only a small minority feel very comfortable consulting with clients using AI tools, while most describe themselves as neutral or uncomfortable. This hesitancy reflects concerns about accuracy, privacy, and professional responsibility. Participants note that actuaries must first gain confidence in understanding how AI tools generate results before relying on them in professional communications or client deliverables.

Several barriers to adoption emerge, including uncertainty about where to begin, lack of time, and concerns about data governance and potential bias. Others worry that overreliance on AI could reduce valuable early-career learning opportunities traditionally

gained through hands-on analysis. These themes reinforce the need for thoughtful integration that complements, rather than replaces, actuarial judgment and skill development.

Even with these challenges, participants see significant opportunities. AI can automate routine tasks, improve consistency, and allow actuaries to focus on higher-value advisory and analytical work. Emerging roles around AI oversight, governance, and ethics represent potential new areas of professional contribution. The discussion emphasizes that AI is unlikely to replace actuaries but will continue to reshape how they deliver value.

Members express a strong interest in practical, collaborative learning through the CCA. Desired resources include hands-on demonstrations, real-world use cases, prompt libraries, and guidance tailored to small and mid-sized firms. Ethical and governance frameworks also remain a high priority as actuaries navigate how to apply professional standards to AI-driven work. The CCA plans to continue annual surveys and focus groups, using member feedback to refine educational content and resource development.

The session transitions to a detailed discussion of professionalism issues arising from AI use. Several Precepts of the Code of Professional Conduct are particularly relevant. Under Precept 1, actuaries must ensure that AI tools support work performed with skill, care, integrity, and competence. Precept 3 reminds actuaries that responsibility for meeting standards of practice cannot be delegated to a tool; AI output must be treated as work prepared by a subordinate whose limitations are understood and managed. Precept 4 emphasizes the actuary's duty to ensure clarity and appropriateness in communications, requiring careful review of any AI-generated text. Precept 8 cautions against misleading others, noting that AI systems can produce fabricated or overly confident explanations. Precept 9 reinforces confidentiality obligations, reminding actuaries to avoid sharing client data with public AI systems.

Additional concerns include plagiarism, copyright, and the challenge of maintaining originality when using generative tools. The discussion underscores that plagiarism can occur unintentionally and that actuaries must remain vigilant when adapting AI-generated material. Questions also arise about whether AI-created content can be copyrighted, with general consensus that authorship protections apply only to human creators.

The session concludes with a review of AI tools commonly used in actuarial work, including Microsoft Copilot and Google Gemini. Both platforms offer integration with familiar productivity software, strong data security features, and varying subscription options.

Demonstrations illustrate how Copilot can assist with programming, report writing, and summarizing information without altering existing files. Regardless of the tool, participants stress that firms must implement guardrails such as data containers, endpoint security, and contractual reviews to ensure compliance with confidentiality and professional obligations.

As the CCA continues to explore AI's role in actuarial practice, the message is clear: actuaries should actively engage with emerging technologies while maintaining the discipline, skepticism, and professionalism that define the field. AI provides new ways to enhance accuracy, efficiency, and insight, but the profession's integrity remains grounded in human judgment and ethical responsibility.

Session 107

In the Line of Fire—Actuarial Consulting in the Public Sector

Speakers:

Koren Holden, FCA, EA, MAAA (Moderator): Colorado PERA

Paul Angelo, FCA, FSA, EA, MAAA: Retired

Todd Tauzer, FCA, FSA, MAAA, CERA: Segal

Session Host: Brad Ramirez, FCA, FSA, EA, MAAA: Segal

Program Description:

Public sector consulting is called public for a reason! Our work product and consulting advice is presented in public meetings in publicly accessible documents. This means our work may be challenged in high pressure forums that require professional and resolute responses. This session will explore real-world situations that involve such adversarial conditions as well as control of work product issues. Bring your favorite war stories and questions for discussion.

The session explored a range of real-world challenges actuaries face in public sector work. One recurring theme was the difficulty of managing boardroom dynamics. For example, the “hit by a bus” rule refers to situations where a single trustee drives a specific conversation or changes the direction of actuarial decision making. Discussion surrounded how the discussions would continue if that trustee were no longer present (or hit by a bus).

In some meetings, trustees may engage in side conversations or become distracted—such as using their phones to search for negative news stories about the actuary’s firm—undermining the seriousness of the discussion. One technique offered to regain control was simply to stop talking until the distractions ceased.

Audience members and presenters shared examples of trustees making dramatic public statements, such as claiming that “houses will burn to the ground” as a result of the actuary’s work. In another case, a trustee wanted to fire the actuary specifically because an experience study was expected to lead to higher contribution requirements. These moments illustrate how emotionally charged and politically sensitive actuarial work can become.

The session also highlighted the tension between fiduciary responsibility and personal agendas. A newly appointed board member might declare that they represent a specific group, rather than acknowledging their duty to represent all plan members. In another instance, a trustee with non-actuarial expertise might dispute an actuary’s recommendation—such as an inflation assumption—based on their own professional background. These situations require tact and

strategy. One technique suggested was to let others draw conclusions from the data rather than delivering the ultimate “bad news” directly.

Despite the discomfort, the session emphasized that hard discussions often lead to more realistic assumptions. While these may result in higher contributions, they ultimately place the plan on stronger financial footing. The presenters encouraged actuaries to stand firm in their recommendations, even when facing resistance.

Adversarial relationships with other actuaries were another concern. The phenomenon of opinion shopping—where stakeholders seek favorable actuarial opinions, sometimes from hired experts who are not credentialed actuaries—can erode trust and objectivity. In some cases, audits reveal sloppy work, and the responsible actuary may be unresponsive, while the board shows little interest in pursuing accountability. Examples of restatements and messy audits were shared to illustrate the consequences of poor oversight.

Control of work product was a particularly sensitive topic. Actuaries may face pressure to edit or remove items from their reports, especially when the content is informative but politically inconvenient. The presenters described a spectrum of interference, from subtle editorial suggestions to overt demands for changes in material recommendations. A guiding principle shared was that “whatever they don’t want to talk about is probably the thing they need to talk about.”

The session also addressed the challenges of working with board members who consider themselves experts—sometimes even actuaries themselves—and the complications that arise when legislation mandates specific actuarial assumptions or methods. These constraints can limit professional judgment and create tension between actuarial standards and political directives.

The speakers encouraged ethical vigilance, strategic communication, and a commitment to professional integrity, even when the environment is adversarial and the stakes are high. Audience engagement throughout the session enriched the discussion.

Session 202

Betting on the Future: Impact of Legislation and Innovation on DC Plans

Speakers:

Stacey Marie Schmid – Empower

Michael S. Clark – Gallagher

Dan Froehlich – Fidelity Investments

Grace Katherine Lattyak – Aon

Summary Author: Michael S. Clark – Gallagher

The session opened with a historical overview of defined contribution (DC) plans, tracing their evolution from the 1921 Revenue Act's profit-sharing provisions to the transformative SECURE Acts of 2019 and 2022. Data highlighted explosive growth, with total DC assets reaching \$8.7 trillion by Q1 2025—up from \$0.7 trillion in 1994—driven largely by 401(k) plans, which now account for over 90% of private-sector DC assets per ICI statistics. Adoption of automatic enrollment has surged to 44% of plans by Q2 2025 (Fidelity data), correlating with average deferral rates climbing to 9.5%, though smaller plans lag in implementation. Investment menus have standardized around target-date funds (99% penetration), while balanced/hybrid options have declined to 50%, and lifetime income products remain niche at 4%. Fiduciary safe harbors for lifetime income, bolstered by the Pension Protection Act (2006), DOL regulations (2008), and SECURE 1.0, emphasize “time-of-selection” prudence in annuity provider evaluation. Amid this maturation, litigation risks persist, with excessive fee and other claims—alleging ERISA breaches—now targeting even mid-sized plans.

Turning to the present legislative landscape, the panel dissected the DC reforms in SECURE 1.0 and 2.0, which prioritize coverage expansion, savings accumulation, and asset connectivity. SECURE 1.0 raised safe harbor auto-escalation caps to 15%, deferred minimum required distributions (MRDs) to age 72 (further to 75 under 2.0), and extended eligibility to long-term part-time workers (further to 500 hours over two years under 2.0). It also mandated lifetime income disclosures and streamlined fiduciary reviews for annuities. SECURE 2.0 introduced mandatory auto-enrollment for new plans (3% with escalation to 10%), Roth catch-up for high earners, student loan repayment matching, and emergency savings accounts (PLESAs) up to \$2,500, alongside expanded qualified longevity annuity contracts (QLACs) and hardship self-certification. IRS/DOL guidance provides some operational clarity, with many final rules still pending.

Pooled employer plans (PEPs), enabled by SECURE 1.0, were examined as a scalability and access innovation, with 564 PEPs and 176 providers registered by July 2025 (DOL filings), aggregating over

1 million participants and \$15+ billion in assets. Pooled plan providers (PPPs) assume ERISA 3(16) and 3(38) fiduciary roles, easing administrative burdens for adopting employers—particularly small plans seeking cost reductions (34% cite lower recordkeeping fees) and compliance simplification (24%, per Cerulli). Growth is robust, but barriers persist, including the need for IRS model language, expanded determination letters, audit threshold modernization, and regulatory relief for transitions (e.g., short-form 5500s for frozen plans).

Lifetime income integration remains a focal point, with adoption stymied by fiduciary (83%) and utilization (77%) concerns—less than 10% of eligible participants engage (Alight 2024). Common objections include illiquidity, complexity, and portability gaps, yet solutions like guaranteed lifetime withdrawal benefits (GLWBs), single premium immediate annuities (SPIAs), and managed payouts offer decumulation pathways. Sponsors are advised to assess employee needs via engagement surveys, conduct due diligence per SECURE safe harbors (e.g., insurer financial stability, fee structures), and monitor via investment policy statements.

Looking ahead, the panel emphasized balancing post-SECURE complexity with sustainability amid leaner benefits teams and reimagined employer-employee dynamics. An August 2024 IRS private letter ruling (PLR) illustrates innovation in how retirement dollars can be allocated. The PLR permits directing nonelective contributions across vehicles like 401(k)s, HSAs, student debt repayments, and retiree HRAs. Future legislation, eyed for 2027 or later via bipartisan efforts, may focus on expanding access, automatic features, spousal protections, and lifetime income.

Session 205

Large Claimant Trends and Risk Mitigation

Speakers:

- Douglas Punt, FSA, MAAA – Symetra
- Leslie Lucas, FSA, MAAA – Mercer

Moderator: Jennifer (Jenny) Leming, FSA, MAAA, FCA – Mercer

Session Host: Paul Albarano, FSA, MAAA, FCA – Alliant

Overview

Healthcare cost trend inflation is the highest it has been in years. A significant driver of this has been rising costs associated with large claimants. In this session, the speakers address the main causes of these large claimants – on both the medical and pharmacy side – potential risk mitigation strategies and the responses large, self-funded employers have taken to combat these significant cost pressures.

Large Claims Background

Key drivers of large claimants (i.e., claimants exceeding \$200,000 in medical/Rx paid claims), based on medical diagnoses are malignant neoplasm, cardiovascular, leukemia/lymphoma/multiple myeloma, newborn/infant care and transplants. These top diagnostic areas have been evolving over the most recent 3-5 years, with neoplasms/cancers and diseases of the circulatory system both increasing in prevalence. A multitude of risk mitigation strategies exist for these large claimants, including stop loss insurance, alternate payment models, predictive analytics, case management, chronic disease management, network management, utilization management, Pharmacy Benefit Managers (PBM) managements and bill review. Some have reported Reference Based Pricing (RBP) as being effective in driving large claimant costs down over the most recent 3 years, even resulting in slightly negative year-over-year claims trend, compared to positive year-over-year claims trend with traditional PPO networks.

Gene therapy drugs have also been a significant driver of the recent rise in large claimants. The incidence of gene therapy treatable patients is currently expected to increase considerably in the near future, with some therapies exceeding \$4,000,000 in total estimated claims cost.

Employer Perspective

Health benefit cost per employee is projected to rise above inflation again and many inflators are related to high-cost claimants (e.g., cost impact pressures from hospitals and providers, Rx inflation and the rise of behavioral health).

Based on a survey of CFOs of companies with 500+ employees, a majority believe that annual increases in health care costs of CPI or less are sustainable while many CFOs believe business results would be materially impacted if actual experience exceeds budget by more than 4%. Based on what we know of expectable claims volatility, many clients could exceed this creating a disconnect with CFO expectations.

Strategies exist for managing claims volatility, including proactive communication/expectation management, funding arrangement, level of stop loss coverage, appropriate level of conservatism in budgets and accruals, clinical management / steerage to high value care, and strategies to share costs between employers / employees (e.g., plan design, contributions, network). Further, managing high-cost claimants and managing cost for expensive specialty drugs are the two most important strategies for larger employers.

Various funding methods, spanning from fully insured coverage (which provides less risk for the employer) to self-funded without stop loss (which provides more risk for the employer), exist to help employers manage the risk of claims volatility. Similarly, stop loss coverage – both aggregate stop loss and individual stop loss – exist to specifically help employers manage the claims volatility of high-cost claimants. Funding and stop loss considerations change as employers grow in size (budget size and population size). Strategies for managing gene therapy cost exposure also exist, such as: gene therapy carveout coverage (1st dollar coverage), conventional stop loss coverage, gene therapy only stop loss policy (covers only the cost of the gene therapy drug), gene therapy networks discount contracts, and outcomes-based agreements.

Session 206

What Do Your Clients Think About You?

Speakers: Philip Merdinger FCA, ASA, MAAA – October Three
Sherri Nadeau – Retired
Rob Hoglund – Vernay Laboratories
Eric Feinstein – FSA, EA – BJC Healthcare

Session Host: John Lowell FCA, ASA, EA, MAAA – October Three

Background:

Do you know what is important to your clients and how they value/leverage their outside advisors? The panelists, all of whom have worked with actuaries, serving in executive levels at their companies give honest, frank, and important answers to a series of questions.

What, in your opinion, do effective communications look like?

Talk to me at my level. Communication should be honest and transparent in a way I can understand it. Communication with your client should show that you understand the problem your client is trying to solve. For example, for a low margin organization with large, underfunded pension plan, you have to understand that the pension in that context cuts into the margin very significantly. How does it affect from a bottom-line perspective? From a talent perspective? Clients don't like surprises. As soon as you notice that there might be a surprise, reach out to your client by their preferred means of communication.

Everyone talks about being “proactive.” What does that mean to you?

Someone who is considering my goals about my plan. Someone who understands my long-term goals both with the plan and with the company even outside of the plan. Understand your client's business from a financial impact and talent impact, *e.g. a nursing shortage*. You do not need to have really deep knowledge of my industry, but you should know the top three to five pain points. A good way to kick off the year should be to discuss the biggest pain points for the year. If you're dealing with multiple people at the client, some have different issues than others. Be careful about who you are talking to and know your audience. Understand the demographics. Some industries may require some very specific industry-related knowledge and competitor knowledge is really important. One person on the panel **hates** client satisfaction surveys and meetings. Solutions looking for a problem to solve are really bad. Getting honest feedback is difficult so use the relationship to do that rather than through surveys.

Describe what a great consultant/client relationship feels like to you. Can you provide an example of one that wasn't great?

A great relationship is proactive and understanding of our goals. An example of a train-wreck is: we're paying too much to a 3rd party for brokerage and general agent fees. They were double-dipping and "hiding the pickle" was a terminable offense. Good relationships are with people who have skills that fit the company's needs. Two-way honesty is important and bad relationships have a lack of trust. Don't overpromise. Stating you can do something when you actually can't is really bad in the long run. No one likes bad news. How do you expect your advisors to communicate bad news? Email is not your friend. People have different expectations after the initial conversation. If you see an issue, communicate it early and get it fixed sooner rather than later. Come with a problem-solving solution in mind. Be immediate and direct. If you have an offset to the problem, that might be helpful. Email is okay after you have called or tried to call. There should be a gut feel as to how much depth you go into.

Have any of your advisors ever asked you what your personal goals are for the year? How about what your business goals are?

The panelist never had anyone ask about their personal goals. They should ask about the overall business goals. This is a great question to ask your client. Personal goals begin to get at insights on what the consultant and their firm can help with. How do the business goals translate into your specific work area? *Q: Is there a best time of year for the consultant to ask those questions?* Toward the end of Q4 might be good because that's when planning is done. Don't ask right before the Board meeting. Ask the client when they want to address an issue.

What really delights you in a client relationship? What really irritates you?

It delights me when it goes so well that when I move to a new company that I want to take that relationship with me. They do what they say they will do at a reasonable price and on time. It's frustrating when you get the reverse. If you are doing good work at a fair price, on time and thinking about our business, it's not appropriate to fire you. So while I'll talk to you as a different firm, I'm not going to fire someone I like. Corporate executives are busy and the cost to switch is meaningful. So, we don't like to switch for the sake of switching. *Q: How do you know what is a fair price?* Rush situations are whatever it takes. Commodity work should not increase by more than inflation and less than that or cutting fees is a winner. A fair price is if I think you are underpaid. Value creation sets your price. Occasionally, we will check the market for market prices. Do not cut corners to make a fee lower.

How should your advisors work with multiple stakeholders?

It is dependent on client and different in every situation. The person who pays your invoices is the most important. You can still navigate political situations carefully. If you're delivering bad news to a CFO and the CHRO is your main contact, tip off the CHRO first. Know your client.

How do you prioritize where you spend your time?

The starting place is the business issue that is pressing, enterprise risk and the value that I get. What can adversely affect the financials? What comes at you next? The ability to effectively triage

problems is a C-Suite skill. What are the things that I personally am the only one that can do? Those are high on the priority list.

When things are not going well, or when something doesn't have a good feel to it, what should happen?

Email is not your friend. Pick up the phone and call the person directly. Ask how do we get it back on track? If that doesn't work, include the person's supervisor. Email is not the way to approach a difficult conversation with your client. Both parties should look at where the accountability is/was and get that resolved. What's the timeline for the fix? What's the cost for the fix?

How do you define value?

It's about a fair price. Does it meet our needs? Is it timely? Is it innovative? Understand my company's goals and constraints. I'd rather get a high quality product that takes a little bit longer as long as it meets my deadlines. The client needs to help define the priorities among time/quality/cost. Does the client need the \$3,000 answer or the \$20,000 answer? Give them the answer they need not the one that will get you more revenue.

What advice would you give to the actuarial profession?

Know your client and the level at which you should speak to them. Be strategic. I don't need to know every detail of every step you went through to get to the end result. Give me just enough particularly if the audience is multiple people. Some actuaries tend to focus on the financials, but also understand the talent implications. Bring the data that will support the talent implications. Increasing turnover costs more money than you might be saving us.

What does the ideal presentation look like?

If it's a thick presentation, I will leave the meeting. Deliver the deck via email the night before. An executive summary is important. Here is the problem, here is the 3-step solution, and here are the takeaways. Give me as much as necessary and as little as possible. Leave flexibility. BLUF: Bottom Line Up Front.

What is your perspective on subcontracting?

I couldn't care less about who is doing the work so long as there is accuracy, accountability, timeliness, fees, and in the case of subcontracting, data security and other securities including an NDA. I'm holding **YOU** accountable.

Have you used AI to summarize our documents? How effective is it?

There are restrictions in the healthcare sector. Our company is limited in what we allow in the company with respect to AI.

How do you interact with Procurement when you are looking to contract professional services?

Procurement is not my friend. They don't know the issues with regards to professional services. I'll use their contract language, but I don't want to hide behind Procurement. My company doesn't use Procurement. It's not about the number, but about the value-add.

What are your thoughts about the value of meeting in person? How often should it be done? Are there specific issues that should be in person? Junior people? Should you be on camera if on Zoom or Teams?

Teams or Zoom are the default, but you develop a richer relationship in person. I would eat lunch or dinner with my consultant but not talk about business. It's a great way to strengthen relationships. I do value in person for big meetings, but people even at the client might be scattered. Bringing young people around is important because it shows that you're developing the team.

In summary, the client representatives each have their own styles and their own personal wants and needs. Getting that right comes from knowing your clients. However, they are consistent in their beliefs that getting it right should be automatic, but trust, quality, and relationship are necessary to win.

Session 209

Impact of Global Economy on Transactions

Speakers:

James Jones, FCA, FSA – EY

Vaibhavi (Bhavi) Patel, FCA, FSA, EA – WTW

Mike Spetko, FCA, ASA – Deloitte Consulting LLP

Al Phelps, FCA, ASA, MAAA, EA, CEBS – Gallagher

Session Host: Kelly Fischer, FCA, EA – Deloitte Consulting LLP

Overview

Global economic conditions continue to shape the pace, structure, and intent of mergers and acquisitions (M&A). Persistent geopolitical uncertainty, shifting capital markets, and advances in artificial intelligence (AI) are redefining how organizations pursue growth. Transformation has evolved beyond cost reduction toward redesigning business models, technology strategies, and market approaches to create sustainable value.

CEO Outlook and the Case for Transactions

A global survey of 1,200 chief executives conducted by EY-Parthenon in August 2025 illustrates a measured but optimistic view of the near-term economy. While 70% of respondents expect current uncertainty to persist beyond a year, most anticipate increasing investment to strengthen competitiveness and drive portfolio transformation. Leaders across industries—including financial services, technology, energy, and consumer sectors—view localization and regionalization as long-term strategic imperatives that enhance resilience and adaptability.

This confidence is reflected in M&A activity. Overall deal value has increased roughly 15% year over year, even as deal volume has declined. Organizations are executing fewer but larger, more purposeful transactions, emphasizing technological capability, market entry, and operational synergy. Private equity remains a powerful influence, supported by record levels of uninvested capital (“dry powder”) and a strong appetite for transformative investments. Stabilizing inflation and interest rates are expected to encourage continued deal flow, with selectivity and strategic alignment serving as primary decision drivers.

Evolving Deal Strategies

The nature of M&A has shifted toward precision and purpose. Corporations and private investors are increasingly pursuing acquisitions that enhance future growth capacity rather than simply expanding scale. Carve-outs, divestitures, and targeted joint ventures have become common mechanisms for realigning portfolios around high-value competencies. Public companies seeking capital flexibility increasingly explore privatization or partnerships with private equity, while large organizations reevaluate sprawling structures in favor of streamlined, independent entities.

As dealmaking continues, the emphasis moves from the quantity of transactions to the quality of strategic fit. Value creation depends on clarity of purpose, rigorous execution, and integration discipline—factors that remain constant even as deal structures evolve.

Artificial Intelligence and Transaction Transformation

Artificial intelligence now stands at the center of M&A transformation. Traditional AI tools enhance data analysis, pattern recognition, and anomaly detection, while generative AI (GenAI) introduces new capabilities for synthesizing information, drafting analyses, and identifying linkages across complex datasets. These technologies accelerate every stage of the transaction lifecycle, from target screening to due diligence and post-close integration.

Applications include automating document review within virtual data rooms, populating benefit and financial models with structured data, and enriching actuarial and operational assessments through external behavioral or socioeconomic insights. Yet the sophistication of these tools also introduces new governance imperatives. GenAI's limited numerical reasoning and reliance on training context can produce plausible but inaccurate outputs. Effective use therefore requires strong oversight, independent validation, and a clear understanding of data provenance and privacy obligations, including compliance with the General Data Protection Regulation (GDPR) in the European Union and United Kingdom.

A growing organizational challenge lies in how different generations of professionals use AI. Junior staff, often the earliest adopters, can fall into the trap of accepting model outputs as authoritative without fully understanding the underlying logic. Without sufficient mentoring and technical grounding, this overreliance risks eroding the ability to question assumptions and test analytical reasoning—skills essential in actuarial and financial disciplines. Senior professionals, meanwhile, must balance efficiency with education by integrating AI into workflows that still promote learning, critical review, and professional skepticism. Shared analysis sessions, side-by-side review of AI-generated outputs, and structured model validation offer practical mechanisms for maintaining analytical rigor while leveraging technology's advantages.

AI achieves its greatest value when used to augment, not replace, professional expertise. Analytical efficiency allows specialists to focus on interpretation, scenario design, and value realization while maintaining accountability for accuracy and compliance. The human element—

judgment, context, and ethical discernment—remains the defining factor in effective M&A decision-making.

Execution Discipline Across the Deal Lifecycle

Every transaction—regardless of type—demands consistency across planning, diligence, negotiation, and integration. Early strategy defines rationale, scope, and workforce implications. Diligence extends beyond finance to include pensions, retiree medical plans, and compensation obligations that can materially affect valuations.

Clear documentation of these liabilities within purchase agreements minimizes risk. Integration, beginning during diligence, aligns culture, total rewards, and systems to realize value efficiently. Effective coordination and transparency remain key to sustaining momentum post-close.

Looking Forward

M&A continues to serve as a catalyst for reinvention and resilience. Organizations that pursue targeted, high-quality transactions and integrate AI thoughtfully will capture competitive advantage. The next era of dealmaking emphasizes governance, precision, and partnership—balancing technological acceleration with human discernment and ethical discipline.

Session 301

From Formula to Funding: Navigating Cash Balance Plan Design

Speakers:

Lance Roteman, FCA, EA, MAAA, MSPA – National Professional Planning Group, Inc.

William Horowitz, FSA, EA – WTW

Daniel Jaffe, EA – Gallagher

Samantha Klingler, FCA, FSA, EA – Mercer

Session Host: Casey Shork, FCA, ASA, EA, MAAA – KPMG

Why are cash balance (CB) plans coming back into the spotlight? While the retirement program landscape has changed over the past couple of years, the retirement program workforce and business objectives have not. CB plans remain a solution to meet objectives within the current landscape.

Pension plans experienced higher funding levels in the past few years, giving employers the opportunity to commit or recommit to CB plans. One example of re-committing is the IBM pension plan “reopening” with a new employer CB plan benefit effective 1/1/2024, and the removal of the defined contribution employer match and non-elective contributions. Currently, CB plans represent over half of all defined benefit plans. High contribution potential and regulatory support make CB plans attractive to employers.

CB design brings value to both employees and employers. For employees, a CB plan is understandable, portable, has high perceived value, shares risk with the employer, and is more predictable than traditional defined benefit or defined contribution plans. For employers, a CB plan is a valuable attraction and retention tool, has lower costs than traditional defined benefit or defined contribution plans, provides de-risking possibilities, has cost predictability and administrative simplicity. In addition, for small employers, a CB plan provides tax efficiency and design flexibility and allows for accelerated retirement funding.

CB plan design decisions should flow from objectives. For large employers, objectives are influenced by plan status, complexity of current benefit design, composition of workforce, composition of legacy retirement programs, and administrative complexity. For small employers, the additional objective is often tax efficiency while keeping non-discrimination testing in mind.

One of the main design elements for CB plans is the pay credit, which is generally either pay-related or a flat dollar. Use of pay-related pay credit supports the following objectives: ease of communication/understanding, predictable cost (% of payroll), and replacement for 401(k) match.

Use of a flat dollar pay credit supports the following objectives: benefit accruals for participants with earnings over the IRC 401(a)(17) limit, predictable cost for participants with highly variable pay, and no need to adjust for inflation. Pay credits with age-service grading mimic a traditional DB accrual pattern and can be a great retention/attraction tool, but the employer must demonstrate compliance with IRC 411(b)(1) explicitly. When designing pay credits, employers must consider the impact of IRC 401(a)(26) and 415. Neither of those IRC sections is typically a concern for plans covering broad employee populations, but they are a significant concern for owner plans.

Another main design element is the interest crediting rate (ICR). IRS regulations provide the “exclusive list” of permissible ICRs that are deemed not to exceed a market rate of return. Preservation of capital is required at annuity start date, and at plan termination, the ICR becomes a fixed rate set to the 5-year average of rates prior to plan termination. Employers can use another ICR if capped at a single permissible rate. If stability period and lookback month are used, those must meet the 417(e)(3) requirements, but need not match the plan’s basis for 417(e). Investment-based ICRs are also permissible; however, no annual fixed minimum floor is allowed (but can do a cumulative floor of up to 3% per year). Interest must be credited no less frequently than annually, but compounding more frequently than annually is allowed. The selection of ICR basis will be driven by employer objectives. For example, a lower ICR will result in lower liability and PBGC variable rate premiums. ICR less than the plan’s return on investments allows the employer to fund pay credit with excess returns. Higher ICRs may improve non-discrimination testing results.

The other two design elements that employers should consider are annuity conversion and in-service distributions. If a plan has a lump sum-based benefit formula, the plan must convert the account balance into an annuity using a **reasonable actuarial equivalence basis**. The choice is either to convert to an immediate annuity benefit in the normal form at every commencement age or to convert to the accrued benefit starting at NRA. Small plans should consider annuity conversion carefully, as such plans are usually designed with the expectation that annuity will rarely be paid. Additionally, while the fixed annuity rates provide stability for non-discrimination and 401(a)(26) testing, the mismatch between fixed conversion rates and market rates can provide an incentive to elect the annuity when market rates are much lower. In addition, for small plans, variable rates may push participants over limits if interest rates rise. In-service distributions continue to be an attractive feature as they allow for rollovers and participant investment control and may support de-risking options. But it increases administrative demand and reduces assets under management.

Small plan employers need to be aware of the valuation issues for CB plans. CB plans in the small plan market are commonly subject to 1.401(a)(4)-5(b) “Top-25” benefit restrictions since current owners are generally among the highest 25 paid employees. Also, such plans will frequently fund current year pay credits with an adjustment for prior year difference between interest credit and actual plan investment returns.

Employers also need to be aware of general non-discrimination testing issues as follows: minimum participation rules under 401(a)(26) can limit small employer design; benefits must be converted to DB-equivalent basis at retirement age; rate group testing under 401(a)(4) generally limits ability to skew credit towards owners (particularly for smaller employers); fixed ICRs can amplify age differences and limit cross-testing flexibility. These issues can often be addressed by aggregating and cross-testing with a DC plan but satisfying the minimum allocation gateway can be restrictive or create added cost.

A question was asked about how to handle in-service distributions with multiple annuity starting dates. The answer from the panel was that the best practice is to include in the plan document how it is administered, including actuarial adjustments, and have legal counsel sign off on it.

Session 305

Current Topics in MAPD, Zero Premium, Plans and Trends

Speakers

Richard Shrewsbury, ASA, MAAA – Optum

Jennifer Carioto, FSA, MAAA – Milliman

Martin Hill, FCA, FSA, MAAA – PwC

Moderator: Dan Hoffman, FCA, FSA, MAAA – Optum

Session Host: Steven Draper, FCA, FSA, MAAA, EA – EY

Medicare Advantage Part D (MAPD) plans have experienced recent changes in how they are funded due to the CMS changes as well as the Inflation Reduction Act (IRA). Understanding the current or upcoming year's costs is not as simple as projecting forward with trend.

Medicare Advantage Topics

Rates for Medicare are increasing at 9% which is the highest rates in several years. Medical education expenses that were loaded into rates are now fully phased out in 2026. Geographic factor changes from 2025 to 2026 and the middle to 90% of risk scores ranged from a 4% decrease to 3% increase.

Risk scores in 2026 now include the full phase in of the V28 risk scoring HCC modeling from CMS. Overall, that is a 3% decrease.

For 2026, the premiums are stable and the OOP max or MOOP is generally increasing from \$5800 to about \$6200. Sequestration changes from the One Big Beautiful Bill Act (OBBBA) indicate that 2% sequestration is increasing by 4% to 6% and member premiums are set. Contracting on a percentage of the Medicare fee schedule is down 4% which is putting pressure on profit margins impacting providers as well. The proposed rule was released in July after the bids were due and submitted.

RADV audits – 2008 introduced RADV audits and in 2012 they began to extrapolate. They were then paused, but in 2023 they started again and are going to catch up on past years back to 2018. All plans can expect to be audited back to 2018. The court has paused the audits at least temporarily. When they restart it will take time to catch up as they need to hire certified RADV auditors.

Part D Topics

Cost trends have been accelerating. They will be affected by Maximum Fair Price (MFP) negotiations, which take effect next year and will expand to additional drugs in subsequent years. It is uncertain how changes in revenue, changes in tariffs, and changes due to Most Favored Nation (MFN) pricing will impact future cost trends.

The costs in the first half of 2025 are trending 16% higher than the first half of 2024. This may largely be attributed to the reduction of out-of-pocket requirements for Medicare part D beneficiaries. Manufacturer patient assistance programs (PAPs), which previously provided coupons to retirees to offset out-of-pocket costs, no longer apply, resulting in all costs flowing directly through the Medicare Part D program. Part D plans have likely built some or all of these additional costs into their 2026 bids which is one of the drivers of the significant direct subsidy increase.

Plans have moved away from copays to coinsurance for brand drugs to better match the standard Part D benefit. The percentage of enrollees subject to coinsurance rather than copays is up significantly; this includes stand-alone Part D and MAPD plans. The “Greater of” MOOP accumulation is helping to drive this change.

The Medicare Prescription Payment Plan (M3P) enrollment is lower than expected (through February 2025). However, that population using that program has much higher utilization of specialty drugs.

The Maximum Fair Price (MFP) set by CMS has lowered the gross costs by 38% to 79%, but rebates have decreased which should also be considered in the overall net costs.. Reduced rebates and lower coinsurance for participants lead to increasing net costs for Part D sponsors. Plans used to keep 90% or more of rebates, but now they are shared with participants. As a result the coinsurance that is paid is going down. MFP pricing in 2027 will impact another 15% of the total Part D spend. A resulting effect is that all of those drugs will be required to be on formulary, whereas only 7 of 15 selected drugs for 2027 today are typically on formulary.

Direct subsidy is now approaching \$200 per month for some plans. With this higher direct subsidy the Rx HCC risk score really matters now for Part D plans and EGWP sponsors. Tariffs are expected to apply if the manufacturer does not agree to build and manufacturer in the US. Trump Rx is allowing for direct-to-consumer pricing. If MFN pricing is applied consistently, this could lower overall Part D plan costs.

Employer Topics

The AAA Practice Note on Medicare Advantage is expected to be in final form sometime before the end of 2025. It presents a framework that requires trending all the components rather than just projecting the net costs.

Creditable coverage regulations now allow for a new test for 2026. 72% actuarial value is a new standard that can be used to determine if the plans are creditable. For purposes of actuarial equivalence, the discounts for funding from the Manufacturer Discount Program (MDP) do not count as being paid by the Part D plan. Note that because the Maximum Fair Prices (MFPs) for selected drugs are applicable to Part D but not in employer plans, the same drug will have a lower allowed cost in a Part D plan vs Employer plan, so this complicates comparisons for the Gross Value test. Note also that in the initial coverage phase of Part D, there is a 10% federal subsidy in place of the MDP for selected drugs. It is not part of the federal reinsurance, nor is it part of the MDP. So, it is unclear how it should be counted for actuarial equivalence tests and is not currently addressed in CMS' guidance.

EGWP costs will not project with the same trend as gross costs because of all the components and reimbursements. OPEB actuaries may want to have their clients request from the Part D EGWP or PBM administrator an "Illustrative Premium" for 2026 which should provide a relevant data point for 2026 EGWP costs and all the components.

Cost sharing under EGWPs on a PMPM basis is reducing throughout the year starting in 2025 due to how the out-of-pocket maximum is accumulated under Part D due to the Inflation Reduction Act. This applies to all types of plans whether they involve lower copays or more traditional deductible / coinsurance. Overall, retiree cost-sharing will generally be less in 2025 than 2024 due to this provision.

Summary

Plan sponsors should account for the full range of changes in the Medicare Advantage and Part D landscape to optimize plan design and cost projections. Ongoing IRA and CMS regulatory changes beginning in 2025 and continuing into 2026 and beyond mean that historical costs cannot just be projected forward..

Session 307

Balancing the Stakes: How Public Pensions Share Risk With Members

Speakers:

Todd Kanaster, FCA, ASA, MAAA – S&P Global Ratings

Tina Leiss – Public Employees' Retirement System of Nevada

Koren Holden, FCA, EA, MAAA - Public Employees' Retirement Association of Colorado

Kevin Spanier, FCA, EA, ASA, MAAA – Gallagher

Session Host: Amy Williams, FCA, EA, ASA, MAAA - Gabriel, Roeder, Smith & Company

Risk Sharing Introduction and Concepts

Investment returns are volatile from year to year, but return assumptions are expected to be achieved over the long-term. High pension costs and volatile pension costs can affect credit ratings.

There are different types of risk-sharing (variable employee contribution rates, contingent or limited COLAs, cash balance hybrids, DB/DC hybrids). However, categorizing risk sharing is hard since plans may incorporate more than one risk sharing concept, which makes plans unique.

Risk Sharing Aspects of the Public Employees' Retirement System of Nevada

Nevada PERS is a multiple employer cost-sharing plan that covers all public employees in Nevada. The Nevada legislature sets all benefit provisions and the contribution rate mechanism (there is no negotiating of benefits or rates). The Retirement Board is comprised of three active members representing employers, three active members representing employees and one retired employee, all appointed by the Governor. Pursuant to the Nevada Constitution, the Retirement Board: 1) governs the System, 2) appoints an independent actuary, and 3) adopts the assumptions recommended by the independent actuary.

Since the inception of the System in 1948, employers and employees have contributed the same rate. The rate was set at a rate similar to Social Security (plan members do not participate in Social Security). There was an initial large unfunded liability since credit was given for past service. Contribution amounts were set in statute until 1993 and required legislative action to change the rates (which didn't necessarily match the actuarial rate). Separate police/fire rates were implemented in 1971 and "employer pay" was implemented in 1975.

The total contribution rate (normal cost, unfunded liability and administrative expenses) is shared equally by the employers and the employees. The employee contribution can be paid in one of two ways: 1) after-tax deduction from employee salary of employee portion, or 2) payment of employee portion by employer (employer pay). Employees do not receive applicable pay increases under

employer pay because that money is used by the employer to make the employee contribution. Employers must certify which method was used for the employee contribution. Under employer pay, a factor is applied at retirement in calculating retirement benefits to reflect the salary the employees would have received had employer pay not been in effect.

Beginning in 1993, contribution rates change every two years (in odd numbered years) based on the preceding year's actuarial valuation. The rate changes are an automatic process that do not require Board approval or legislative action. The employer pay rate (covering both the employee and employer portion) was not adjusted if within 0.5% of the actuarially determined rate and the employee/employer rates were not adjusted if within 0.25% of the actuarially determined rate. The adjusted rate was rounded to the nearest 0.25% and there was no limit on how much the contribution could change.

The current contribution rate mechanism (beginning in 2010), limits decreases in the contribution rate, but maintained the other provisions. The contribution rate doesn't adjust if the employer pay rate is 2% of pay higher or the employee/employer rates are 1% of pay higher than the actuarially determined rate. If the rates are more than 2%/1% higher than the actuarially determined rate, they are decreased such that they are 2%/1% higher.

There were significant contribution rate increases in 2023 and 2025. In 2025, the regular fund total contribution rate is 36.75% and the police/fire funded rate is 58.75%.

Effective pay decreases due to contribution rate increases has been an issue and affects retention. There was legislation in 2023 to change the employee portion for state employees to 50% of normal cost, but it was vetoed.

Risk Sharing Aspects of the Public Employees' Retirement Association of Colorado (Colorado PERA)

Colorado PERA is a multiple employer cost-sharing plan with five divisions (state, school, local government, judicial and DPS). It is a statutory rate plan and members do not participate in Social Security.

Prior to legislative changes under Senate Bill 18-200, full funding for the school division was projected to take 78 years with significant decreases in the funded ratio to below 20% prior to the anticipated rebound. There was a "PERAtour" in 2017 to inform stakeholders of the funding situation and to invite their involvement in the discussions, recommendations, and decisions regarding the proposed reforms. The resulting SB 18-200 enacted reforms proposed to achieve a 30-year funding target of 100% funded by 2048.

The Automatic Adjustment Provision (AAP) was enacted under SB 18-200 with the principle of "shared sacrifice". The AAP ratio is calculated as the Total Contribution Rate (dollars contributed by employers, members, and the State) divided by the Total Required Contribution Rate (actuarially

determined contribution plus member rate). The contribution rates considered in the AAP ratio test are blended rates across the five divisions, weighted by the unfunded actuarial accrued liability (UAAL). If the AAP ratio is <98% or >=120%, changes are made to: 1) member contribution rates, 2) employer contribution rates, 3) the retiree annual increase (COLA) rate (subject to an annual change limit of 0.25% and a minimum of 0.50% and a maximum of 2.00%), and 4) the direct distribution (contribution) from the State (subject to an annual change of \$20 million and a minimum of \$0 and a maximum of \$225 million). Member and employer contribution rates cannot be adjusted by more than 0.50%, each, as the result of an AAP adjustment.

Through December 31, 2023, the cost of SB 18-200 has been shared 29% by retirees, 35% by current and future active members, 15% by employers and 21% by the direct distribution. The 2024 AAP ratio based on 2026 contribution rates is 102.58%, which means no adjustments are needed to the contribution or COLA rates. The current blended rates used to determine the 102.58% AAP ratio are as follows: member – 11.0%, employer – 19.71%, direct distribution – 1.89% and actuarially determined contribution – 20.78%.

AAP Adjustments have been triggered twice since implementation of the AAP ratio test based on the AAP ratio being lower than 98% and both times a full adjustment of each element was required. The annual direct distribution from the State is \$225 million. The AAP ratio test performed since 2018, has allowed for automatic and timely changes, as necessary. The PERA total funded ratio was 58% in 2016 and has increased to 69% in 2024. The funding progress was due, in part, to the AAP mechanism, based on the concept of “shared sacrifice” (a.k.a. “Risk Sharing”) involving all stakeholders.

Risk Sharing Around the US and Looking Forward

There are additional statewide plans that have variable contribution rates. Arizona PSPRS Tier 3 members, Connecticut SERS Tier IV members, Wisconsin Retirement System, and Pennsylvania SERS and PSERS new hires.

There are actuarial considerations in variable contribution rates and risk sharing including: 1) modeling complexity, volatility management, intergenerational equity and communication challenges. There are also consulting implications including: 1) plan design support, 2) stakeholder engagement, and 3) governance and policy. Variable employee contributions are a growing trend in public pension plan design and actuaries play a vital role in bridging technical design with stakeholder understanding.

Session 308

The Art of Constructing an Expected Rate of Return Discount Rate

Speakers:

Joshua Shapiro – Groom Law Group, Chartered

Johnny Ngoc Hong – Horizon Actuarial Services, LLC

R. Evan Inglis – Pension Benefit Guaranty Corporation

Piotr Krekora – Gabriel Roeder Smith & Company

Session Host: Alex Knights – PNC Bank

The session explores how multiemployer actuaries determine discount rates for minimum funding requirements by grounding those rates in expected long-term returns on plan assets. The discussion emphasizes the economic theory underlying return expectations, the empirical tools used to develop them, and the challenges created by today's valuation environment. Additional considerations include the professional judgment required to balance model output and market conditions, as well as trustees' fiscal integrity.

The session begins by framing all core financial assets—equities, bonds, and real estate—as discounted streams of future cash flows. The discount rate applied to these cash flows conceptually equals the asset's expected return, which itself consists of two components: a risk-free interest rate and a risk premium. This framing parallels familiar structures such as Treasury yields plus corporate bond spreads. Expected returns are described as arising from three forces: the yield investors actually receive (such as coupons, dividends, or rent), the growth of that yield over time, and the change in price that results from variations in the discount rate.

The presentation highlights the importance of valuation metrics in long-horizon forecasting, particularly the cyclically adjusted price-to-earnings (CAPE) ratio, also known as the Shiller P/E. The CAPE ratio relies on inflation-adjusted earnings averaged over 10 years, which helps normalize cyclical fluctuations. Historically, the CAPE ratio has shown a strong negative correlation with subsequent 10-year equity returns: high valuations today tend to correspond with lower long-term returns. Although the relationship weakens for short horizons, the correlation strengthens meaningfully for periods of five years and becomes robust over ten years or more. The discussion notes that, across nearly 140 years of U.S. data, the CAPE ratio explains a significant portion of the variation in future returns and remains similarly predictive in many global markets.

The current environment, with CAPE levels near those last observed in the late 1990s, suggests compressed equity risk premiums. High prices imply low risk premiums, which in turn imply lower expected returns. Comparisons with corporate-bond spreads reinforce this view: the session notes that spreads and equity-based risk-premium indicators often move together, reflecting a shared market perception of broad financial risk. Today, both measures indicate risk premiums at levels similar to 1998, reinforcing the expectation that returns over the next decade will be well below long-term historical averages.

Using simplified but representative methods, the session illustrates how these valuation inputs translate into portfolio-level expected returns. For fixed income, the starting point is current market yield, adjusted for expected default and downgrade losses where appropriate. For example, a U.S. Treasury portfolio with a constant 10-year duration may produce an expected return composed of the initial yield plus a modest contribution from roll-down and price effects. Corporate-bond expectations similarly start from current yield levels near 3.5 to 3.7 percent, adjusted for credit risk.

For equities, expected returns derive from the sum of dividend yield, earnings growth, and expected valuation change. Dividend yields remain unusually low due to elevated market prices. Earnings growth expectations are anchored in inflation plus real economic growth, with real growth often linked to Congressional Budget Office (CBO) projections of future gross domestic product (GDP). The most consequential component is the assumed change in valuations. With a CAPE ratio near 38, forecasters must grapple with whether valuations remain elevated or revert toward long-term norms. Even an assumption that the CAPE ratio falls only to the low 30s—still far above historical averages—introduces a significant negative contribution to expected returns. When these components are combined, the resulting 10-year expected return for U.S. equities is roughly 3.5 percent, far below historical averages.

International equities and real estate, generally priced more attractively than U.S. equities, offer somewhat higher expectations, but the overall portfolio outlook remains subdued. Using a standard 60/40 or 70/30 asset mix, the illustrative methodology produces expected returns in the mid-6 to low-7 percent range. Investment consultants often publish somewhat higher figures over 10- or 20-year projection periods, although actuaries must consider much longer time horizons. This session, however, emphasizes that many traditional forecasting models may under-recognize the impact of today's extreme valuations.

The conversation then turns to the Survey of Capital Market Assumptions, an industry resource that aggregates expectations across investment advisors. The survey provides helpful insight into consensus views, ranges of expectations, and changes over time. Recent surveys indicate a wide dispersion in 10-year expected returns across advisors, often spanning three percentage points or more for the same portfolio. The range reflects

differences in modeling approaches, treatment of alternative asset classes, assumptions about inflation, and views on valuation mean reversion. The surveys show that expected returns have trended downward in recent years as market valuations have climbed.

The session also addresses the challenges of mapping a plan's unique asset allocation to the survey's standardized asset classes. Advisors and actuaries often need to adjust categories or reconcile differences in asset definitions to derive meaningful comparisons. Because each consultant uses its own blend of asset classes, methodologies, and capital market assumptions, actuaries must supplement survey data with direct inquiry and professional judgment.

Finally, the discussion places these expected-return considerations within the actuarial framework. The discount rate must remain reasonable and support long-term funding goals while also reflecting regulatory expectations and the plan sponsor's tolerance for contribution volatility. Actuaries must balance the desire for stability with the imperative to align assumptions with observable market conditions. While actuaries generally need to consider much longer time horizons than those being evaluated by investment professionals, the near-term cash-flow horizon of many multiemployer pension plans—where 10 years may represent half of benefit obligations—underscores the importance of using realistic and supportable expected-return assumptions. Since the near-term investment results are more immediately evident and impactful, special attention should be paid to these time frames.

Overall, the session provides an integrated view of the theory, empirical evidence, and practical tools actuaries use to construct discount rates grounded in expected asset returns. It demonstrates how valuation metrics, economic forecasts, survey data, and actuarial judgment interact to form defensible, transparent, and strategically meaningful discount-rate selections in today's complex market environment.

Session 309

Emerging Use of Captives for Benefits: A US and Non-US Perspective

Speakers:

Mitsu Nishiwaki, FCA, FSA, EA – WTW

Amy Hollis – Employees First

Kathy Huynh, FCA, FSA – WTW

Clement Chen – United Airlines

Session Host: Minyi Chen, FSA – Aon

Background

Employers have several options for funding their benefits, including self-insured, captive, pooling, and fully insured arrangements. These options represent a spectrum, with self-insured plans involving the most risk retention, corporate control, and access to data, while fully insured plans offer the least. Pooling refers to the combination of multiple employers' fully insured contracts, or for multinational companies, contracts from multiple countries. Pooling arrangements can result in savings for employers when there is a surplus in the overall pool. This session focuses on captives, which are formed by one or more employers to assume risks and manage claims. Captives operate as insurers but often partner with local fronting insurers to meet compliance requirements.

Captive 101

Employers consider captive arrangements for several reasons. Captives provide financial benefits by helping manage cash flows, reducing insurer profit margins, and allowing surplus to be reinvested into employee initiatives. They also offer data access and transparency, giving employers deeper insights into claims, expenses, and loss ratios, which enables improved forecasting and plan designs. Additionally, captives allow employers to customize and govern their benefit offerings, and once established, can simplify processes by covering a wide range of employer risks. Captives also empower employers to manage their exposure and focus on risk mitigation.

There are two common types of captives. A single parent captive is typically formed by a large employer, which owns the captive and assumes all financial responsibility and risk. In contrast, a protected cell captive is owned by an external sponsor, with participating employers sharing in the captive's benefits and risks. With healthcare costs continuing to rise, captives have become increasingly popular as employers seek greater control over their benefits and insurance expenses.

US-Based Benefits in Captives

Within the United States, regulatory hurdles—especially those related to the Employee Retirement

Income Security Act of 1974, (ERISA) and Department of Labor (DOL) approval—make it challenging to place employee benefits in captives. Many employers address this by placing medical plans under a stop loss captive solution, since ERISA does not apply to stop loss coverage. To place US ERISA benefits in a captive, employers can either pursue a single parent captive, which involves a lengthy process to obtain a DOL exemption, or opt for a protected cell captive, which is owned externally and can avoid the requirement for a DOL exemption.

For employers with fully insured employee benefits who desire transparency and access to data to fulfill their fiduciary responsibilities, captives offer a solution. Captives also tend to have lower fixed fees, and any surplus can be used to support other health and welfare plans. Large employers, such as United Airlines, have leveraged captives for supplemental health benefits to achieve full transparency regarding claim costs, realize cost savings, and enable the return of surplus premiums. Surplus from captives can be redirected to employee health initiatives, program enhancements, and lowering employee payroll contributions.

Global-Based Benefits in Captives

Globally, pooling remains the most common financial tool, but employers are increasingly interested in captive arrangements due to several key advantages. Captives enable employers to set sustainable prices, reduce administrative costs, recapture insurer profit margins, and benefit from the return of surplus with favorable experience. They also eliminate the need for extensive negotiations, accelerate decision-making and implementation, and can accommodate provisions not typically offered in local markets, which supports global headquarter initiatives with improved underwriting. HR teams benefit from captives through enhanced access to data for decisions, budgeting, and working with global network partners to improve local service delivery.

For employers that already have a US captive in place, expanding into international captive programs for global benefits is generally easier, as they are familiar with the essential stakeholders and processes. When considering the addition of a global captive, it is critical to conduct a cohort feasibility study for global operations. As with US-based captives, transparency is a primary driver for employers entering global captive arrangements. Large employer captives are investing in data warehouses to improve transparency and timely reporting, and some employers are encouraging their network partners to provide more comprehensive data.

Session 401

All Bets are Off: Experience Studies and Assumption Setting in an Unbiased Way

Speakers:

Baron James, FSA, EA – Mercer

Crage Lu, ACA, ASA, MAAA – New York City Office of the Actuary

John Redmond, FCA, ASA, EA, MAAA – Segal

Craig Rosenthal, FCA, FSA, EA, MAAA – Mercer

Session Host: Casey Shork, FCA, ASA, EA, MAAA – KPMG

Overview

Why do an experience study? In compliance with ASOPs 27 and 35 actuaries are required to provide a rationale for each significant economic and demographic assumption. In addition, enrolled actuaries are required to use their best estimate assumptions. And auditors look for well-rationalized assumptions with documentation.

When you drive a car, you look forward; when you do experience study, you look in the mirrors.

Typical assumptions review looks at the historical experience for the last several (5?) years. When determining the lookback period for the historical experience take into account the definition of business cycle. Don't just look for average, look for trends! Consider the sample size for credibility (especially for retirement / turnover in small plans).

Consider basing assumptions on standardized tables where available (2003 SOA withdrawal study, disability, SOA healthcare trend model, Yamamoto aging). Standardized tables can be adjusted by scaling tables either uniformly or with break points x% up to age z, y% after.

If dealing with incomplete data due to acquisition, new plan / plan design, or change in benefit provision, make best estimate assumption now and further refine over time.

ASOP 27, 3.5d selection of actuarial assumptions say assumption "... is expected to have no significant bias (i.e., it is not significantly optimistic or pessimistic) ...". The panel noted that while they don't observe built-in conservatism anymore for private plans, it is still present on public side.

The panel also noted that for multiemployer plans they observe the use of the best estimate, erring on the conservative side when in doubt.

Common biases that can come up in the development of the assumptions are anchoring, availability (you don't know what you don't know), confirmation, overconfidence, recency, status quo, aggregation.

The remainder of the session was spent focusing on considerations for specific assumptions and the biases that could be encountered while setting these assumptions.

Assumptions for both pension and retiree medical plans

Withdrawal / turnover assumption: recency bias (outside factors – recent layoffs, economic factors), aggregation bias (segregate by different type of participant - younger or lower service example of grocery workers, students vs. late age employees), overconfidence and confirmation biases.

Retirement assumption: aggregation bias (different groups; level of income or benefit (lower levels may retire later as they can't afford to retire early); recency bias (certain days of year e.g. teachers at end of school year) – affect timing of the decrement and timing of study); overconfidence and confirmation biases.

Consider use of data maturation, an experience study data process that uses hindsight to correct historical data. Example – active to retire to disabled. Initially – retirement decrement; then corrected to disability decrement. This would address availability and anchoring biases.

For the salary increase assumption, sometimes it's best to split base and other pay. That will avoid avoids large swings in liability when bonuses are larger / smaller in particular year and address recency and basis. As it pertains to union-negotiated pay increases, those can be considered wage inflation. Example when doing experience study – look at the total increase and remove negotiated increase.

Case study social unrest in New York City. Social unrest and protests in the Summer of 2020 led to higher retirements and terminations across the ranks of the New York Police Department. Higher than usual retirements in 2020-2022 are good example of status quo and recency biases. Actuary considered some ways to account for this such as giving less credibility to 2020-2022 experience or delaying experience study (actual outcome). In addition, due to the reduced police force, and high demand for public safety, a significant number of overtime hours were worked to provide coverage, prompting actuary to consider whether this experience is an accurate representation of a long-term overtime rate.

Forms of payment assumption is subject to anchoring, status quo, and recency biases. Actuary needs to consider several factors such as optional forms available; subsidies; % married, gender

and age at benefit election. Panel shared a number of observed social factors: married participants are less likely to annuitize than single; married women prefer life annuity; LS elections slowing down because of economic environment; larger benefit amounts tend to annuitize more than smaller ones; LS election % is very plan specific, as well as social effect on the election – people talk to each other (hive mind).

Case study pension plan covering three difference classes of employees:

- Officers and management: high compensation, annual bonuses, stock purchase option, long hours, low turnover, retired past NRA;
- Manufacturing: moderate compensation, physically demanding, shifting hours based on product demand, higher turnover & disability, retire at younger ages;
- Clerical and support stuff: low compensation, steady hours, high turnover, don't retire until eligible for Medicare / Social Security.

Same retirement plans are offered to all: DB 1% FAE as SLA, J&S, LS and optional 401(k) with up to 6% ER match. When setting benefit form assumption, need to take into consideration 401(k) utilization and LS elections by class; if own stock that can sell back at retirement – less likely to take LS; low benefit will prefer SLA, don't want additional reduction for J&S or ER.

New entrant profile assumption used for forecasting is subject to recency, overconfidence and status quo biases. Consider taking into account plan sponsor expectations and demographic profile of recent hires.

Contributions (Income) & Intensity (Accruals) assumptions for multi-employer plans are subject to recency (current large projects and will they continue), availability (need to get info from employer for the next 7 yrs), anchoring (should you assume FT workers are working FT), and status quo (maintaining old employment levels as the assumption “to be conservative”) biases.

Job classification assumption for multi-employer plans need to consider regional differences (seasonality matters in Chicago, but not in Dallas); how easy to change classification (store worker to manager); advantage in being in one classification over another. The assumption is subject to availability, overconfidence (expecting groups to behave in a certain way), confirmation, aggregation biases.

Disability assumption setting is subject to availability (plans not large enough to develop credible data set) and recency (2024 SSA long-range disability assumption report observed that incidence rates have fallen since 2010, but assumption that will increase over long-term) biases. When setting disability assumption consider composition of workforce; definition of disability; value of benefits available; and how disabilities are reported (can be shown as actives or retired, not disabled).

Mortality assumption setting is subject to recency (significant impact of COVID-19 impact on mortality levels in 2020-2022) and status quo (ASOP 35 indicates actuary is obligated to consider emerging experience) biases.

Assumptions specific to retiree medical plans

ASOP 6 provides additional guidance with respect to setting assumptions specific to retiree medical valuations.

Asymmetric risk may arise because pre-65 benefits are generally more valuable / costly than post-65 benefits. In addition, eligibility / availability for retiree medical plan may or may not be tied to pension plan, so use of different demographic assumptions from pension plans might be appropriate.

Per Capita Claim Costs assumption is subject to anchoring, status quo and recency biases. Separate assumptions are developed for pre/post Medicare. Assumptions are then calibrated to a central age (typically 65) and aging factors are applied. Panel observed that retirees tend to incur higher medical costs than actives at the same age as they have more time to go to doctor.

Medical trend and aging assumptions are subject to availability, status quo and aggregation biases. Medical costs have historically increased at faster pace than general inflation, so most trend assumptions reflect a long “select and ultimate” assumption.

Participation / spousal coverage assumptions are subject to recency, overconfidence and status quo bias. Assumptions may vary by age at retirement; spouse’s own active or post-retirement coverage; and access to other retirement programs (pension).

Persistency assumption is subject to recency, overconfidence, confirmation, and anchoring (not quite 100%) biases. Assumption may vary by subsidy levels, age, other coverage (spouse, Medicare).

Account based plans (HRA) assumptions need special attention as spending patterns vary. The assumptions are subject to availability, overconfidence, confirmation, and status quo balances. Plans that provide carryover option need to focus on participants hoarding balances.

Case study pension plan terminated, retiree medical is ongoing.

Both plans cover the same population and early retirement criteria is the same for each plan.

Access or lack of thereof to guaranteed income through pension plan is likely to affect participant behavior and retirement patterns. Retirement age might increase due to lack of pension. Retiree medical elections might decrease longer-term, due to lack of lifetime income or increase longer-term, due to higher need for financial security without the pension income.

Session 402

High Stakes Pension Funding Strategies

Speakers:

Michael Antoine, FCA, FSA, MAAA, EA – Gallagher

Bruce Cadenhead, FCA, FSA, MAAA, EA – Mercer

Session Host: Gail Steward, FCA, MAAA, EA – USI Consulting Group

Background

Pension plans have faced volatile funding for the last several years. Plan sponsors prefer predictable funding patterns and might be looking to work toward termination, especially those sponsoring frozen plans.

Interest Rates

Rev. Proc. 2017-57 is where approval to change interest rate method lives. The IRS has approved at least one plan's move from full yield curve to another interest rate method. Rev Proc. 2017-56 provides a phase-in option for moving to a different asset method. The stabilized rates are not always the highest rates, so moving to full yield curve might lower the discount rate, but could introduce more volatility. On the other hand, if assets and liabilities are well-matched, the full yield curve may reduce volatility. A change to the full yield curve is always automatically approved.

Asset Methods

Asset methods can be changed automatically after 4 years using the same method, although if any mergers have taken place, care is needed. Well-hedged plans that are considering using full-yield curve might want to consider switching their asset method to market value, especially if there have been gains in the last several years.

Special Funding Rules

Multiple Employer Plans (which are not multiemployer plans) have some special rules that need to be followed and depend on when the plan was created.

Strategies Other Than MRC

Some sponsors prefer a more predictable funding pattern or want to meet a specific target such as avoiding benefit restrictions, or at-risk status. Avoiding PBGC variable premiums or ability to pay lump sums are other possible motivations. COB/PFB >20% of liability should be reviewed – does that really help?

Credit Balances

Standing elections can be helpful and note that they can be suspended or modified if circumstances warrant such an action. Might need to (or be forced to) waive balances to avoid benefit restrictions and/or 4010 filings. Can also strategize to keep carryover balance but need to consider the impact on future funding and potential impact on future quarterly contributions and whether the additional flexibility afforded by the carryover balance (relative to prefunding balances) is worth the trouble.

Maximum Deductible Contributions

Most plans have plenty of room to maximize if the plan sponsor wants, but new plans with no past service might have restrictions. There is a possible risk of overfunding if the plan is scaled back or frozen. Be careful of rules regarding “erroneous actuarial computations” and “mistake of fact” when trying to recover excess contributions at plan termination.

Proposed Strengthening Benefit Plans Act of 2025 would allow transfer of some surplus assets to DC QRP without requiring plan termination. Also might provide for recovering 401(h) surplus assets.

Benefit Restrictions

Remember to add back annuity purchases in prior two years for NHCEs when calculating AFTAP - same amount in both numerator and denominator. This is often easier said than done, since the HCE/NHCE status of those covered by the purchase may not be known – especially for participants who terminated employment prior to the adoption of PPA.

Range certifications cannot reflect receivable contributions, but can reflect future funding balance waiver.

Risk Transfers

Annuity purchases and lump sum windows will impact funding ratios – sometimes in negative ways. Best practice is to consider hedging assets to avoid surprises between decision to purchase and premium payment.

Liquidity shortfall for plans with more than 100 participants might be triggered after a risk transfer.

PBGC Premiums

Multiple options exist. Accelerate scheduled contributions so they can be designated as prior plan year; designate any contributions made before the final due date as prior year contributions (provided not already used on a prior filing). There are other ways as well, but these are most popular.

Possibly change rate election to full yield curve – although this is likely a permanent change.

Session 406

Productivity, Project Management, and Talent Development in the Hybrid Workplace

Speakers:

- Ellen L. Kleinstuber, FCA, MAAA, FSA, EA, FSEA – Bolton Partners, Inc.
- Kelly Boschke, FCA, FSA, EA – Fidelity Investments
- Marcie Smith Gunnell, FCA, MAAA, ASA, MBA – Deloitte
- Jami Eckman, FCA, FSA, EA – Mercer
- Rodolfo Ernesto Garcia, FCA, MAAA, EA – Bolton Partners, Inc.

Session Host: Danielle Almeida, EA, MAAA – Gallagher

Overview

The migration to a hybrid work environment provides flexibility and opportunity for employers and employees. It also necessitates rethinking many of the aspects of how we manage work and develop talent. Speakers explore how consulting firms are using these issues as a springboard for innovating how we run the modern actuarial workplace.

Defining the Challenges and Benefits of a Hybrid Work Environment

As an introduction to the session, the audience was asked to provide one-word responses on both the largest hurdles and greatest benefits of a hybrid work environment. The word clouds are shown below in Images 1 and 2 for completeness.

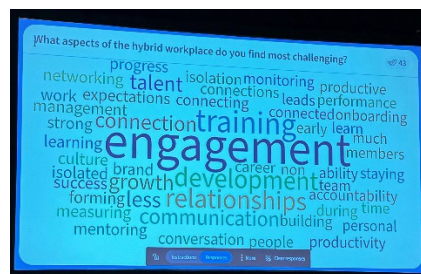


Image 1

Some of the most noted challenges were engagement, training, development, and relationships. Both the audience and panelist group expressed agreement that it is difficult to gauge and build engagement of the workforce in virtual environments. Audience participation included some feedback for ways to foster engagement in work settings (i.e., scheduling prep calls and debrief sessions and reserving time on calendars). To aid in training and minimize multitasking, it was suggested to schedule one on one time to share screens and to step through details and questions. With regards to development, it was discussed that feedback provided timely was most impactful for junior staff. Lastly, a panelist noted that accountability is not often listed as a primary concern,

but often appears in situations where there is a lack of productivity in a remote environment. **Fostering communication with employees and setting clear boundaries were suggested as ways to improve concerns related to accountability. In summary, intentionality was the most common theme to help abate these concerns.**

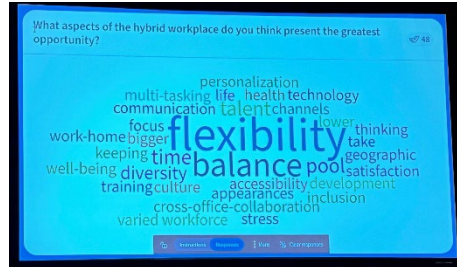


Image 2

The second word cloud was used to highlight the greatest opportunity afforded to employees and employers when considering the hybrid work environment. **The main takeaway is that the flexibility associated with a hybrid work environment allows for personalization of the work experience and increases the employee’s ability to balance time.** The inclusion of the term balance in the word cloud garnered additional feedback from the audience that balance is an individual definition and is a practice that requires discipline. The panel noted that separating time into buckets is helpful in some cases, such as scheduling one day a month to think through ideas and considerations without other distractions. Accessibility for a wider network was unanimously voted as an opportunity, both for individual success as well as for recruiting diverse talent.

Intergenerational Differences

The audience noted that intergenerational differences were evident especially in context to how each generation approaches the hybrid work environment in relation to work-life balance and flexibility, as shown in the polling result in Image 3 below. Because of the consistent use of technologies, the younger generations tend to adapt more quickly to changing technology and expectations in a hybrid environment. The audience was polled, and the prevailing generation represented in the room was Millennials (birth years 1981 – 1996).

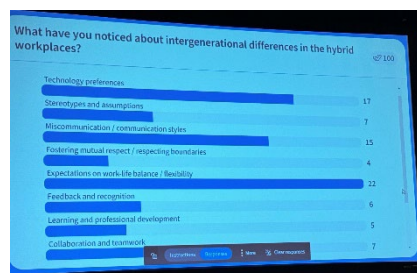


Image 3

Discussion from audience members indicated that they find members of differing generations have a challenging time empathizing with the desires of workers from other generations (i.e., younger

unmarried employees wanting work/life balance as opposed to leaning into career opportunities that may require heavier time commitments). “Off-hours” working was noted as another point of contention intergenerationally. Some workers finish their days into the evening but are not expecting others to follow their lead. **An important aspect of virtual working is to set expectations on working hours for team members to facilitate training and collaboration opportunities.**

Managing and Developing Talent in a Hybrid/Remote Workspace

Many components go into developing talent in a hybrid workplace, but they all center on addressing individual needs and preferences to optimize the investment of time from both an employee and employer perspective. Recruiting talent can yield a wider net when the job is remote but could also be a detriment to an employee looking for an office-based culture. Bias should be considered when fostering the corporate culture.

Supporting actuarial exams for employees still in the process should focus on making sure that the employees are supported to take their allocated time in the corporate exam programs. Often, it’s not as easy to study independently, so a suggestion was made to have virtual study groups for employees that are not local to colleagues taking the same exams.

Building consulting skills can be fostered in a hybrid work environment by allowing junior staff to attend virtual meetings with clients more frequently than they may have been given an opportunity for an in-person meeting. This ensures our clients are aware of the many consultants servicing their accounts and allows junior staff to witness the client interaction with more senior colleagues. **It was noted as most important to model good consulting skills as most people learn by example.** (And make sure to always have a backup plan in case technology fails.)

Managing relationships is easiest with visual cues. If in-person collaboration is not an option, video conferencing to connect with employees and best nurture those relationships is ideal.

Networking: Building and Navigating Corporate Culture

When a subset of the workforce is remote, it is important to build community in other ways. Suggestions from the panel and the audience included a monthly meeting for those employees not headquartered out of a hub and building time into calendars to chat. It has been effective for some to replicate what would have been “water cooler” conversations by encouraging all team members to schedule time on calendars to catch up socially.

Another suggestion included intentionally allowing time to meet with colleagues during travel. For example, if an employee is attending a client meeting in a city that has an office location, encourage them to allocate time to connect in person.

Lastly, time zone differences were noted as a point of consideration for all to keep at the forefront of remote work, especially if those you work with are spread geographically.

Session 502

When Pension Funded Status Comes Up Snake Eyes

Speakers:

Katherine B. Kohn – Thompson Hine LLP
Toyoto Borgmann – WTW
Caroline Pisacka – Fidelity Investments
Michael S. Clark – Gallagher

Summary Author: Michael S. Clark – Gallagher

This session explored the multifaceted challenges facing sponsors of underfunded defined benefit plans, with a focus on navigating funding and plan administration rules, PBGC oversight, and termination scenarios. The presenters began by reviewing how a plan becomes “at-risk” under PPA funding rules, the implications, and timing for accelerated contribution requirements and participant communications. They discussed the consequences of falling below certain AFTAP thresholds and resulting benefit restrictions. Lastly, presenters introduced a topic of increasing prevalence in recent years, liquidity shortfall requirements, including the relevant calculations and impact on quarterly funding requirements. The presenters also discussed remedies for avoiding the aforementioned funding issues, such as accelerating cash funding, voluntary credit balance forfeitures, and changes to PPA interest rate method elections. The speakers also highlighted the impact of low funded status on non-qualified deferred compensation plan funding restrictions and annual disclosure requirements.

The discussion then turned to PBGC oversight, beginning with PBGC 4010 filings. Attendees were guided through the criteria that trigger a 4010 filing, key components of the filing, and potential strategies to avoid it—such as additional cash funding, changing discount rate methodology to the full yield curve, or forfeiting credit balances. The session also reviewed PBGC reportable events and the Early Warning Program, emphasizing how the PBGC identifies potential risks through corporate actions or deteriorating plan funding. Presenters discussed strategies for negotiating settlements under the Early Warning Program, including additional contributions, security interests, and letters of credit.

If required contributions become unaffordable, the presenters described the process and implications of requesting an IRS funding waiver. They outlined the eligibility criteria for such waivers, the types of financial and plan data required, and the typical conditions the IRS and PBGC may impose—such as enhanced reporting or security requirements. The message was clear: funding waivers should be considered temporary relief mechanisms rather than a long-term solution to chronic underfunding.

The session concluded with a discussion of plan termination scenarios—both distress terminations initiated by sponsors and involuntary terminations initiated by the PBGC. Using real-world case studies, the speakers illustrated the financial, legal, and administrative steps involved in each process, from participant notifications to PBGC trusteeship and termination liability settlement. The speakers also addressed how bankruptcy proceedings intersect with pension plan obligations, including how PBGC claims are treated in bankruptcy and the implications for both plan sponsors and participants.

Overall, the session provided a comprehensive overview of the regulatory, actuarial, and legal landscape that actuaries must navigate when advising sponsors of underfunded pension plans. The speakers stressed proactive management of funding levels, early engagement with the PBGC when challenges arise, and careful coordination between actuaries, legal counsel, and plan sponsors to mitigate risks before “snake eyes” become a reality.

Session 503

OPEB Considerations for Pension Actuaries

Speakers

- Adam Reese, FCA, FSA, EA, MAAA – PRM Consulting Group
- CJ Zahradka, FSA, EA – WTW
- Jenny Bain, FSA, MAAA – Deloitte

Moderator: Rebecca Trauger, FCA, FSA, MAAA – Bolton

Session Host: Steven Draper, FCA, FSA, MAAA, EA – EY

For many retirement actuaries, retiree medical is practice area that has significant overlap with retirement work and can provide additional opportunities to serve clients. However, it requires an additional skillset and understanding of healthcare costs and how Medicare programs impact the costs of retirees.

Retiree Medical Basics

There is a big distinction between Pre Medicare and Medicare eligible retirees. Pre Medicare retirees often participate in the same benefit plan as active employees. So, the cost of the average participant is much lower than the cost of the retiree because cost generally increases with age. It is important to understand that the actual cost of retirees will be much higher than the average insurance rate that is pooled with active employees. This is called the implicit subsidy and is sometimes called the hidden subsidy. Medicare retirees have benefit plans that pay secondary to Medicare or are integrated with Medicare and generally there is not an implicit subsidy because they are not pooled together with active employees.

The HCI data shows that retirees cost a lot more than other plan participants.

Auditors are not just checking the numbers that are provided to them but they will also be looking at the overall process, whether there are any plan design changes, and they will be comparing the costs provided this year compared to the prior year. They will be confirming that each of the audit considerations listed in this presentation have been considered. For example, they will look for employer cost caps and confirm whether the valuation includes any implicit subsidy in addition to the explicit employer cost.

Medicare has three parts namely: part A which covers hospital benefits, Part B which covers physician and professional services, and finally Part D which covers Medicare prescription drugs. At one point there was a Medicare Part C which combined Medicare Part A&B into a private insurance

product that worked with subsidies from the federal government to replace Medicare Part A and Part B, Medicare Part C is now known as Medicare Advantage.

Medicare supplement plans are provided by private insurance companies or by employers to supplement the gaps in coverage that a retiree has when they have signed up for traditional Medicare Part A and Part B. A Medicare Advantage plan replaces Medicare Part A and Part B and provides coverage similar to Medicare Part A and Part B plus a supplement; however, the cost is usually less than a Medicare supplement plan because a Medicare Advantage plan often includes a narrow network and will include care management to reduce overall utilization and cost. Medicare Advantage plans are becoming more popular because of their lower cost and supplemental benefits that they sometimes offer that go beyond what standard Medicare Part A&B will cover with the supplement.

Medicare Advantage plans are sold in the open market, but an employer can also purchase a group Medicare Advantage plan for their own retirees. This avoids the need for retirees to shop in the open market for their own coverage. A Medicare Advantage Part D (MAPD) Plan combines a Medicare Advantage plan, which covers medical, with a Part D prescription drug plan. Medicare Advantage Part D plans have had declining premiums in recent years. Over the last 15 years they have dropped from an average premium of \$40 per month in 2010 to \$13 per month in 2025. \$13 is the average premium but 75% of the plans have a \$0.00 premium.

A retiree medical actuary should consider the components of cost within a Medicare Advantage plan when projecting trends into the future. A Medicare Advantage plan includes a large cost for medical services, some additional costs for administration and then an offset due to CMS funding. Because of the large dollars involved, small changes on a percentage basis on either the medical costs or the CMS funding can cause significant increases in the net premium.

Professionalism Considerations

Actuaries performing retiree medical services need to consider the US qualification standards. An OPEC valuation requires a pension skill set as well as a healthcare skill set. Actuaries need to look in the mirror and ask, "Can I competently perform both services, or do I need to split the work with another actuary?" Retiree medical actuaries need to follow the actuarial standards of practice (ASOPs) and determine whether they have the skill sets to perform all of the work. Assumptions include economic and demographic assumptions. Demographic assumptions are similar to those for pensions, but also include trend, initial claims costs, retiree participation, spouse participation, etc., and often persistency or lapse assumptions.

Although some retiree medical assumptions appear to be similar to pension assumptions, the impact and materiality can be very different. For example, an average retirement rate of age 62 may be appropriate for a pension plan even if retirees retire anytime between age 55 and age 70. However, the exact timing of retirement for retiree medical plans impacts the cost much more than the timing of retirement does on a pension plan cost. This is because the benefits are much larger

for an early retiree who receives benefits at a higher level for a longer period of time than for an older retiree. This contrasts with pension plans where the retirement age assumption is somewhat self-correcting because older retirees get a bigger benefit that offsets the shorter period of time they receive the benefits.

Future gross cost trends may be dampened as the government negotiates the cost of the highest cost drugs in the Part D program. This can be used to lower healthcare cost trends for prescription drugs however it is important to consider the net cost because as the gross costs decrease often the rebates decrease and sometimes for our Part D plan the direct subsidy reinsurance and manufacturer discounts can go in different directions. It is important to request as much detail as possible on the components of drug costs and not simply rely on lower trend projections on the gross costs

Cash based HRA or retiree health reimbursement arrangements

HRA plans are sometimes also called retiree medical spending accounts and can go by other names as well. The key features are that the employer sets aside dollars in a notional account the retiree can use towards purchasing insurance coverage and sometimes can be used to cover out of pocket expenses. The IRS limits what items can be purchased on a tax free basis and the employer can choose to limit the definition further for its own plan. Some plans only reimburse premiums while others also allow for reimbursement of out-of-pocket expenses.

Some key assumptions for HR plans include participation and utilization. Reentry assumptions also need to be considered in case retirees are allowed to waive coverage and then opt back in later. Some plans provide an annual allocation in which case it is important to understand what portion of the allocation is used each year and what portion is rolled forward to future years. Additionally, assumptions should consider whether or not rollover balances will be used and over what time period.

When retirees are given a lump sum in an HRA at retirement then the key assumption is how quickly the amounts will be drawn down over time.

Auditors will ask for support of the selected assumptions. It is important to review recent plan experience, and adjust the participation and utilization assumptions to reflect recent retiree behavior. At one point it was common for retiree medical actuaries to value an annual allocation into an HRA as a fixed life annuity. However, when retirees do not use the full balance that approach will overstate the obligation. Auditors will be looking for best estimate assumptions not assumptions that are conservative in a worst-case scenario

Summary

Retirement actuaries should involve healthcare or retiree healthcare actuaries in the valuation of retiree medical plans. There are nuances that require experience and a different skillset for working with retiree medical plans.

Session 504

Impact of Unique Solutions and Digital Health Innovations on Health Costs and Outcomes

Speakers:

Cheryl Ham, FCA, FSA, MAAA – Aon

Mike Clarke, FCA, FSA, MAAA – Aon

Dave Osterndorf, FSA – Centivo

Sara Tappema, FCA, FSA, MAAA – Alta Advisors / Wildflower Health

Session Host: Paul Albarano, FCA, FSA, MAAA – Alliant

Overview

In a city built on bold moves and big bets, this session dives into the high-stakes world of digital health and point solutions. Are these innovations truly reshaping health outcome and cutting costs – are they smoke and mirrors? Join industry consultants as they reveal insider methods for evaluating these evolving solutions, and a panel of vendors ready to lay their cards on the table with real-world results, ROI and impact stories. Whether you're risk-averse or ready to go all in, this session will help you bet smart on the future of healthcare innovations.

Summary

Health care payers and employers continue to face the challenge of managing rising costs while striving to improve health outcomes and enhance the member experience. Recent years have brought an influx of digital health technologies and targeted “point solutions,” each designed to address specific conditions or behaviors. However, many organizations now face “point solution fatigue,” as the financial and clinical impact of these programs often remains uncertain. This session explored how actuaries and consultants can measure these innovations more accurately, integrate them effectively, and redefine value beyond short-term financial returns.

A central theme of the discussion was the growing need for independent validation of vendor claims. While many solutions advertise significant cost savings, actual performance varies with potential validation depending on data quality, methodology, and time horizon. Aon's evaluation framework, for example, gathers detailed claims information to isolate where savings occur—whether through better care coordination, reduced waste, care redirection or negotiated lower unit costs. This approach allows consultants to compare results fairly and transparently, minimize “double counting” between vendors, and link outcomes directly to service categories such as

inpatient, outpatient, and pharmacy care. Surgical Center of Excellence point solution vendor represent a great candidate for these types of evaluations.

Health plans are also rethinking benefit design through high-performing networks and value-based arrangements. These models shift the focus from price discounts to total cost of care, emphasizing preventive and primary care, virtual coordination, and the redirection of services to lower-cost settings such as ambulatory centers. The hope is that Machine Readable Files, additional transparency data and new AI-driven technology can make this shift feasible. However, evaluation is complex because new payment structures—like bundled payments and capitation—change both the price and the pattern of care. Actuarial models that account for these dynamics are essential to determine whether lower costs stem from improved efficiency or simply altered utilization.

A case study from Wildflower Health illustrated how integrated maternity care programs combine digital engagement, remote monitoring, and personalized human support to improve outcomes. Among enrolled participants, the program achieved fewer cesarean deliveries, lower NICU utilization, and fewer emergency visits, demonstrating measurable clinical and financial benefits. Results were strongest among high-risk and Medicaid populations, underscoring the potential for digital innovation to advance health equity.

Speakers also challenged the notion that all programs must produce immediate financial ROI. Many interventions deliver long-term or societal benefits—such as healthier families, higher productivity, and increased trust in care systems—that fall outside one-year accounting cycles. A blended value framework was proposed to measure impact through three lenses: financial ROI, value on investment that captures long-term benefits, and social ROI representing community-level gains. This broader approach recognizes that effective health innovation strengthens both individual wellbeing and organizational sustainability.

Ultimately, the session emphasized that actuaries are uniquely positioned to evaluate this evolving ecosystem. Their analytical expertise helps separate correlation from causation, ensuring that measurement reflects real improvement rather than marketing claims. The future of cost management, participants concluded, depends not on multiplying disconnected solutions but on integrating them strategically, measuring rigorously, and valuing outcomes that extend beyond immediate cost savings.

Session 505

Leveraging Stoploss and Captives for Effective Risk Management in Self Insured Medical Plans

Speakers:

Tim Stawicki, FCA, FSA, MAAA – WTW

Caitlin Blackmon, ASA – WTW

Linh Ebbers, ASA, MAAA – WTW

Dale Sagen, ACI – QBE

Douglas Punt, FSA, MAAA – Symetra

Session Host: Bob LaLonde, FCA, FSA, MAAA – LaLonde Consulting

The speakers noted that the medical plan risk continuum ranged from fully insured all the way up to self-funded. In a fully insured plan, the employer pays a monthly premium to an insurance company, and the employer's costs are predictable. The insurance company assumes all the claims administration and financial risk but there is only limited flexibility in plan design. A buyer of these services can only take what the company is offering. Fully insured plans are governed by both federal and state insurance regulations. Unfortunately, employers have little access to their own claims data limiting insight into how employees use their plan.

In a self-funded plan, the employer assumes all the financial risks. Costs are variable to some degree depending on the number of covered members in the plan. The plan allows for high customization so you can design any plan you want, aligning with ERISA and federal standards but are exempt from most state insurance mandates. Lastly, you have much better access to your own claims data, allowing you to better analyze trends and manage costs.

Self-funded plans are exposed to potential large claimants in which case medical stop loss insurance and/or captive insurance may be needed to protect against a catastrophic loss. These can be designed either at the covered member level (specific) or on an overall plan loss (aggregate) basis.

Several vendors offer stop loss coverage to self-funded plans. On a specific stop loss basis, plans include a specific loss deductible which covers claims that exceed a certain threshold. For example, the insurer will reimburse the company for claims over \$300,000 for any individual covered member. The group discussed considerations for setting specific stop loss deductibles.

Separately, a carrier may provide aggregate stop loss which protects against the sum of claims in a particular year exceeding a certain value. For example, if the company's medical claims exceed \$3,000,000 in a year after applying individual stop loss reimbursements, the aggregate stop loss coverage will cover the amount above \$3,000,000

There are key differences between unbundled and bundled stop loss arrangements. In an unbundled stop-loss arrangement, the employer contracts separately with a third-party administrator and a stop-loss carrier, rather than purchasing both through a single carrier. Claims administration and stop-loss coverage are handled under separate agreements. In a bundled network the employer might make an arrangement with the insurer where the insurer has their own network, administers the claims and, pays the claims. This is very similar to one-stop shopping.

Stop loss contracts can either be on an incurred basis or a paid basis. A common contract is called 24/12 which means it covers any loss paid in a 12-month period that was incurred in the prior 24 months. Contracts can also come with various ancillary provisions such as no new layering or a renewal rate cap. If the stop-loss carrier becomes aware of a claim that is expected to incur significant or ongoing costs, the carrier may apply a layer to that claim, increasing or excluding stop-loss coverage so that the employer remains responsible for the associated expenses. Ensuring the appropriate payment timing basis can protect companies from unintended risk exposure.

It was pointed out that a trend in first dollar claims understates the trend in claims with a deductible. The higher the deductible, the higher the trend will be which is referred to as trend leveraging

A captive is a wholly owned and licensed business performing as an insurance company to insure risks as outlined in its business plan. These captive insurance companies can be effective for companies as an alternative or an addition to traditional stop loss coverage.

Two types were discussed: single parent where the captive only insures the claims of its owner; group captive where the captive insures the risks of multiple employers. The main benefit of a captive is that it can hold reserves whereas the single parent cannot. There are also tax advantages, especially when diversifying multiple lines of coverage. Many large employers already operate captives to manage property and casualty risks, and adding unrelated risks—such as medical stop-loss coverage—can improve capital efficiency and tax outcomes.

Summary:

Overall, this was a well-attended session, and many questions were asked by the audience.

Session 507

CCA White Paper – The Great Beyond

Speakers

Todd Tauzer, FCA, FSA, MAAA, CERA – Segal

Matt Larrabee, FCA, FSA, MAAA, EA - Milliman

Andy Blough, FCA, FSA, MAAA, EA – Indiana Public Retirement System

Joe Newton, FCA, FSA, MAAA, EA – GRS

Session Host: Jody Carreiro, FCA, ASA, MAAA, EA – Osborn, Carreiro & Assoc.

Overview

There were many practical changes in actuarial practice and discussions about these policies which culminated in the first edition of Actuarial Funding Policies and Practices for Public Pension Plan, the “white paper”, in October 2014 (and the second edition approved in July 2024). These practices included closed, layered amortization bases. The larger initial amortization bases in many of these plans are at or near full amortization. This results in increased variability in the actuarially determined contribution (ADC) rates reported by plans. The speakers will discuss various output smoothing methods to create strong contribution patterns needed to attain and maintain fully funded plans.

Direct Output Smoothing and Example of Oregon

A direct output smoothing method is one which there is often little to no smoothing done on the inputs, for example, little or no smoothing on the market value of assets. A target ADC is calculated using the usual amortization methods of the white paper, then agreed upon smoothing method would smooth the difference between that target ADC and the current contribution rate.

There are several practical lessons from the changes implemented by Oregon over the past 12 years. Any smoothing should only be made to the UAAL portion of the contribution. The contribution rate change should be limited and asymmetrical. That is, the UAAL portion of the contribution should only go down when certain funding percentage levels are reached. The method should be stochastically tested for a high probability of fully funded status and the ability to withstand low probability, bad results.

Contribution Rate Determinations in Iowa and Indiana PERS

The PERS of these two states calculate a “white paper” consistent ADC and then apply rules for changing the contribution rate. Both apply the ADC as the contribution rate until fully funded. Iowa does have a limit on the amount that employee contributions can increase in a single year due to

their shared cost structure. Both states maintain the previous year's contribution rate until at least 95% funded. At that point, the Iowa rate can decrease the contribution rate up to 50 basis points if the ADC is lower than the current contribution. Indiana decreases by 25% of the difference between the ADC and the current rate. The Iowa method will not decrease the contribution rate to below normal cost unless the plan is over 110% funded for three consecutive years. Although a different method than above, the concept of the final rate being changed on an asymmetrical basis applies in both states.

Surplus Management Concepts and related contribution rate volatility management

A pension plan that is over 100% funded, has an UAAL less than zero, is often considered to be in a surplus position. The primary risk for a plan in a surplus position is that of agency risk. That is, the political risk of the board wanting to significantly reduce contributions or increase benefits. These mistakes can be avoided by stakeholder education before the surplus position develops. This could involve moving to more conservative assumptions or developing a glide path from the current contribution rate to a normal cost-only type contribution rate.

Previous examples and suggestions for surplus management focused mainly around a long (30-year) rolling amortization of the surplus. New surplus management concepts being explored include a glide path to reduce the UAAL contribution rate to 0% over a period of time, continuing to pay full normal cost until some buffer beyond 100% funded (like 110% funded), and rolling 30-year amortization of any surplus amount over the chosen buffer. The speaker reviewed the effect of a glide path policy on a sample plan showing how an asset shock or an assumption change would be applied. One suggested glide path would be to decrease the contribution rate by half the change in ADC, after a minimum amount, and then cap the decrease by an amount, say 2% of payroll. This proposed policy would also have an overall minimum of full normal cost. This method would also give the investment managers time to deal with increasing negative cash flow.

Negative Cash Flow Considerations

A mature pension plan will develop a negative cash flow rate (or a cash out flow rate) that can increase as contributions decrease due to reaching a surplus position. The cash flow percentage would be the expected contributions to the plan less benefits paid, divided by the assets in the plan. If a plan reaches an ADC cliff when near fully funded status, the negative cash flow can increase significantly. Larger negative cash flows can impact on the expected future returns in various ways. If the plan has significant exposure to illiquid assets, the other plan assets might have to be rebalanced. The need for additional cash each year may cause a reallocation to more income producing assets, which typically lead to less expected future return.

The speaker pointed out a relationship between the cash flow rate and wage inflation with the return assumption for plans that are fully funded and pay the normal cost. The result of this relationship is that a plan can lose funding percentage over time if they are not earning at least the cash flow percentage plus wage inflation over a long period of time. Any glide path method that is

considered should be reviewed in conjunction with the cash flow percentage due to the reduced contributions in order to achieve long term funding stability.

Session 601

Understanding the Rules: A Guide to Professional Standards for Pension Actuaries

Speakers:

David Driscoll, FCA, FSA, MAAA, EA – Gallagher

Jaime Eckman, FCA, FSA, EA – Mercer

Tonya Manning, FCA, FSA, MAAA, EA - Gallagher

Session Host: Gail Steward, FCA, MAAA, EA – USI Consulting Group

Background

The actuarial profession is self-regulated, and we work hard to remain that way. The profession uses a principles approach to achieving this, providing guidance on how to approach our work rather than providing a road map to doing the work.

Framework

The framework for self-regulation is based on the US Qualification Standards maintained by the American Academy of Actuaries (AAA), the Code of Conduct adopted by all five US based actuarial organizations, the Actuarial Standards of Practice maintained by the Actuarial Standards Board (ASB), and the Discipline / Guidance process overseen by the Actuarial Board for Counseling and Discipline (ABCD).

Enrolled actuaries signing Schedule SBs for defined benefit pension plans must follow the continuing education requirements of the Joint Board for the Enrollment of Actuaries (JBEA). Insurance actuaries must follow the continuing education requirements and other rules from the National Association of Insurance Commissioners (NAIC) and all actuaries signing accounting reports need to adhere to the methods issued by the various accounting standards boards (FASB, GASB, IASB, etc.).

US Qualification Standard

Apply to all actuaries who are members of any of the 5 US-based actuarial associations (Conference of Consulting Actuaries, Society of Actuaries, American Academy of Actuaries, Casualty Actuarial Society and American Society of Enrolled Actuaries). Outlines education and experience requirements and recently added requirements for bias and models.

Code of Conduct

Approved by and applies to members of the 5 US-based actuarial associations.

Disciplinary Process

Applies to all actuaries who are members of any of the 5 US-based actuarial associations. ABCD members are volunteers from each of the actuarial organizations representing all types of actuaries. ABCD investigates and makes recommendations, but each actuarial organization decides on whether disciplinary action will be taken. Possible actions: nothing, private reprimand, public reprimand, suspension or loss of credentials.

Continuing Education

Each of the organizations has their own requirements, however there is much overlap. A practical approach is to focus on the JBEA requirements and the AAA / USQS requirements. This approach works because the JBEA must be followed for Enrolled Actuaries, and satisfying the USQS will automatically satisfy the requirements for SOA, AAA, and CCA. Actuaries must certify that they have met the CE requirements. EAs have a 3-year cycle and SOA members must certify annually. MAAA members are not required to certify but can choose to do so on the AAA website.

Maintaining documentation of continuing education is important in case you are audited by one of the organizations. This is especially important if you are changing practice areas – you must make sure that you meet the requirements for your new area of focus.

Actuarial Standards of Practice (ASOPs)

58 ASOPs have been issued, but many have been revised, and some have been repealed or consolidated. ASOPs are minimum standards, not best practices. Most ASOPs are specific to a practice area, but some are applicable to multiple practice areas.

Actuarial Board for Counseling and Discipline

Primary functions are to respond to requests for guidance and to consider complaints about possible violations of the Code of Conduct. There is one staff member – the ABCD Counsel – other members are volunteers representing all the practice areas. ABCD guidance, inquiries and mediation are confidential unless the actuary agrees to make public or allow publication, or a court required disclosure, or a redacted version is made available for a generic situation that has educational value.

Requests for Guidance can be on anything that might affect your obligations under the code. All responses are confidential and from an appropriate individual member of the ABCD with the same professional practice area.

Complaints to the ABCD can be made by clients, another actuary, a regulator, or based on a public document that might suggest a violation. Inquiries following a complaint are not adversarial, but a fact-finding forum. The ABCD cannot impose discipline. The membership organizations do that after their own procedures are followed (or they can decide no discipline is needed).

Session 602

Market-Based Cash Balance / Variable Annuities

Speakers:

Craig Rosenthal, FCA, FSA, EA, MAAA - Mercer

Scott Hittner, FCA, FSA, EA, MAAA - October Three

David Little, ASA, EA, MAAA - Fidelity Investments

Lee Gold, FCA, EA, ASA, MAA - Mercer

Session Host: Ken Lining, FCA, MAAA, EA – Gallagher

Background

Sponsoring a retirement program shouldn't be like going to a casino when new market-based designs can tilt the odds in everyone's favor. Speakers at this session will explore innovative strategies to provide secure retirement benefits that mitigate risks for both employees and employers alike.

Summary

During this interactive session, the speakers discussed the following aspects of market-based plans: introduction and experiences from around the world, mechanics of these plans, the employee choice, the accounting / funding considerations, and a potential market-based cash balance design.

Introduction and Market Based Plans Around the World

The introduction shared EBRI data that indicated DB plan participation was 9% in 2023 (down from 38% in 1979) while DC plan participation was 53% in 2023 (up from 17% in 1979). DB plans, which are usually under-appreciated by younger participants, excel at providing lifetime income. In contrast, DC plans are great accumulation vehicles for those who participate but are not as good at distributing lifetime income. For this comparison, DB plans are considered to be plans that are not DC plans.

A market-based cash balance plan is still a defined benefit plan with a definitely determinable benefit and for which the plan sponsor still holds some risks; however, it is based on some variable factors such as investment returns which can eliminate the investment-based risks. Market-based plans are gaining in popularity as they marry features from traditional DB and DC plans such as expressing benefits as balances and having benefits adjust based on market returns.

Market-Based Plans Around the World

Observing retirement plans from countries outside the US can provide some valuable insights and learnings from these retirement experiences around the world. We want to find out the changes made in other countries and their rationale. In our designs, we wish to replicate the changes that have worked well in other countries and avoid the changes that have not worked as well. The speakers reviewed the experiences from the Netherlands, Canada and the UK.

The Netherlands was the first country to adopt a collective defined contribution plan for occupational pensions. The Netherlands design attempts to challenge inequity and provides for three approaches that all provide the same employee contributions but have different annuity benefits at retirement, which are based on the amount of investment control selected by the participants.

The Canadian plan has a fixed contribution rate ranging from 5% to 9% of pay with a benefit accrual rate of 9.5% of pay after January 1, 2025 (increased from 8.5% prior to that date). While participants receive stable retirement income, benefits are not actually fixed. Of note, the Canadian members of the UAW are now covered under this pension arrangement in connection with their most recent union contracts under which they requested DB pensions.

The UK – Royal Mail pension scheme has a similar design to the prior Netherlands plan. The main features of the UK plan include fixed contributions with variable benefit payments, pooled investment management, lifetime CPI-indexed income priority (only a small lump sum at retirement), and benefit adjustments based on plan experience.

The common elements of these market-based plans in other countries include fixed contributions and variable benefits, pooled and professionally managed investments, emphasis on lifetime income payments, and a risk management benefit adjustment mechanism to reflect actual experience.

As these plan designs are considered for US plans, some considerations include the valuation frequency for the determination of individual accounts, investment control (individual vs. pooled and professionally managed), notional vs. actual accounts, and how much (and how often) the experience of the underlying assets is reflected in participant accounts. Items typically missing from US market-based plans include the ability to adjust benefits based on total plan experience, employee choice, and investment changes. Items that should be reconsidered for US market-based plans include PBGC premiums and the notions of “preservation of capital”, “definitely determinable”, “accrued benefit”, and “normal retirement age”.

Mechanics of Market Based Plans

Prior to SECURE 2.0, cash balance plans had to test benefit accrual rates under the 133-1/3% method using a 0% interest crediting rate. However, SECURE 2.0 has provided cash balance plans

with the ability to test benefit accrual rates under the 133-1/3% method using a “reasonable” interest crediting rate (but not more than 6%), which allows plan sponsors to utilize more significant age/service grading for developing benefit accrual rates. The relief under 411(d)(6) provided in Notice 2024-02 permits plan sponsors to amend plans to eliminate a minimum interest crediting rate in certain circumstances. While the current account balance cannot be reduced, plan sponsors are permitted to apply a new interest crediting rate on a prospective basis; however, these changes may only apply to those participants who are actually benefitting under the plan.

Market-based interest credits must use the rate of return earned during the interest crediting period (no lookback). The investment-based interest crediting options for market rate cash balance plans include the actual rate of return on plan assets, the actual rate of return on a subset of plan assets, or the actual rate of return on a regulated investment company (RIC). The regulations do not allow the use of a broad index, e.g., S&P 500, in place of a RIC. The pros / cons of using an asset-based vs. RIC-based interest credits and conservative / moderate / aggressive investment strategies were reviewed.

Nondiscrimination testing for market-based plans is generally performed under the General Test using the Annual Method with contributions tested as benefits. While there is a special testing safe harbor available for cash balance plans, this safe harbor is not typically used. There is no testing safe harbor available for Variable Annuity Benefit plans and the General Test is also typically used for those plans.

Employee Choice / Accounting & Funding

Some possible employee choice design features include choice of investments at hire, choice of hurdle rate at retirement, and optional forms of payment at retirement. However, employee choice features generally do not work well in DB Plans. Participant directed investments represent a departure from the fundamental nature of DB Plans, shift investment direction to participants, may result in the loss of ERISA 404(c) protection, and the investment changes may be considered interest rate cutbacks under 411(d)(6). These designs are neither explicitly permitted nor prohibited under current guidance, but Treasury will continue to study these and may conclude they are not permitted.

Other investment choice options that might be permissible include a service-based approach, different sub-accounts based on demographics, or a one-time irrevocable participant choice of asset allocation, target date fund, or target rate of return. The one-time participant choice option provides participants with a choice of investment strategy and risk/return profile but maintains professional asset management (sponsor responsibility), 404(c) protection, and eliminates the concern regarding interest rate cutbacks. One audience member indicated that they would actually prefer no choice over a one-time choice option (but a panelist suggested that might be considered an age discrimination issue if there were different allocations made for different participants).

There was a discussion of Variable Annuity Plans and specifically how the choice of a hurdle rate at retirement would apply to a Variable Annuity Benefit plan to allow for an implicit COLA election. When this choice of a hurdle rate at retirement is combined with a choice of funds with different target rates of return, sponsors may offer benefits across a range of risk profiles and target cash flows.

Offering optional forms of payment at retirement increases the flexibility for retirees to choose a payout option that aligns with their unique situations, accommodates factors such as life expectancy and legacy planning, and offers choice of predictability and security. Longevity risk may be managed by choosing market-consistent actuarial equivalence assumptions. The use of subaccounts allows assets for annuities to be invested differently than accumulating assets.

Benefit obligations for accounting purposes are typically measured under the project forward / discount back method. However, in situations where the interest crediting rate (ICR) is less than the discount rate (DR), the project / discount method may produce benefit obligations that are less than the sum of the account balances (and vice-versa). The 2024 CCA White Paper on market rate cash balance plans concluded that the current economic value of a market-return plan is the current value of the account, regardless of the market-return interest crediting basis. The paper also stated that if the accounting rules truly require a project / discount approach, then either the ICR should be set to the DR or, alternatively, the DR should be set to the ICR.

For funding calculations, a market-based plan can be fully-funded to account balances at all times but can have funding gaps under the various liability measurements, which could require accelerated contributions to meet required minimums when the ICR assumption exceeds funding interest rates, and can cause VRP requirements when the ICR assumption exceeds the PBGC interest rates (in spite these plans' low risk to the PBGC). Permitting valuation methods where funding targets for market-based plans equal account balances would alleviate the minimum funding and VRP concerns.

A Potential Market Based Cash Balance Design

A potential "straw-person" market-based cash balance design was presented.

During the accumulation phase while the participant is working, the market-based cash balance pay credit would be similar to a non-elective contribution in a DC plan that is invested in a target date fund with a one-time investment choice at hire (likely compliant today). This would reduce volatility as the target date approaches and total plan assets would be allocated to match the participant choices. This approach would minimize the balance sheet impact since the benefit liabilities are potentially aligned with the cumulative account balances and the underlying assets move directionally with the account balances, which minimizes gains/losses.

At termination or benefit commencement, perhaps only a relatively small lump sum is available while the majority of the balance is designated as lifetime income (i.e., annuity payments under various options). The majority of the balance remains in the plan and continues to grow, which will limit the impact of the preservation of capital requirement. The lifetime income options may include joint and survivor, certain and life payments (e.g., 15 years since there is no large lump sum option), and a flat COLA increase (e.g., 2% per year regardless of actual CPI). Participants could also be permitted to rollover amounts from other plans into this plan. From an asset management perspective, the underlying plan assets for the retired employees would be nearly fully hedged, mitigating post-commencement investment risk for the sponsor.

Session 604

Healthcare Trends and Forecasting in a High Inflationary Environment

Speakers:

- Katie Martin, MPA – Health Care Cost Institute
- Liz Kochneff, FCA, PhD, FSA, MAAA – Alight
- Ivy Dong, FSA, MAA – Wakely Consulting Group
- Wayne Pages, FCA, ASA, MAAA – Marsh McLennan Agency

Session Host: Piotr Krekora, FCA, ASA, MAAA – Gabriel, Roeder, Smith & Company

Overview

The healthcare industry continues to experience cost pressures in excess of general inflation. In this session, the speakers attempt to identify key drivers behind the recent trends in healthcare costs and discuss their near-term impact on consumers, insurers, and other stakeholders.

Historical view of main factors behind changes in healthcare costs

Based on commercial claims data from the Health Care Cost Institute (HCCI) covering approximately 50 million lives, per person healthcare spending grew approximately 18.7% from 2018 through 2022. In broad terms, healthcare spending is often decomposed between utilization (or use) and price. Other commonly analyzed factors are demographics and case mix. Prices have been the primary driver of the growth in gross spending, accounting for approximately 14% with the remaining 4% attributed to increased spending. Demographic distributions remained relatively stable with very little net impact on the cost changes over the study period, while case mixes had a small decreasing effect on both the utilization and the price which is reflective of a shift towards less complex and less expensive treatments and procedures. It is worth noting that while overall spending during 2020 was down from 2019, owing to a drastic decrease in utilization, total spending for 2021 and 2022 was in line with pre-pandemic trends.

While general inflation has a major impact on changes in healthcare prices, healthcare cost also affects inflation, making it difficult to isolate the role of inflation. Nevertheless, data from the Bureau of Labor Statistics (BLS), as compiled by the Kaiser Family Foundation (KFF), shows healthcare costs outpacing general inflation in most pre-pandemic years since 2000, with the price of medical care, including services provided as well as insurance, drugs, and medical equipment, increasing by 121.3% from 2000 through 2024, while prices for all consumer goods and services rose by 86.1% in the same period.

Three structural factors can explain some of the price increases: decreased competition resulting from higher market consolidation activity (the majority of providers and hospitals in a given area are associated with just one or two organizations), increased facility fees caused by shifting the site of

service from independent offices or laboratories to hospitals, and increased private equity acquisitions.

Impact of Trends on Individual Markets

The analysis of the individual health insurance market can be divided into broad categories: pre-Medicare and Medicare. While the health insurance market for Medicare-eligible individuals has been growing steadily for a few decades, the pre-Medicare counterpart exploded in 2014 when provisions of the Affordable Care Act (“ACA” or “Obamacare”) took effect. Affordability is a key government priority to combat healthcare costs in both markets.

Pre-Medicare individual insurance participation increased particularly amongst lower-income individuals and families due to substantial governmental premium subsidies as well as amongst individuals with preexisting conditions, who couldn’t get coverage prior to ACA. Enrollment increased from 8 million in 2014 to over 21 million in 2021. It is worth noting that governmental premium subsidies have the effect of insulating lower-income consumers from actual healthcare prices as they are typically driven off income rather than the prevailing cost, and are higher in more expensive areas further reducing differences in premiums actually paid between regions. This effect spilled to other income groups upon implementation of the American Rescue Plan Act in 2021 as extended by the Inflation Reduction Act.

Average total premiums had been increasing through 2019 followed by small decreases through 2022 (believed to be a combination of COVID impact and a rollback of pre-2019 overcorrections) and increased after that reaching 2019 levels for 2024. Total premiums are projected to increase a little faster for 2025 and 2026 primarily due to utilization of diabetes and obesity medications (commonly referred to as GLP-1) and hospital consolidations. Income-related premiums dropped substantially in 2021 due to increased government premiums. It was more dramatic in nominal terms for individuals with incomes at 400% of the Federal Poverty Level (FPL) who paid unsubsidized premiums in 2020 but only approximately 60% of a full premium in 2021. Lower-income individuals (represented by 250% of FPL) paid approximately 30% of premiums in 2020 dropping to 15% for 2021. Increased subsidies are scheduled to sunset after 2025 which, if it happens, will result in substantial increases in premiums actually paid by covered individuals. Furthermore, if subsidies are not extended, smaller insurers are likely to exit the market resulting in additional premium increases.

The insurance market for Medicare-eligible individuals currently covers approximately 40 million individuals nearly equally divided between Medicare Supplement (Medigap) products and Medicare Advantage Prescription Drug (MAPD) plans. Medigap plans are medical products designed to wrap around Traditional Medicare and require a separate subscription in a Medicare Part D plan (PDP). MAPD plans, on the other hand, are designed to replace the Traditional and Part D Medicare. They tend to be more managed than supplemental plans with more cost controls. Many of MAPD plans feature a \$0 premium which increases the difficulty of analyzing trends in consumer cost. For a better comparison between plans, analysis often combines

premiums with out-of-pocket expenses (OOP). Based on data from Alight's retiree exchanges, the cost for supplemental plus PDP insurance increased steadily between 2019 and 2024 at an average rate of approximately 3%. At the same time, the cost of MAPD coverage had been decreasing at an average rate of approximately 3.3% and is now less than half of the cost of a Medigap plan with PDP added. Costs for both groups are projected to increase for 2025 and 2026 but Part D changes (lowering pharmacy out-of-pocket to \$2,000) will have a dampening effect for 2025.

Value Based Care Impacts

Value-based care has been enjoying an increasing presence across all markets. Value-based payment (VBP) models garnered attention from both the government administration and private equity investors.

Centers for Medicare & Medicaid Services (CMS) as well as private investors participating in Health Care Payment Learning & Action Network (HPC LAN) have goals of moving providers towards value-based payment projects. One of the avenues is the acceleration of tying US healthcare payments to quality and value. HPC LAN data shows increasing adoption of Value-Based payment models across all lines of business, with the most success in MAPD markets. Interestingly, commercial markets are lagging behind both MAPD and Medicare fee-for-service. CMS aims to provide all Medicare and half of Medicaid coverage through Accountable Care Organizations (ACO) by 2030. They utilize two payment models: Medicare Shared Savings Program (MSSP) and ACO Realizing Equity, Access, and Community Health (ACO REACH). Both models experienced promising success and currently affect care for approximately 13.5 million beneficiaries (10.8 million through MSSP and 2.6 million through ACO REACH). CMS proposed changes to all VBP models. Changes proposed for REACH ACO will make it more difficult for these groups to reach their financial targets forcing them to look for efficiency improvements. MSSP changes, among other items, aim to soften the current benchmark design penalizing ACOs for their good past performance. The new Part D score model and MAPD star ratings are expected to increase uncertainty and increase pressure on insurers to improve efficiency.

Commercial Markets Trends

A recent study analyzed trends in cost experienced by a book of self-funded plans from January 2020 through June 2024. The medical and prescription study was based on nationwide (but dominated by East Coast clients) experience and focused on the allowed gross amounts before any rebates, stop-loss reimbursements, or cost-sharing adjustments.

The main observation is that the increases over the recent post-pandemic period were similar to historical norms. The annualized Med/Rx PMPM trend for the most recent two-and-a-half-year period averaged at 6.68% per annum, with upward pressure coming mostly from pharmacy experience, mainly diabetes and obesity (GLP-1) medications.

Going forward, gross pharmacy prices are expected to increase for 2025 by approximately 10% to 12%, accompanied by medical increases between 6% and 8%. Plan sponsors may want to look for ways to dampen those trends, for example, discourage members from overutilizing emergency rooms and monitor other high-cost utilization patterns.

A dental and vision cost study analyzed data from the West Coast area and was based on gross claim lags. Dental cost trends have been declining in the post-pandemic period but stayed positive and averaged at 1.46% per annum. At the same time, vision trends also followed a declining pattern but were lower than dental, often negative, averaging at -2.13% per annum.

Conclusions

Healthcare costs have been increasing except for a short period during the COVID-19 pandemic. Although further increases are expected, there are major efforts to control those increases, most notably by employing value-based payment models.

Session 605

Predictive Modeling, ASOPs, AI Governance – What’s an actuary to do?

Speakers:

Jim Dolstad FCA, ACA, MAAA – Optum

Kev Coleman – Paragon Health Institute

Moshe Radinsky FCA, ASA MAAA – Surest

Session Host: Shelley Zhao, FSA, MAAA – Aon

Background

In the face of rapid Artificial Intelligence (AI) adoption, its disruptive potential calls for updated professional standards, and renewed emphasis for actuaries to understand both the opportunities and risks. Speakers in the sessions represent those involved in policymaking, in technology development, as well as consumers/users of the technology. The session discussed AI use, governance, and implications for the actuarial profession.

AI in the Healthcare Industry and Actuarial Profession

Actuaries are increasingly integrating AI into their healthcare modeling work, utilizing both specialized actuarial tools and general business software. AI is leveraged for provider evaluations, consumer behavior analytics, feedback categorization, as well as automating operational tasks like real-time transcribing, coding, documenting, provider appeals. Large Language Models (LLMs) and Artificial Neural Networks (ANNs) are being used to analyze vast amounts of unstructured, non-numeric data (e.g. patient information, contract requirements, and payment records) to enhance activities like billing analysis, claims prediction, and prior authorization. These AI approaches allow actuaries to generalize statistical models beyond traditional methods and adapt their functionality to specific scenarios, a process known as localization.

Usage in clinical areas that is driving a fundamental shift from a reactive “Detect & Treat” paradigm to a proactive “Predict & Prevent” approach also has implications for actuaries. For example, with AI devices, predicting future illnesses can be based on medical imaging or genetic data well in advance than human practitioners, what are implications on trend assumption and health risk modeling?

These limited examples point to the fact that both market and professional landscapes for actuaries are poised for significant transformation due to AI. The market is already seeing the start of competitive “arms race” between Claims Analysis and Revenue Cycle Management technology. Advancing clinical predictability may not fully replace practitioners, but could disrupt the

healthcare labor market. Firms will need to invest heavily in high-quality AI talent and its data assets to keep pace. And for actuaries to stay relevant, we must develop a deep understanding of AI tools, their capabilities, and limitations.

AI Governance and Responsible Use of AI

Traditional actuarial modeling relies on well-established statistical techniques such as regression analysis, which are built on clear assumptions and transparent methodologies.

Large language models (LLMs) bring new challenges for actuaries to develop the same level of deep understanding of how the models are producing their results. LLMs may contain billions of neurons and hundreds of layers. Despite techniques such as SHAP and Layer visualization of CNN, neural networks have so far not yielded to interpretability. Their lack of traceability and explainability presents governance challenges for the profession.

In considering how ASOP 56 applies to AI and LLM, the speaker quoted a former CCA president and suggested that actuaries should consider whether AI is a tool or a model to begin with. Although this is a reasonable distinction, when a GenAI was asked to provide sources for such a distinction, the GenAI hallucinated a response, fabricating a quote in ASOP 56 on the distinction between a tool and a model.

As AI transforms actuarial work, it is crucial not to rely on an AI “black box”—doing so can lead to reputational and financial risks. Truly understanding how these models work and making the distinction that these are models and not tools will be important as actuaries navigate the integration of advanced AI technology into their workflows, ensuring that professional standards are upheld, and that modeling practices remain robust and defensible.

Disclosure of AI usage to clients is also essential. Actuaries need to understand the specifics of what has changed in AI-based workflows and be able to justify their use to clients. Assuming that responsible best practices such as AI disclosure are employed, AI use is improving outcomes and adding value for clients. As actuaries, we benefit from championing responsible use as well as properly framing the positive value of this emerging technology.

Conclusion

Responsible use of AI starts with understanding its capabilities and limitations. Actuaries must be transparent and accountable about how they use AI and data. Challenges such as bias, explainability, and potential IP infringement will persist, and actuaries should position themselves around strengths AI cannot replicate, such as domain expertise and contextual understanding. Continued improvement to understand the technology, appropriate disclosure and staying informed & proactive are key to maintaining professional relevance and integrity for actuaries.

Session 609

Pension Surplus Management – U.S. and U.K. Perspective

Speakers: Mitsuyasu Nishiwaki – WTW
Jessica Kachur – Mercer
Bryan R. Falato – GE HealthCare Technologies Inc.
Mark Daniel – WTW

Session Host: Marie Jerralyn Mendoza Khanal – WTW

Background

The session *Pension Surplus Management – U.S. and U.K. Perspective* addresses the growing importance of managing surplus assets in defined benefit (DB) pension plans as many plans reach historically high funded levels. The discussion explores strategies for surplus optimization, regulatory and tax considerations, and practical approaches in both the U.S. and U.K. contexts. The recent analysis done by GE HealthCare illustrates real-world applications of these strategies.

U.S. Perspective

Corporate DB plans in the United States achieve strong funding positions, with funded status averaging 107% as of July 2025. This improvement creates opportunities for sponsors to rethink pension strategies. Sponsors define end goals—whether maintaining, downsizing, or terminating plans—and managing size, cost, risk transfer, and investment strategies for long-term sustainability.

Surplus optimization often uses glidepath strategies that dynamically adjust investments as funded status changes.

Sponsors use surplus assets in several ways:

- Enhance participant benefits through cost-of-living adjustments or early retirement windows
- Fund future benefit accruals
- Transfer assets to retiree medical benefits
- Leverage surplus for corporate transactions such as mergers, acquisitions, and spinoffs
- Return surplus to the sponsor upon plan termination

Some actions such as returning surplus to the employer could trigger significant tax implications. However, legislative proposals under consideration aim to expand flexibility by allowing surplus transfers to a qualified replacement plan (QRP) defined contribution plans or healthcare accounts.

U.K. Perspective

DB schemes in the United Kingdom collectively hold an estimated £160 billion in surplus. Historically, surplus refunds to employers remain heavily restricted except during buyouts, limiting sponsors' ability to unlock economic value. Current uses of surplus include paying scheme expenses, offsetting DB or DC accrual costs, and granting discretionary pension increases.

Regulatory changes expected by 2027 introduce greater flexibility. These changes empower trustees to refund surplus to employers (taxed at 25%), lower the funding threshold for surplus release, and remove the 'member interest' test that previously constrained surplus use for plan sponsors. These reforms drive new behaviors among sponsors, such as agreeing surplus-sharing packages, making payments to employers, and enhancing member benefits.

Meanwhile, the risk transfer market thrives, with buyouts dominating and bulk annuity volumes approaching £50 billion annually. Longevity swaps and superfund transfers also gain traction as schemes seek to de-risk and settle obligations efficiently.

Case Study – GE HealthCare

GE HealthCare demonstrates surplus management strategies in action. In the U.S. and Puerto Rico, the company managed risk and surplus in its DB plans through plan mergers, lump sum windows, and PBGC premium adjustments, while prioritizing participant experience during terminations. In the U.K., GE HealthCare explored several options but ultimately decided to keep surplus within the plan and recently completed a buy-in transaction. These actions reflect a broader trend of sponsors using surplus to balance financial optimization, risk mitigation, and employee benefits.

Summary

Pension surplus management becomes a critical focus as DB plans achieve strong funding levels. In the U.S., sponsors explore creative ways to use surplus for benefit enhancements, risk transfer, and corporate strategies while navigating complex tax rules and potential legislative changes. In the U.K., upcoming regulatory reforms unlock surplus flexibility, enabling refunds and benefit improvements. Both markets show strong demand for risk transfer solutions, with buyouts and annuity transactions at record levels. Effective surplus management requires a holistic approach that balances financial objectives, compliance, and stakeholder interests.

Session 701

Retirement Plan Litigation

Speakers: David Godofsky FCA, FSA, EA, MAAA, JD – Alston & Bird

Robert Newman JD – Covington & Burling

Moderator: Richard Goehring FCA, FSA, EA, MAAA – Richard O. Goehring, Inc.

Session Host: John Lowell FCA, ASA, EA, MAAA – October Three

Background:

Litigation in retirement plans is rampant. The attorney-speakers, both experienced in retirement plan litigation, provide an overview of current interesting cases they are seeing while also informing the attendees of some of the legal underpinnings such as precedent and reliance.

Here are the topics the attendees learned about:

Actuarial equivalence cases.

Started in December 2018. More than 30 cases. Challenging reasonableness of actuarial assumptions in DB plans. Focus on conversion from SLA to J&S and/or early retirement factors. Focus is predominantly on “out of date” mortality tables. In the case of tabular factors, Plaintiffs say they are outdated; they must be.

Plaintiffs say assumptions must be reasonable at the time they commence their annuity. They have focused on 417(e) as a benchmark saying you have to be as detailed as month to month.

Defense side says there is a range of reasonableness. And defense says that various parts of ERISA require reasonableness, but actuarial equivalence “rules” do not.

Problems with 411(d)(6) protection every time you amend the assumptions.

Plaintiffs take the “we can use any mortality table” argument to an extreme. Mayfly versus tortoise would result in \$100 month SLA being reduced to a QJSA of a few cents.

Some judges say plans have been administered according to their terms.

Other judges have said of course the mortality table needs to be reasonable. One judge says of course actuaries know that they know what reasonable is. Waiting on decisions from 11th and 6th Circuits. If Circuit split, SCOTUS could take. Plaintiffs focus on age of the mortality table, but the real question is the result. When you combine the mortality table with the interest rate, you get a result and the real question is the result.

In Georgia case, P's expert is saying that if "your factor" produces a result that is infinitesimally less than "my factor", it's not reasonable. Say headcount weighted factors don't work. You can't use anything but SOA tables. Some cases say must use accounting mortality. Other cases say must use 417(e) mortality. Other cases say you must use August lookback. Not allowed to reflect adverse selection. Plaintiffs have been boxed in to take actuarial positions that are very tight as to what can be used. Since 2018, no judgments/decisions on any particular assumptions. All dismissals have been on more procedural issues. *Knight v IBM* has an internal statute of limitations in the plan. Court held that internal statute of limitations does hold if in effect and shorter than legal statute of limitations. But the fiduciary breach claim still has the 3-year statute under ERISA. 2nd Circuit overturned on technical grounds.

Discussion of Motion to Dismiss, and that the Court must assume that the complaint presented by the Plaintiffs is true without regard to external facts.

Annuity Purchase Cases

- Claim chosen insurer is unsafe.
- Desire to pursue a PRT transaction is not a fiduciary decision.
- Threshold issue is Article III standing.
- Plaintiffs claim that injury is "reduced value" due to lack of safety and therefore anxiety.
- Claim that annuity is less secure than the plan. PBGC more secure than State Guaranty Associations.
- Courts can only decide on controversies but cannot set policy. Cannot give advisory opinions.

In *Thole*, SCOTUS said you only have standing if you can show that there is an imminent, concrete, and particularized harm. Two District Courts have said they do have standing.

Alcoa dismissed on lack of standing. Lockheed (on same day) said close call, but Plaintiffs have alleged enough to establish standing although that might not hold up through the life of the litigation. GE dismissed for lack of standing (5% chance of bankruptcy not substantial). Bristol Myers allowed to move forward. ATT had standing, but they did not adequately allege fiduciary breach. ATI: Magistrate recommended dismissal for lack of standing.

Insurance companies are required to hold assets exceeding reserves.

Even Interpretive Bulletin 95-1 doesn't matter. "It is bunk" as it is not in the law. Multiple courts have reached that conclusion.

Supreme Court Cases plus one other interesting "non-precedential" case

Cunningham v Cornell

Case about pleading. Could a Plaintiff come in and say you hired somebody (therefore prohibited transaction)? Yes. Defense can then raise an affirmative defense. However, lawyer cannot bring a case (Rule 11) they do not believe they have. SCOTUS did not care about 408(b)(2) saying that it's ok if fees are necessary and reasonable.

Loper Bright v Raimondo

Overtaken Chevron. Courts are just as able to determine law as agencies are. So, Courts should not give deference. From a practical standpoint, many courts will follow many regulations.

Corner Post v Federal Reserve

When can you challenge a regulation? You as the taxpayer can challenge the regulation within a period of time after you, personally, have been affected. This means regulations are never beyond challenge.

McCutcheon v Colgate-Palmolive (2nd Circuit)

When you are calculating a lump sum, can you apply preretirement mortality? No in 2nd Circuit. The Court used the term "law of the case" meaning the defendant did not raise the issue early enough. So, does the case have precedent, even within the 2nd Circuit?

Multiemployer plans

In re Yellow Corp (District of Delaware)

Discussion of funding assumptions versus withdrawal liability assumptions. Funding must be individually reasonable. W/L must be reasonable in the aggregate. Only difference is usually interest rate. Q: who is to say the funding assumption is good and the W/L bad? A: no plan has ever made that claim. Court decided difference was too big, therefore the Segal Blend is not permitted.

Ace Saginaw

Actuary said W/L interest rate is not his best estimate. Said there is a 77-95% the fund will out-earn the W/L rate. Court said they cannot both be reasonable. Maintaining the health of the fund is not your job as actuary. Your job is to set your best estimate. Court said the mean is the best estimate. Speaker said, perhaps in jest, that median or mode could be better.

National Retirement Fund v Metz Culinary

Because you must set your W/L assumption as of 12/31, you must “announce” your assumption on or before 12/31. 2 Circuits said you cannot take NYE off. DC Circuit said you can.

Other interesting and noteworthy cases

Bafford v Northrop Grumman

Court said if you produce wildly inaccurate benefit statements, it's as if you have not provided them. However, were participants harmed? What do you have to show?

US v Sagoo (ND Texas)

District court holds that for certain kinds of tax penalties the taxpayer has a constitutional right to a jury trial. If it is a penalty and not a tax, you are entitled to a jury trial. It is not clear which employee benefits cases will be affected.

Houk v NCR

Top-hat case. Cannot amend plan in way that would adversely affect benefits. Court said that was adverse. After NCR terminated plan and paid out lump sums. Court would not defer to plan administrator's interpretation because the plan was unambiguous.

Summary

In summary, the speakers as much as say that retirement plan litigation is a way of life for plan sponsors, particularly sponsors of larger plans. While most cases are not litigated at trial, when plaintiffs can get past the Motion to Dismiss stage, plaintiff's attorneys succeed financially even when their clients don't see significant rewards.

Session 702

Betting on Yourself: Planning for Your Own Retirement

Speakers:

Brian Boring, FSA, EA, CERA, MBA – EY

Chris Chaplain, Retired - Social Security Administration

Craig Rosenthal, FCA, FSA, EA, MAAA – Mercer

Jake Rust, CFP®, ChFC®, CLU®, CEPA® – Hudson Oaks Wealth Management

Session Host: Keith Sartain, FCA, FSA, EA, MAAA – Railroad Retirement Board

The purpose of this session is to provide information and strategies to assist with planning for retirement, which may be your own retirement, or for family and friends who come to you with questions or for advice, assuming you know more about this topic than the average person. Many of the actuaries reviewing this session are probably familiar with some aspects of what is covered but may not have put it all together.

The session agenda:

- 1) Social Security
- 2) Medicare Overview
- 3) The Spend-Down Dilemma
- 4) Retirement Financial Planning

This session is not financial advice. Everyone has a unique financial situation, and financial advice should be unique and specific to each situation.

Social Security presented by Chris Chaplain

The Social Security program provides benefits to over 60 million individuals based on their covered earnings. FICA payroll taxes paid on these earnings support benefits for retired workers, disabled workers, their spouses, and several categories of dependent beneficiaries.

Your base benefit is called the Primary Insurance Amount (PIA) and depends on your covered earnings. These covered earnings are indexed with the SSA National Average Wage Index up to age 60 for retirement benefits. The Average Indexed Monthly Earnings (AIME) is computed using the 35 highest indexed earnings years for retirement benefits. The PIA is calculated directly from the AIME using a progressive formula with two “bend points” and may be adjusted for commencement ages other than full retirement age.

The presentation provides calculation examples for retirement and disability benefits. It also provides a general summary of benefits for other dependent beneficiaries.

An important retirement age consideration may be whether working another year improves your 35-year AIME much by replacing low / zero years used in the average and what bend point multiplier applies to that AIME increase. If the AIME is already over the second bend point (\$6,172 in 2025), then any improvement is only receiving a 15% benefit multiplier.

The panel strongly encourages you to establish an account at [my Social Security | SSA](#) to review your personalized Social Security Statement, check for any discrepancy, and explore the benefit estimates. The Login.gov security requirements may seem daunting but are necessary to protect you and are worth the effort. You may go to a local Social Security field office if you need assistance with setting up an account. Of course, please be vigilant about scams claiming to be SSA – notice in the phishing e-mail screen shot if Security is misspelled.

Medicare Overview presented by Craig Rosenthal

Medicare provides medical benefits beginning at age 65 (not increasing like the Social Security full retirement age):

- Part A – Hospital Insurance generally has no required contribution (paid with active payroll taxes) but applies a high deductible to hospital visits.
- Part B – Medical Insurance has income-related premiums: 2025 monthly amount starts at \$185.00 for income up to \$106,000 (single) / \$212,000 (joint) and increasing in steps thereafter until reaching \$628.90 with income over \$500,000 (single) / \$750,000 (joint).
 - Considers income two years prior, so it is more difficult to avoid higher premiums shortly after working years
 - Must be careful managing annual income as you approach the premium steps for each year
- Part C – Medicare Advantage replaces parts A, B, and sometimes D with a managed care plan with varying costs; more than 50% enrolled in these plans.
- Part D – Prescription Drug coverage with income-adjusted monthly premiums starting at \$0 increasing up to \$82.50 in 2025

Insurers also offer a variety of Supplemental plans with standardized designs that provide additional Part A and Part B benefits.

Generally, you will want to enroll in Medicare at age 65 unless you are working and covered by an employer's plan, in which case you may opt out to avoid paying premiums.

The Spend-Down Dilemma presented by Craig Rosenthal

You may have been saving all your life and have difficulty switching into a spending mode: risk aversion to spending dollars and to depleting savings later. Underspending may create missed opportunities to enjoy activities before physical ailments impact you later in life.

The session reviews several common barriers to retirement planning. One with which actuaries are well equipped to advise is understanding “life expectancy”:

- It’s the “average” future lifetime based on current age
- It does not decrease by 1 every year – as you live longer, your remaining life expectancy extends
- Some suggest adding 5 years for planning purposes to account for this extension and to provide a longevity buffer

Those without much guaranteed monthly income may be more susceptible to underspending – a “retirement paycheck” approach might help. What is a “safe” withdrawal rate? The widely touted “4% rule” proposes an initial withdrawal rate of 4% that increases with inflation each year may be prudent. An individual’s sequence of investment returns during retirement is important to the outcome, but funds were shown to last at least 33 years in a worst-case scenario (the original author of the 4% rule more recently suggested a rate as high as 4.7% might be appropriate).

Approaches to reduce “sequence of returns” risk:

- Bucket method – segregate funds and investments by time horizons
- Periodic rebalancing
- “Actuarial method” by Ken Steiner (link in presentation)
- Purchase an annuity

Another potential income source may be a reverse mortgage – for example, a home equity conversion mortgage (HECM) is a reverse mortgage credit line that includes some government guarantees. Using these funds strategically can mitigate sequence of return risk by accessing when you don’t want to sell other investments and for emergency expenses.

Retirement Financial Planning presented by Jake Rust

Transition to Retirement: STEP – moving into retirement is a challenge.

S: Sense of purpose – It’s important to retire into something

What do you care about? What’s important to you? What makes a difference to you?

T: Things

E: Experiences

P: People

Your earlier retirement years (age 65-75) are likely to be your “go-go” years with more spending on travel and hobbies. That activity will slow down in later years with more spending absorbed by health care costs and potentially long-term care (LTC) expenses (Northwest Mutual says 50% - 60% of retirees will need LTC). You may want to consider LTC insurance (traditional or hybrid where it’s combined with a permanent life or annuity policy) before retirement while denial rates are low and it’s less expensive.

The presentation provided some case study illustrations of the potential impact of LTC expenses on retirement savings.

It also had a Social Security case study and discussed considerations around timing for claiming:

- If you will live into early 80s, then it makes sense to defer claiming until after full retirement age.
- Your spouse may not take a spousal benefit (50% of your primary annuity) until you retire, but that spousal benefit will not increase after their full retirement age.
- When one spouse dies, the smaller of their two benefits goes away and the survivor takes whichever benefit was large; therefore, the person with the higher benefit may want to defer commencement to a later age, especially if expected to die first.
- If planning to continue working, then delay commencement to at least full retirement age to avoid earnings reductions.

The presentation covered more retirement considerations:

- When can I retire? What’s my magic number?
- Bucket method strategy / Allocation Table
- Tax-Smart Retirement Strategies, particularly the benefit of Roth conversions to lower the tax liability during retirement years
 - Consider whether moving to a state with higher / lower income tax during retirement years
- Medicare Part B premium surprises as you withdraw taxable funds, make Roth conversions, or have required minimum distributions

Estate planning should also be addressed.

There may be value in obtaining advice from a retirement planning specialist.

Session 706

Project Management Jackpot

Speakers:

Mark Thomas Stanley Anderson – Bolton Partners Inc

Christina Byrne – Wakely Consulting Group

Michael S. Clark – Gallagher

Ann Pogrebitskiy – Wakely Consulting Group

Summary Author: Michael S. Clark – Gallagher

The session started off with speakers addressing why project management matters. Consulting actuaries operate in environments defined by tight deadlines, evolving client expectations, and complex analytical workflows. Because actuaries frequently manage multiple stakeholders—clients, internal teams, and external data providers—project management becomes essential. Strong project management creates structure, improves predictability, and ensures clear accountability. Actuaries who apply project management principles can more effectively balance accuracy with efficiency, reduce fire drills, and build trust with clients by consistently meeting expectations. Additionally, project management helps prevent scope creep, aligns team members around shared objectives, and promotes better time management across competing priorities.

The panel then addressed effective project management techniques. Effective project management begins with a precise definition of project objectives, deliverables, and success criteria. Actuaries must clarify client expectations early – including assumptions, timelines, data requirements, and review points. Successful project management also requires anticipating risks such as data delays, complicated modeling updates, regulatory nuances, and shifting client priorities. Flexibility is equally important: actuarial work often evolves as new insights emerge, requiring iterative approaches. Strong project management integrates lessons learned, encourages proactive communication, and tailors processes to fit each project's complexity, team composition, and timeline.

The speakers then discussed various tools and frameworks for managing projects. Actuaries can leverage a wide range of tools depending on project type and team preference. The choice of tool should prioritize clarity, scalability, and ease of adoption rather than complexity. The panel also discussed how Excel or Google Sheets can be customized to manage tasks, deadlines, and ownership. SharePoint and Teams provide centralized locations for shared notes, file management, and version control. Outlook task lists and calendar reminders offer lightweight personal tracking solutions. For small or ad hoc projects, simple spreadsheets or even email

summaries can suffice. The key is consistency – whatever method is chosen must be used reliably by the team to maintain visibility and alignment.

The panel then talked about how communication is one of the most critical components of project management, especially for actuaries who balance technical depth with client-facing responsibilities. Clear communication helps reduce ambiguity, ensures alignment, and supports better decision-making. Documenting decisions, capturing open questions, and establishing communication norms all ensure that projects stay on track.

Project management challenges often stem from unclear priorities, shifting scope, or a lack of shared ownership. The panel then discussed common roadblocks to successful project management including overengineering processes, external dependencies (e.g. as delayed client data or unclear input from cross-functional teams), and quality issues. Addressing these risks early – through documented expectations, early sampling of data, and realistic timeline planning – helps keep projects on track. Identifying potential bottlenecks and building contingency plans also strengthens project resilience.

Another challenge that the speakers discussed centered around people issues. Actuarial teams consist of individuals with varying communication styles, work habits, and preferences. Effective project managers must adapt their approach to different personalities while maintaining consistency in expectations. Remote work adds challenges such as reduced informal interaction, limited visibility into workload, and greater reliance on written communication. Coordinating across time zones can shrink collaborative windows, requiring more foresight in planning. Intentional relationship-building – through informal calls, team lunches, or periodic in-person sessions – helps maintain trust and cohesion. Leaders who understand their team's strengths can delegate more effectively and support professional growth.

Leadership Development Forum

How to Use AI to Lead (Yourself and Others)

Speakers:

Michael S. Clark – Gallagher

R. Logan Grime – Athena Actuarial Consulting

Summary Author: Michael S. Clark – Gallagher

This interactive Leadership Development Forum explored how actuaries and other professionals can use generative AI tools such as ChatGPT, Gemini, and Grok to enhance leadership effectiveness. The session, framed around the HBR Guide to Generative AI for Managers, demonstrated practical, real-time examples of how AI can serve as both a “co-pilot” and “co-thinker” to improve personal productivity, team management, and reflective leadership practices. Attendees were encouraged to actively engage with AI tools during the presentation to experience firsthand how prompting techniques shape the quality of responses and insights generated.

The session began with a discussion of how AI can augment day-to-day tasks—summarizing complex documents, improving the clarity and tone of written communication, and assisting in time management and goal setting. One demonstration involved iteratively refining an email to a colleague who had missed a deadline. Through audience input, the presenters showed how small prompt adjustments could help navigate tone, shifting from overly formal or defensive language to something more constructive or empathetic. Participants observed how AI can help save time and reduce the stress of drafting potentially sensitive communication. The presenters emphasized that AI tools are not replacements for professional judgment but powerful aids for efficiency, clarity, and creativity when used thoughtfully.

From a leadership perspective, participants explored how AI can improve team management by supporting better meetings, more effective goal-setting, and balanced performance feedback. Examples included asking AI to generate discussion questions that foster transparency in project updates or using it to draft individualized feedback and development goals. These applications illustrated how leaders can create more meaningful engagement with their teams by using AI as a brainstorming and communication partner rather than a mechanical assistant.

The discussion also addressed how AI can support self-leadership through structured self-reflection and professional growth. Using a four-step reflection framework, attendees saw how AI can guide users through defining a context, exploring challenges, identifying lessons learned, and formulating actionable commitments. This approach helps leaders internalize experiences and convert them into intentional growth strategies—an especially valuable exercise for actuaries accustomed to analytical problem-solving but seeking to develop more reflective leadership skills.

The presenters concluded by reinforcing key cautions: avoid over-reliance on AI-generated “workslop,” maintain professional skepticism, and safeguard confidentiality when using generative tools. The overarching message was that actuaries—already skilled in logic, structure, and precision—are well positioned to use AI effectively, provided they approach it with curiosity, ethical awareness, and critical thinking. The session challenged attendees to not just use AI but to lead with it—harnessing its capabilities to elevate both individual and organizational performance.