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THE CONSULTING ACTUARY

Published by

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CCA NEWS

2015 CCA Annual Meeting Recap

The 2015 CCA Annual Meeting, held Sunday, October 25 to Wednesday, October 28 at the Hyatt Regency Coconut Point Resort and Spa in Bonita Springs, Florida, was a resounding success with over 600 actuaries and guests in attendance.

More than 50 continuing education sessions provided up-to-date information on relevant topics to help keep consulting actuaries current on issues impacting specific areas of interest to their daily work. There was a discussion session where representatives from PBGC offered insights and perspective for participant questions.

Participants enjoyed this unique opportunity to network with colleagues, exchange ideas, and catch up with long-time friends in a relaxing setting. Special networking sessions toengage participants of the CCA's Communities included Emerging Leaders, Public Plans, Healthcare and Smaller Actuarial Consulting Firms community members.

The Annual Meeting of the Conference of Consulting Actuaries is the only meeting designed to address the day-to-day issues facing consulting actuaries. You will want to mark your calendar now for October 23-26, 2016 to join us for the 2016 Annual Meeting at the JW Marriott Las Vegas Resort in Las Vegas, Nevada.

2015 CCA Annual Meeting Business Session

2015 Treasurer's Report

Edward M. Pudlowski delivered the Treasurer's Report. Mr. Pudlowski reported that the Conference of Consulting Actuaries maintains a positive financial position and that the CCA's Board of Directors voted to approve a budget based on a dues increase of $25 for 2016 to $425 per year and increase pricing on audio/webcast programs. He requested that the member present cast their vote in support of this dues increase. By an overwhelming majority (85%), the members in attendance voted to set 2016 dues at $425.

CCA Awards

Lifetime Achievement Award

Barbara Lautzenheiser is honored with the 2015 Lifetime Achievement Award. This is awarded to a volunteer for contributions made to the Conference of Consulting Actuaries, or the actuarial consulting profession in general, during his/her professional career.

2015 Lifetime Achievement Award Recipient Barbara Lautzenheiser

Barbara served six years on the CCA Board of Directors, as our liaison to the Joint Discipline Council (JDC), and as our delegate to the International Actuarial Association (IAA) for many years. Her service to CCA also includes contributions to multiple CCA committees and other liaison assignments. In addition to her CCA service, Barbara served as president of both the SoA and Academy. Barbara was a leader in a mostly male-dominated profession when she started her career and rose to many leadership positions throughout her career to date.

The award is announced at the CCA's Annual Meeting, where the recipient is given a plaque, a small gift, and waiver of registration fees for that meeting. Although nominations are accepted throughout the year,

nominations made by June 1 of each year would be considered for presentation at the upcoming Annual Meeting. Follow this link for details about the Lifetime Achievement Award or to submit a nomination.

Most Valuable Volunteer Award

2015 Most Valuable Volunteer Award Recipient Jerry Mingione Pictured with 2015 CCA President Phil Merdinger

Jerry Mingione is honored as the 2015 Most Valuable Volunteer. This is awarded to a volunteer for contributions made to the Conference of Consulting Actuaries, or the actuarial consulting profession in general, during the past 12 to 24 months.

Mr. Mingione designed the CCA's current investment policy and continues to serve the CCA through a variety of roles. He is an avid volunteer for CCA, and has served on a variety of committees and the Board of Directors. He is a highly regarded speaker at all of his CCA speaking events.

The award is announced at the CCA's Annual Meeting, where the recipient is given a plaque, a small gift, and waiver of registration fees for that meeting. Although nominations are accepted throughout the year, nominations made by June 1 of each year would be considered for presentation at the upcoming Annual Meeting. Follow this link for details about the Most Valuable Volunteer Award or to submit a nomination.

Wynn Kent Public Communication Award

Joshua Shapiro is honored with the 2015 Wynn Kent Public Communication Award. The recipient of this award can be recognized for a single event, or for a lifetime of making the public aware of the profession.

2015 Wynn Kent Public Communication Award Recipient Josh Shapiro Pictured with Actuarial Foundation Representative Carol Sears

Mr. Shapiro selection is during a tumultuous year for the multiemployer (collectively bargained/union) pension plan arena. Many of these plans are dangerously underfunded, and many participants could have lost most or all of their pension benefits had some rule changes not occurred. Mr. Shapiro was instrumental in bringing reason to this debate. He facilitated changes to the law which balances the need for reduced employer contributions with mitigating benefit reductions. He has educated regulators and others about actuarial issues throughout the process. Mr. Shapiro is a frequent speaker and educator to "John Q Public" about the need and reasoning behind these rule changes as unions address change.

In 2005, a prize was established by family and members of the CCA Board in memory of Irwin I. "Wynn" Kent (CCA President 1989-1990) and his contributions to financial risk and the profession's work product. The Wynn Kent Public Communication Award is given to members of the actuarial profession who have contributed to the public awareness of the work of the actuarial profession and the value of actuarial science in meeting the financial security of society in the fields of life, health, casualty, pensions and other related areas.

Any actuary is eligible for the Award.

Follow this link to The Actuarial Foundation website for details about how to submit a nomination for this award.

Click here to contribute to the Wynn Kent Public Communication Award through The Actuarial Foundation (select "other," and indicate "Kent Award" to designate your donation to support this Foundation initiative).

John Hanson Memorial Prize

Jonathan B. Forman and Michael J. Sabin are awarded the 2015 John Hanson Memorial Prize for their paper entitled "Tontine Pensions." CCA members may view this prize-winning paper by logging into the CCA website and viewing this web link: http://www.ccactuaries.org/Portals/0/Library/Hanson/hansonprize2015.pdf.

2015 John Hanson Memorial Prize Recipient Jon Forman Pictured with Actuarial Foundation Representative Carol Sears

The John Hanson Memorial Prize was established in honor of John Hanson, a long-time member of the Conference of Consulting Actuaries, for the best paper submitted on an employee benefits topic.

Up to three authors may be awarded with the John Hanson Memorial Prize each year. The author need not apply to be considered for the prize nor be a member of the CCA. The prize consists of a cash award, waiver to the Annual Meeting where the award is presented, and a plaque. Click here to access the submission form through The Actuarial Foundation web site.

CCA Welcomes New Directors to the Board

CCA welcomes to the Board for three-year terms new members Joan Boughton, Stephen Eisenstein and Donald Fuerst, and returning Board members Robert Reiskytl, Ellen Kleinstuber and Paul Zeisler.

Special thanks and appreciation go to retiring Board members Rebekah Bayram, Nadine Orloff, Patricia Rotello and Thomas Swain for the time and commitment they dedicated to the CCA through their Board service.

Address by Phillip A. Merdinger, CCA President 2014-2015

Good morning. I'd like to thank all of you for helping to make the Annual Meeting a success and I hope you all found our unique combination of professional development and networking opportunities to live up to your expectations. An event like this doesn't happen by itself. Lots of hard work from the CCA staff and our great volunteer base goes into the planning and execution. Thanks, Rita and the CCA staff, Pat Rotello, Justin Hornburg and the Annual Meeting Committee, and the speakers and the session assistants, for all you've done.

Our main mission at the CCA is to advance the profession for consulting actuaries of all types. We do so by providing quality learning, professional development and networking opportunities throughout the year. And we work closely with the other major professional organizations to be sure the voice and perspectives of our members are heard and that, collectively, we advance and keep our profession viable, sustainable and relevant to current and future actuaries.

One of our key goals is to make CCA membership a valuable experience for our members. 2015 has been a busy year for us and I'd like to briefly share some of our accomplishments.

- We have completely revamped our technology platform, which includes several enhancements. You'll see a new website and increased functionality, including opportunities for communities and special interest groups to interact, network and collaborate. (Coming in early 2016.)
- Our Membership Committee has invested a major effort in reaching out to members to help us keep focused on member needs and interests and how we can deliver more value. More on that in a moment. The Committee also created a communications campaign to help articulate that value.
- We expanded our Communities and special interest groups to better reflect the needs of our membership. We are exploring further expansion of additional communities and special interest groups, including multiemployer plan actuaries, based on input we received from membership. Let us know if you have ideas for other communities.
- Our Public Plans Community has continued to be an advocate and respected source of information on sound Actuarial practices in this critical area.
- We are reviewing what we deliver from a professional development standpoint and how we deliver it. This includes self-study learning opportunities and more soft skills development content aimed at consultants in the early to mid-career.
- Networking is important to all of us. Our Annual Meeting offers great networking opportunities, but we realize that not all our members can attend the meeting. We are considering other ways to create networking opportunities for members on a more local basis. Stay tuned for more information on this idea, or join a community or special interest group (SIG) to experience our new networking platform.

Volunteers are what make us successful. We have a strong volunteer base, but we want to add to it. More volunteers will help us accelerate our development of new offerings and services to help our members thrive. And it's also a great way to network and meet others, while giving back to the profession and having some fun in the process. There are a variety of ways to get involved, many of which do not require huge time commitments or travel. If I've successfully piqued your interest, please let me or any of the Board members or staff members know, and we'll get you connected to the right people.

Although we are a not-for-profit organization, we still

need to be mindful of our financial affairs. Our financial position continues to be strong, and that provides us with the privilege of investing in the future and bringing you new high touch technology, available to our communities and special interest groups.

I'd like to thank all of you for the honor and privilege of serving as the President of the CCA. It has been an exceptional experience. And, I'd like to thank the Board and staff for their support and guidance. I've worked with a group of great people and built friendships that will endure well beyond the end of my term. My goal when I accepted this opportunity was to help guide a great organization, leave it an even better place and not to mess anything up. I think we've succeeded. We have a strong leadership team, a strong and growing volunteer base, and a solid membership base. Our future looks great.

Thank you again.

Address by Donald J. Segal, CCA President 2015-2016

My fellow consultants, I am honored by being selected by you as President of the Conference of Consulting Actuaries.

I and the Board are looking forward to "Advancing the Practice." We want to hear from you as to how to make the Conference better, what we can do for you, and for the profession. How can we make our meetings, seminars, and webcasts better? We look forward to working with the various communities and interest groups. We are here to serve you.

I want to thank Phil Merdinger for the fine job he has done "fulphilling" the role of President.

Again, thank you and I look forward to the coming year serving you.

2015 CCA Annual Meeting Session Summaries

Session 104
EVALUATING PRIVATE EXCHANGE OFFERINGS

Speakers:

- Justin N. Hornburg – American Benefits Consulting
- Kyle Fabrizio – American Benefits Consulting
- David A. Osterndorf – Health Exchange Resources
- Session Assistant: Michael Helmer – Segal Consulting

The Affordable Care Act gave rise to private exchange offerings as an option for employers to purchase health insurance for their employees on the open market. The success and likelihood of survival of private exchanges into the future will depend on their ability to compete with and perform more efficiently than traditional insurance.

Ms. Fabrizio started the session explaining that private exchanges provide health insurance and other ancillary benefits. Private exchanges provide support tools to help employers and employees compare coverage and cost options to both what the employer currently offers as well as the suite of offerings in the private exchange programs. Private exchanges offer administrative services like call centers for enrollment and customer service; eligibility management and billing services; subsidy administration; vendor set-up and management, and traditional broker functions. Private exchanges also provide employee advocacy services.

When considering moving to private exchanges or continuing their current traditional health insurance offerings, employers need to fully understand their current benefit structure, offerings and costs, then perform a side-by-side comparison to what is offered in the exchange and evaluate the cost and benefit differentials. Employers also need to recognize and understand the amount of administrative burden taken off their plate by contracting with an exchange. If benefits and costs are determined to be a better value in the exchange program, employers then need to evaluate and decide whether they are willing to relinquish control along with some of the administrative burden of their benefit programs.

In addition, employers must decide to what extent and how they want to subsidize their health insurance offerings. For example, does the employer want to subsidize using a defined contribution basis, percentage of costs basis or something else?

Should an employer ultimately decide to purchase health insurance through a private exchange, then that employer must evaluate the different exchange programs available. Key criteria for evaluating exchange programs include plan design offerings, premium and whether to self-fund or fully insure. Employers need to evaluate network access and disruption versus cost issues. Employers also should evaluate technology offered by carriers to determine which technology is most compatible and appropriate with its employee population.

Three broad categories of **providers** of exchanges include consultants, carriers and technology benefit administrators.

Two categories of **exchanges** are *Guided Solution and Self-Directed Solution.*

Guided Solution provides employers with choice of standardized plans, access to a panel of carriers, robust voluntary products, end-to-end administrative services and underwriting support for contribution rate setting.

Self-Directed Solution provides maximum flexibility to customize plan designs and broker or other third party consultation to assist in customizing plan designs.

Exchange compensation comes from a combination of implementation fees, ongoing administration fees and commissions.

Mr. Osterndorf discussed factors which will determine the viability of private exchanges for years to come. The basic question is, can exchanges control spending and trend better than traditional health insurance offerings? The answer is–first year savings will most likely be experienced, but bending the trend curve remains to be seen. Several exchange sponsors, including Aon Hewitt, Towers Watson, Mercer and Xerox Buck, all report initial savings.

In order for exchanges to be successful long-term, they need to do things differently than traditional insurance. Once exchanges have grown to significant size, they need to take advantage of their size and purchasing power for buying opportunities.

Opportunities for exchanges to outperform traditional insurance are shown in four categories. The long-term success of exchanges will depend on the exchanges' ability to capitalize on these four categories of opportunities.

Point of Care reflects opportunities for exchanges to develop more efficient network structures. Currently no single carrier offers best discounts and formularies everywhere. Exchanges have an opportunity to develop high performance networks throughout the country based on quality and lower cost.

Employee "Buy Down" reflects opportunities for exchanges to offer employers and their employees less expensive coverage

through more restrictive networks. Note: if an employer keeps a portion or all of the savings, then employee Buy Down becomes cost shifting.

Reduce Insurer Cost reflects opportunities for exchanges to reduce administrative and overhead costs. Reduced administration allows underwriters more flexibility to be more aggressive with their rate-setting. Exchanges need to identify areas that traditional carriers have overlooked as opportunities to reduce administration costs.

Better Health reflects opportunities for exchanges to invest in programs to instill better health of its participants. Exchanges need to recognize that although their renewals are set annually and their customers can therefore leave them annually, their customers will likely remain with the program long enough, generally three to five years, to experience better health and reflective lower costs to avail. Chronic condition management is paramount. For example, diabetic patients cost between $3,500 and $40,000 per year (average $20,000 per year). Reducing the cost of some of the $40,000 cases will have a significant impact on overall costs. In addition, exchanges have an opportunity to advocate on behalf of their participants to direct their participants to providers who have shown to be best-in-class.

As consulting actuaries, we need to understand our clients' risk factors prior to and during exchange contracting. We need to correlate changes in costs to strategies implemented. We need to help our clients understand that wellness is a long term investment. We need to help our clients understand shared savings opportunities.

Exchange pricing is going to be difficult until more experience is gathered. What types of risk should an exchange expect, what assumptions should be used, what profit is expected are all questions that will not be known until more experience is available.

To recap, exchanges will succeed long term only if they are shown to continuously improve financial terms with providers, provide participants greater choice, reduce administrative costs and better manage their markets and systems.

Question – How can employers hold exchanges accountable?

Answer – Try to negotiate performance guarantees that may include shared savings. Try to structure agreement such that exchange program has "skin in the game."

Question – How can exchanges' wellness programs outperform traditional insurance?

Answer – Exchanges will need to devote larger resources and anticipate that their customers will remain contracted with them at least three to five years. This amount of time and loyalty should be long enough to witness rewards from wellness investments. If an exchange program is working well then an employer will stay with the exchange program.

Question – What is the initial conversation when an employer is deciding to go to an exchange?

Answer – Conversations need to be frank and loss of control is a given. The Employer needs to first identify what it hopes to achieve by contracting with a private exchange program.

Session 106
EVALUATING AND MITIGATING PENSION RISK AROUND THE WORLD

Speakers:

- Doug Carey – Retired
- Brad Howard – Ernst &Young
- Chantal Bray – HSBC
- Session Assistant: Vinaya Sharma – Quantitative Risk Management

There have been many recent derisking actions taken by major plan sponsors over the last five years. Very large plans from notable firms in the U.K. and U.S. – such as British Airways, Verizon, General Motors, Boeing, BT – provide evidence that derisking is a significant topic at corporations everywhere. The market trend is such that the U.S. target for pension risk transfer in 2015 is $15 billion and possibly $20 billion in 2016. There is strong growth and backlog in the U.S. Meanwhile, a more mature U.K. market is further ahead in its derisking evolution.

Corporations see this as an ideal time to act since the cost of funds for borrowing is relatively cheap, legislation and accounting changes encourage a derisking strategy, peer pressure exists to keep up with other organizations taking derisking actions, there is concern about increased longevity, and general pension fatigue associated with having to deal with the pension spectra on financial results has set in. Be it through better funding, voluntary lump sum programs, liability driven investing (LDI) or pension risk transfer; derisking will continue to be a focus in the boardroom.

The true cost of pension obligations extends beyond the traditional benefit obligation. Many hidden costs, fees, asset uncertainty, and increased longevity add to the holistic view that pension costs are more than a current period obligation. Traditionally, pension risk transfer premiums are around 10-15% of economic liability for purchasing a group annuity. However, given the market environment and complexity of plans, that rule of thumb is not hard and fast.

Demographics in Europe highlight the growing concerns with pension risk. By some estimates, male life expectancy at birth may increase 7.9 years for males, and 6.5 years for females by 2060 compared to 2010. Increased longevity plus a larger number of baby boomers retiring translate into larger pension obligations and an impetus for risk transfer. The low interest rate environment also impacts the funding of pensions. Depending on the structure of the underlying investment portfolio and equity performance, the funding ratio may indicate that a glide path to transfer is a strategy on the table.

The regulatory framework in Europe could have had substantial implications too. If pensions had been forced to follow the Solvency II directive, one estimate had plan sponsors contributing about $1 trillion in funding. The Institutions for Occupations Retirement Provision (IORP) regulation instead helps remove barriers for cross border IORPs, contributes to good governance, and provides important information to members and supervisors. In general, regulatory changes may have accelerated the derisking conversation as plans moved away from equities into higher allocations of fixed income securities.

At HSBC* there are approximately 200 plans in 73 countries under review. Ninety plans are Defined Benefit (DB). The top six DB plans account for approximately 91% of liability. The plans have approximately 266,000 active members, and $42 billion in liabilities supported by $45 billion in assets. A staff of six support pension risk management at the group level. They are responsible for approximately 1% of the total company balance sheet. Pension risk is the sixth largest company risk and has 4% of the company group allocated capital. The expectation is that this capital allocation should help drive decision making about pensions at HSBC in the future.

Pension risks come from many areas, including: high level company objectives, members, regulations, and economic environment. The Risk Management Framework supporting plans subject to these pension risk forces must include a strong risk management culture, a coordinated global pension risk team, a focus on the most material plans, and communication of key information among pension staff globally.

The Risk Management Framework has five major guiding principles: honor commitments, be efficient with capital, diversify risk away from the sponsor, communicate with plan participants, and implement strong governance. To achieve these principles, HSBC has instituted a classic "three lines of defense" technique to risk management: risk origination and control, risk oversight and policy governance, and internal audit.

The Risk Management Framework also contains key high level policy documents for DB and DC (defined contribution) plans that set out minimum requirements for all plans. Given the variety of plan benefits, countries, and plan types, creating these documents is no easy task. HSBC maintains a monthly risk management heat map of top global, regional and local risks with red, yellow or green status indicators.

HSBC's risk appetite statement contemplates both DB and DC plans. HSBC's DC metric currently measures performance of the majority fund compared to an external benchmark. It seems that DC risk quantified against an external benchmark highlights a key financial risk, though the company seems to also be concerned about reputational risk tied to whether employees understand the funds in which they invest. For DB plans, the economic capital and value at risk metrics are among the metrics used.

The governance portion of the Risk Management Framework includes a Global Pension Governance Committee, which leads into the Risk Executive Committee, HR Executive Committee, and Finance Executive Committee. The three functions come together to agree on a united message and strategy for pensions. Supporting the global pension governance committee includes a model oversight committee.

The U.K. is usually considered the most advanced country in pension derisking. For example, the U.K. Pensions Regulator has issued 31 DC quality features (many tied to data quality and governance) with which Trustees need to consider and comply. Recently, new legislation allowed individuals more access to their DC funds (no longer required to use all funds to purchase an annuity). This will provide more opportunities for DB plans to reduce their liabilities. The potential downside is that there could be a pension savings shortfall if insufficient contributions are made.

In Hong Kong, there is no longevity risk in the end of service gratuity plan, but a low IAS19 rate for liability discounting (approximately 1.2%) causes problems in a market where little hedging or derisking occurs.

In Switzerland, there is a mandatory cash balance market with minimum contributions. Interestingly, if the funded status dips, accrued balances could theoretically be reduced.

A couple of interesting conversations at the end focused on communication. Who should take a lead role to make sure the employees understand the plans and associated risks, the employer or the regulator? Employers may consider customizing (segmenting) retirement communication based on an individual's situation. Finally, what kind of strategy or discussion takes places when certain funding targets are met? Generally these would translate into higher derisking activity. This may lead to more asset allocation into bonds and away from equity. At the very least, it prompts a conversation.

** HSBC Holdings plc is a British multinational banking and financial services company.*

Session 107
LEGAL AND LEGISLATIVE UPDATE FOR PUBLIC PENSION PLANS

Speakers:

- Paul Angelo – Segal Consulting
- David Levine, Esq. – Groom Law Group
- Caleb Durling, Esq. – RBF Law
- Session Assistant: Deborah Brigham – Segal Consulting

Overview

The presenters discuss the latest legal topics for public plans, including both recent litigation and emerging legislative actions. Topics include plan design and plan funding issues.

Basis for Litigation

When the U.S. Constitution was written in 1787, it included a Contract Clause prohibiting states from enacting any law retroactively impairing contract rights. This used to be a "quiet" provision, but it is now a primary focus for pension litigation.

When they were created, pensions were gratuities, which could be taken back, rather than entitlements. Nowadays, courts are deciding whether they are contracts between the employer and employee.

The Supreme Court has outlined a three-part test for contract cases:

- Is there a contract?
- Is impairment substantial?
- Is the impairment reasonable and necessary to serve a public purpose?

COLAs and Other Plan Changes: Legal or Not?

There are numerous cases around the country where cost-of-living adjustments (COLAs) and/or other benefits for state or city pension plans have been changed.

In Minnesota, South Dakota and Maine, COLAs were reduced for all participants (including retirees), and the District courts found that there was no contractual requirement to provide specific COLA amounts. Similarly, Colorado reduced their COLAs for everyone and New Mexico reduced the COLA for educational retirees, and the State Supreme Courts upheld the changes. The State of Washington froze their COLA altogether at 2010 levels, and again the Washington Supreme Court found that the change did not impair contract rights.

In New Hampshire, legislation was passed that limited "earnable compensation" and changed the variable COLA to a fixed COLA. The New Hampshire Supreme Court held that benefits for vested employees can be changed prospectively, and there is no obligation to provide a COLA. Legislation in Rhode Island froze COLAs and increased the retirement age, and the parties reached a settlement after the court put the burden on the state to prove that the legislation was constitutional.

New Jersey legislation changed prospective accruals and required increased contributions for health benefits. The state court ruled that the statute did not unconstitutionally impair contracts. In a separate case, the Supreme Court held that the state of New Jersey could not be compelled to fund pension contributions at a certain level in the future.

Cases have been filed on pension issues on the city level as well as the state level. St. Louis froze accruals under the old system and instituted a new Firefighter Retirement Plan. In this case, the court found that the City has the right to amend or repeal the system, and that the contract was not impaired. Baltimore replaced their "variable benefit" plan with a tiered COLA, and the U.S. Fourth Circuit Court of Appeals ruled that this was allowable, and there was no violation of the Contract Clause.

All of the cases previously mentioned had rulings in support of the benefit changes. However, there have been a number of judgments on the other side as well. Arizona has specific protection for public retirement benefits, and the court ruled that a reduction in the COLA for judges violated the constitution. In Montana, the trial court found that retirees had a contractual right to the COLA formula, and that there was substantial impairment. (This case is on appeal to the Montana Supreme Court, at the time of the October 2015 Annual CCA Meeting.) The Oregon Supreme Court held that reductions in COLA can only be applied to future service, and therefore do not apply to retirees nor to the accrued service of active employees.

Illinois passed legislation reducing COLAs, putting a cap on permissible salary, and changing normal retirement. But the state constitution clause is absolute and without exception, and the Illinois Supreme Court held the pension changes unconstitutional.

In summary, most courts have upheld COLA changes, including for retirees. Those that have not generally have additional pension provisions in their constitutions.

What about Increases in Employee Contributions?

There are also court findings related to changes in employee contributions for public sector benefits. In New Hampshire, employee contributions were increased, and the trial court held that the increase was an unconstitutional impairment for members with at least 10 years of service. However, the decision was reversed on appeal.

Legislation in Wisconsin prohibited employers from paying the employee share of the pension contribution (i.e., "pick-up" contributions). The Wisconsin Supreme Court upheld the legislature, ruling that since the City of Madison was not contractually obligated to pay the employee contributions, there was no violation of the state contract clause.

In 2012, Michigan legislation increased pension and retiree health contributions, and lowered the benefits for those who did not pay

the higher rates. The Court of Claims held that pension benefits are protected only to the extent that they are for past service and they are vested.

Employer Disaffiliation or Withdrawal

Employer terminations are becoming an increasing issue as employers are dealing with increased contributions and GASB (Governmental Accounting Standards Board) requirements. Every state has its own statutory system, but the default is that an employer cannot withdraw unless there is a means provided to do so, and the employer complies with it. Frequent steps include: (1) a vote of membership, (2) application to and approval by the system, (3) accounting and payment of withdrawal liability, and (4) disposition of vested or non-vested active employees.

Employer disaffiliations in the public sector are similar to employer withdrawals in multiemployer ERISA (Employee Retirement Income Security Act) plans. There is a major role for actuaries in valuing liabilities, but there are no prescribed assumptions, and those used can vary widely. Disputes are mostly handled through negotiations, but we are starting to see litigation. In one such case, in Colorado, a municipal hospital attempted to remove all employees from the retirement system without following procedures and without paying off the liabilities. The court found the hospital did withdraw, and the parties settled for $190 million.

In a related issue, there has been litigation over deliberate privatization to avoid contributions. The City of Houston attempted to privatize the convention workers by several different methods, but the retirement system insisted that the employees remained part of the system. The Texas Supreme Court agreed, ruling that the system's findings are binding and related to fiduciary duty.

Municipal Bankruptcy

Municipal bankruptcies are in the news less often now, but issues still remain. Puerto Rico is a potential bankruptcy on the horizon.

The "old questions" still remain when facing municipal bankruptcy: When can the pension obligation be impaired? What if COLA changes jump to benefit changes for benefits already accrued? (This would be evolution in a direction we don't like.) When can a participating employer withdraw, and what is the cost of withdrawal? What is a governmental entity? What should the assumed rate of return be?

IRS Determination Letters

The IRS has decided not to provide determination letters for ongoing plans in the future; letters will be given only at initial qualification, termination, or in other special circumstances. The last Cycle E ends January 31, 2016, so if there are any changes desired by a public sector plan that the governmental entity wants blessed by the IRS, they should be submitted by the rapidly-approaching deadline. The number of employees at the IRS has declined, and in the resulting reorganization it is unclear who will deal with legal and actuarial issues related to plan provisions in the future.

Governmental plan sponsors cannot rely on a favorable determination letter for whether contributions made to the plan are the employer's "pick-up contributions." (To be "pick-up contributions," the employer must make the contributions but designate them as employee contributions, and employees must not have the option to receive the contributions directly instead of having their employer pay these to the plan.) Sponsors may apply for a private letter ruling. It appears that "vanilla" rulings are being issued, but we are still in a holding pattern when contribution levels differ. Plans are either waiting, working within existing rulings, or moving forward without rulings. In the latter cases, attorneys really should be consulted. It is unknown if we will ever see IRS guidance.

Although the determination letter program is ending, it is expected that there will be an increase in public sector plan audits. Plan should be prepared for compliance checks, document requests, as well as on-site examinations with agents.

Definition of "Governmental Plan"

In November 2011, the Department of the Treasury and the IRS released an Advance Notice of Proposed Rulemaking (ANPRM) announcing their intention to issue regulations defining the term "governmental plan" under Internal Revenue Code (IRC) Section 414(d). The ANPRM included a draft proposed rule and invited public comment. In addition to receiving written comments, the IRS held public hearings.

To date, there have been no final regulations issued. However, Notice 2015-7 was released in January 2015 and addresses whether the inclusion of charter school employees would jeopardize governmental status, and provides a five-part test for a public charter school.

Session 202
MPRA PART II: PBGC AND REMEDIATION

Speakers:

- Eli Greenblum – Segal Consulting
- Leon F. (Rocky) Joyner – Segal Consulting
- Michael J. Noble – Cheiron, Inc.
- Session Assistant: Eli Greenblum – Segal Consulting

The Multiemployer Pension Reform Act of 2014 (MPRA) provides new tools for deeply troubled pension funds, referred to as "remediation" in industry proposals that led to the new legislation. Speakers at this session provide a detailed review of these tools. Panelists also cover the Pension Benefit Guaranty Corporation (PBGC) aspects of the law, including changes to premiums, partition rules, and plan mergers. Proposed regulations have been issued by both Treasury and PBGC; though those are not the subject of the session (nor reviewed in detail), certain aspects are relevant to the discussion.

After providing a brief summary of the pre-MPRA PBGC landscape, and the doubling of PBGC premiums, the speakers cover the definition of the new "critical and declining" status provision of the new law, which involves an actuarial "zone" certification and participant notification. Most importantly, that status (dubbed by the speakers as the "maroon" zone) is the "gateway" to potential benefit suspensions that Trustees may seek via a long and difficult process. Suspensions are a new term describing a temporary or permanent reduction in accrued benefits, including those already in pay status.

The goal of a benefit suspension is to change the course of a plan that has taken "all reasonable measures" under current law but is unable to avoid projected insolvency to one that is not projected to become insolvent – those are findings that the actuary will have to formally certify. Challenging actuarial issues involved include actuarial assumptions (that may need to be revisited for this purpose), use of stochastic versus deterministic modeling approaches, and potential margins for adverse experience.

The statute contains a long list of "reasonable measures" that the plan sponsor (Trustees) is permitted to consider, as well as a long list of factors (such as age, history of prior reductions, extent of subsidies) that they may take into account in order to achieve "equitable distribution" of the suspension. Both sets of items constitute a permissive list – they are not mandatory. Significantly, suspensions may not be applied to older (age 80+ are off limits, and there is phase-in protection between ages 75-80) or disabled participants, and the effect of the suspension may not reduce benefits below 110% of any individual's PBGC-guaranteed benefit. A suspension might also be paired with the new definition of "Partition" and if so, the timing must be coordinated.

Actuaries will need to work closely with the sponsor to identify potential bases for allocating the suspensions, and provide carefully constructed modeling approaches that will demonstrate the avoidance of insolvency. Data to determine the individual's PBGC guarantee may need to be developed, as unlike in a single-employer context, that level is a function of the participants service and benefit accrual. For instance, it is not common to have service information readily available for pay status participants.

All of these aspects are subject to agency review – according to the statute, Treasury has responsibility for the approval process, but it is clear that they will consult with the U.S. Department of Labor (DOL) and PBGC–and the speakers caution that applicants can expect very careful scrutiny. One very large plan has submitted an application thus far, and it was recently posted on the Treasury website and in the Federal Register, along with a request for comments. Coincident with the application, the trustees must also distribute individual participant notices that contain an estimate of the effect of the suspension on their benefit, as well as information about participants' rights, and a review of the factors that were considered in the design. Employers and unions that sponsor the plan also get notices.

After a 225-day review period for the federal agencies, and assuming approval is given to proceed, the next stage is the participant ratification process. A voting process to be overseen by Treasury must be commenced within 30 days of approval, and a majority of ALL participants must vote "no" to reject the suspension. However, a "systemically important plan" may be directed to proceed by Treasury in spite of a "no" vote result. This is a plan for which PBGC projects that financial assistance would exceed $1 billion in the absence of the suspension. The speakers covered the details of that consideration. The required content of the ballot and the potential for judicial review are also factors that have to be considered.

Examples of permitted cuts were also reviewed, illustrating these rules. Finally, the rules for the appointment and duties of a "retiree representative" in certain situations are important to the process, as are the rules for potential benefit increases following a suspension.

The next section of the session describes the PBGC-directed aspects of MPRA. First the speakers describe the new Partition rules, which involve the segmentation of a critical and declining status plan into a portion that will be taken over by the PBGC (expected to start with no assets), as well as an ongoing portion. The latter portion constitutes a plan that is projected to avoid insolvency, usually by means of maximum suspensions to the 110% of guarantee level. Prior to MPRA, a partition may be ordered or approved by PBGC but only three partitions were ever granted in the 25-year history of the multiemployer PBGC program. PBGC appears to have total discretion whether or not to approve a MPRA-

based partition, and it is not clear that they have funds to do much here, given a constraint that they may not "impair" the agency's ability to meet its other obligations.

Finally, new rules on merger facilitation by PBGC are reviewed, including situations where PBGC might provide financial assistance, with the similar constraints to those that exist for partitions – the speakers do not expect that there would be much capacity at PBGC to save many plans with that approach, and also discuss the motivation of plan sponsors to embark on that approach.

Session 203
FINANCIAL WELLNESS

Speakers:

- Robert J. Reiskytl – Aon Hewitt
- Lori Block – Buck Consultants
- Robert K. Beideman – Southern Company
- Jeffrey K. Crowell – Merrill Lynch
- Jason Podvin – Eastman Chemical Company
- Mark E. Smrecek – Towers Watson
- Session Assistant: Andrew Marcus – Fidelity Investments

Financial Wellness has become an increasingly hot topic among retirement plan sponsors. This session explores the concept of Financial Wellness and provides justification for why consultants should be discussing this with clients and why clients should be interested. This session includes two case studies showing specific actions two companies undertook to address Financial Wellness for their employees. Rob Reiskytl acted as moderator, with Andrew Marcus as Session Assistant.

Definitions, Prevalence, Business Case

Lori Block opened by providing an overview of her professional biography and continued by describing her interests on a personal level. She touched on some of her likes and hobbies as well as some aspects of her personal financial life. The key point is that she is more than what she does for a living. People are multifaceted, have many competing interests, needs, and wants, and many important factors in their lives. Similarly, all of a company's employees are more than their production, output, and benefits package utilization. If we, as consultants, want to help our clients' employees get the most out of the benefits programs offered, we should be helping them look at their employees as a whole by considering the total individual.

Ms. Block outlined three historical phases of company-provided employee benefits. The first phase, which Ms. Block called "Benefits 1.0," focused on providing benefits when employees needed them and not thinking about them much until then. For example, pension plans and medical plans only pay benefits upon employee action such as retirement or medical need. Employees may not realize the value of these benefits until they receive them.

The second phase, referred to as "Total Compensation 1.0," derived from escalating benefit costs, particularly those of health care and the introduction of defined contribution plans, which allowed for easy understanding of the company dollars allocated to retirement benefits. Companies looked to provide employees with a full picture of the total dollars allotted to their compensation package, including salary, bonus, retirement, healthcare, etc. The message to employees was, "look how much the company is providing as total compensation, while you are only spending this much!"

We are now entering into phase three by focusing on total wellness.

Surveys from many organizations agree that employees are stressed about several things: personal debt, work, family, health. They bring their financial worries to the workplace. According to a 2013 PricewaterhouseCoopers survey, 80% of workers report spending 12-20 hours of work time per month dealing with personal financial issues! Many employees are living paycheck-to-paycheck and have no emergency savings. Employees' effective take-home pay has been declining for the last five years as wages have increased 1.25% since 2010 while medical costs have increased 9%. Note that these financial issues are impacting employees at all income levels.

Like it or not, employee stresses are impacting employers. Stressed people have a significant impact on healthcare costs because they tend to be sicker, with generally more instances of depression, and tend to present a larger risk for heart attacks. Employers have an influence on all the areas of an employee's life: physical, professional, financial, social, community. It has been shown that companies with healthier employees tend to perform significantly better in the market. Healthier employees are less likely to miss work, seek out a new employer, or file medical claims. These are all areas that directly affect companies in terms of real dollars.

By focusing on employees as whole individuals, companies

can create healthier workforces, better program utilization, and improved company performance. So how can this be accomplished?

The second half of the Financial Wellness session included representatives from two companies and their consultants. Each discussed the approach to implementing Financial Wellness programs.

Case Study: Southern Company

First was Bob Beideman from Southern Company, a utility company with 25,000 active employees and relatively strong retirement programs. Mr. Beideman explained that despite the rich benefits, Southern Company was concerned that they weren't communicating the value of the benefits to employees and that employees were not in tune with the great programs they had to offer. Recent focus had been on educating employees and empowering them to maximize their retirement benefits.

Now, they are focusing on the total well-being of their employees, including physical, emotional, and financial wellness. Southern Company worked with Jeffrey Crowell from Merrill Lynch to help set the company's goals and action plan. Mr. Crowell discussed employee wellness in terms of financial priorities, which have historically been viewed in a binary fashion: pre-retirement asset accumulation and post-retirement asset spending. The modern view of life priorities focuses more on overall wellness. These include family, health, leisure, home, work, and giving. Connecting all of these is the main priority of financial wellness.

Southern Company and Merrill Lynch launched "Financial Life Manager" to tie together all of the priorities and company goals. The process was to Assess the employees' current situation, Act to educate and help form plans, and then Track progress to keep momentum.

First, they had employees fill out a self-assessment that utilized personal data for very targeted and meaningful questions. This helped collect each employee's "financial wellness score," which was likened to a Body Mass Index in the medical world. This allowed for the design of specific communications that targeted certain trouble areas for many participants. Southern Company rolled out Merrill Lynch's Financial Life Manager application which utilizes videos, interactive tools, and articles, and rewards participants for their actions in the form of points and "merit" badges.

Case Study: Eastman Chemical

Next Jason Podvin from Eastman Chemical Company discussed their Financial Wellness initiatives. Mr. Podvin commented that there is no silver bullet in Financial Wellness; it needs to be carefully matched to the culture of each company. Eastman Chemical has 15,000 employees of which 60% are hourly operators with limited access computers, and 40% are highly skilled engineers and scientists. Eastman Chemical wants to ensure that their employees are prepared for retirement, which they believe will help attract high quality talent and make workers more engaged, productive, and healthy.

To implement their strategy, Eastman Chemical started with employee focus groups. One of the takeaways was that retirement seemed like an abstract concept to some employees. Furthermore, the one-size-fits-all communication strategies were viewed as irrelevant. Employees wanted targeted communications. Eastman Chemical also recognized that auto-enrollment and auto-escalation programs are vital; they have only a 10% opt out rate.

Mr. Podvin worked with Mark Smrecek of Towers Watson to implement "myFiTAge," (Financial Independence Target Age), to incorporate health and wellness into planning for retirement, increase participant engagement, and empower employees to make positive choices. Employees are able to use the user-friendly online portal to increase awareness of benefits, model what-if scenarios to see the impact on their FiT Age, and connect to resources on-demand. The tool received a very positive response from Eastman Chemical employees during a test pilot, and is now being rolled out more generally.

Conclusion

Ms. Block concluded the session by discussing the future of employee benefit programs. We are now entering into a third phase of employee benefit programs that are being designed to support "Total Wellbeing" from the end-user's perspective, by helping them improve their financial health today. Defined benefit retirement plans are generally declining in prevalence, but will their replacement, defined contribution plans, provide enough for employees to retire? Loyalty between employers and employee is not the same as it used to be. How should companies try to recruit, attract, and retain employees? By focusing on the total individual and engaging the end-user.

Session 205
CUTTING EDGE HEALTHCARE DELIVERY

Speakers:

- Trevis Parson – Towers Watson
- Jane Jensen – Towers Watson
- Allison Robbins – Imagine Health
- Session Assistant: Derek Ray – Towers Watson

"What do you call the person who graduated last in their class in medical school? Doctor." This phrase kicks off this session and underscores the tremendous variance of health care quality in an industry that continues to see soaring costs, where the costs are not necessarily correlated with the quality of services being rendered. The session discusses the drivers of the cost and quality disparity, the misaligned incentives in place today and the solutions employer groups are considering.

Ms. Jensen highlights a few of the key drivers of health care cost and quality variance, primarily: location, fragmented delivery of care, consumer behaviors driven by employer industry and suboptimal use of available technology, among other drivers. Additionally, too few health care providers have financial incentives that promote an efficient use of resources, as doctors typically get paid more (and financially rewarded) for each service rendered. These drivers create an opportunity to deliver health care using different mechanisms to obtain lower costs.

Some of the core fundamental changes that will be required to successfully change the health care delivery landscape are: customers pay for value instead of volume, integrated care instead of fragmented care, coordinated patient management instead of episodic treatment, and risk to be shared by providers instead of the payers unilaterally at risk. Though many large employer groups have a national footprint with employees spread throughout the country, health care delivery typically has a local or regional landscape, so customers are beginning to realize that a solution that succeeds in one region may not succeed in another.

High-performance networks are beginning to gain momentum among customers, but it is important to realize these can be defined several ways. When something is continually developing, there is a tendency to call them all the same, but high performance networks can take many shapes.

Narrow networks are, by definition, smaller versions of broad PPO networks but can have different variations in cost and quality. Accountable Care Organizations (ACOs) typically have bi-directional data feeds with health insurers to create a more comprehensive continuum of health care. One goal is to minimize unnecessary services, such as emergency room visits, where currently the ER doctor may have incomplete information on how to best render care and what tests have recently been performed on the patient. Custom tier networks, in general, can have various makeups of health care cost and quality, so it becomes important for the consultant and customer to carefully evaluate their options, both locally and nationally.

Ms. Robbins continued the session describing how the utility of the health care system is approaching its limit and we need new solutions that address the core problems that were previously identified. Hospitals have realized that members and patients love "being treated well" when arriving for a surgery, as they see grand pianos in the lobby and enjoy valet parking as perceived perks, yet most patients have no idea how their hospital or doctor rank in terms of quality, and this mentality must change to achieve results and savings for the entire system.

In the simplest sense, an ACO in a local market can be created starting with three steps (and refinement thereafter): 1) identify the top quartile (or defined percentage) of hospitals using national standards of quality, 2) find the physicians associated with these hospitals, and 3) of those physicians, identify the most efficient in terms of cost and ensuing referrals.

With this ACO creation in mind, the question is raised about how to treat towns that only have one hospital that may not be meeting cost and quality standards. It is at this point that the customer and consultants must decide whether to set higher standards for the local hospital or send the members to another geographic area with better metrics, as new hospitals would be more than willing to accept new patients to increase their overall revenue. Often, the poorly performing hospitals know they don't meet certain quality standards, but have no financial incentive to change their protocols unless they are at risk for losing patients, and money.

As the health care landscape continues to evolve, the innovation among hospitals, physicians and health plans will create a "survival of the fittest" environment and customers will need to review multiple criteria that are statistically significant to achieve their desired outcome of higher quality with lower cost. And the movement will require continual evaluation of the system as new payment reform milestones are met.

Session 303
FIDUCIARY RESPONSIBILITY – DEALING WITH THE "3'S": 3(16), 3(21), AND 3(38)

Speakers:

- Kathleen Lamb – Mercer
- William L. Belanger – Towers Watson
- Laura S. Rosenberg – Fiduciary Counselors
- Session Assistant: Michael S. Clark – P-Solve

Background

A fiduciary for an employee benefit plan is defined as a person who: exercises any discretionary authority or control respecting plan management, manages or disposes of plan assets, renders or has any authority or responsibility to render investment advice for a fee regarding plan assets, or has discretionary authority or responsibility regarding plan administration.

The majority of the terms mentioned in the fiduciary statutes are not explicitly defined. For fiduciaries to truly understand their roles and responsibilities there is a large reliance on case law. Mr. Belanger stressed what he refers to as the "duck rule," which is that if you walk and talk like a duck, you are a duck. Persons involved with employee benefit plans who walk and talk like a fiduciary are more than likely a fiduciary (whether explicitly named or not).

Even with the "duck rule," ERISA (Employee Retirement Income Security Act) doesn't leave fiduciary status entirely up to chance. The statutes do identify certain parties and roles as fiduciary in nature. Examples include the plan administrator (ERISA 3(16)(A)), investment advisers (3(21)(A)(ii)), investment managers (3(38)), named fiduciaries (402(a)), and trustees (403(a)). These parties are fiduciaries because their functions satisfy one or more of the elements in the definition of a fiduciary and are usually engaged to specifically function as fiduciaries within their delegated scope of duties.

Duties of Fiduciaries

Anyone acting as a fiduciary has certain duties by which they are judged (especially as it relates to situations where they are parties to litigation):

Exclusive purpose – acting for the exclusive purpose of providing benefits and defraying reasonable expenses of plan administration.

Prudence – acting with care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like alms. Prudence includes the responsibility to monitor fiduciary actions, decisions, appointments, and delegations. This generally starts at the plan sponsor level unless delegated. A plan sponsor can't ever be fully absolved of their fiduciary duties since they will always have the duty to monitor.

Diversification – diversifying plan investments to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

Abide by plan documentation – act in accordance with the "documents and instruments" governing the plan as long as they are consistent with ERISA. This means more than just the official plan document but includes summary plan descriptions and investment policy statements. Fiduciaries also have a duty to periodically review these downstream documents.

While these duties form the basis for fiduciary evaluation, courts have generally evaluated a fiduciary's performance based on their process for adhering to their duties rather than the outcomes of their decisions.

So who isn't a fiduciary? Generally those individuals that act in settlor functions or ministerial functions with respect to a plan are not fiduciaries (although they may also have certain fiduciary roles as well). Settlor functions include items related to deciding on plan design and plan design changes. Ministerial functions are those day-to-day tasks such as calculating benefits, preparing government filings, preparing communications, and making recommendations to decision makers. Actuaries are generally considered to act in ministerial functions.

Plan Administrators

Plan administrators are always fiduciaries and are almost always internal to the plan sponsor's organization. They are the primary party responsible for ensuring overall compliance with legal requirements and plan document provisions. They may, and often do, delegate the actual performance of certain duties to others but they still maintain the duty to monitor those to whom they delegate responsibility. Plan administrators are defined as either the entity or individual designated by the plan document; if not specifically designated, it is automatically the employer or plan sponsor (single employer plans), the employee organization (union plans), or the committee, association or board of trustees (multiple or multiemployer plans).

Investment Managers

Investment managers are fiduciaries because they exercise authority or control related to management or disposition of plan assets (one of the defined fiduciary functions). They are also fiduciaries because they are specifically mentioned in ERISA 3(38). Investment managers have to acknowledge in writing in their investment management agreements their fiduciary status. A 3(38) investment manager's authority does not have to extend to the entire fund. Appointing a 3(38) investment manager limits an appointing fiduciary's liability; however, the appointment of the manager is still a fiduciary act so the appointing fiduciary is responsible for monitoring the manager's appointment for continued prudence under ERISA.

Conclusions

Case law has helped to define certain fiduciary functions. One thing that is key to fiduciary functions is documenting the process that fiduciaries use to meet their duties. Those processes should also be followed consistently. There should also be policy statements, up-to-date compliance calendars, and appropriate service providers to help fiduciaries fulfill their duties.

Preferred practices include ensuring roles and responsibilities are clearly assigned, communicated, and understood (within the organization and among service providers); establishing, following, and documenting a process for monitoring the governance model, delegations and assignments, investment performance, level and appropriateness of fees, and service providers; avoiding prohibited transactions; staying current with trends and training; knowing your plans; making use of compliance tools; and performing periodic compliance reviews of plans. In addition, fiduciaries will want to make time for regularly scheduled committee meetings that include preparation beforehand and participation during the meetings. Finally, documenting and maintaining documentation of these preferred practices is key to protecting fiduciaries and helping them meet their duties under ERISA.

Session 305
IS WELLNESS WORKING?

Speakers:

- Deb Gold – Quantum Health, Inc.
- Ryan Lore – Towers Watson & Co.
- Jason Whitehair – LHP Hospital Group
- Session Assistant: Michael Muir – Quantum Health, Inc.

Background

As a result of rising health care costs, the topic of wellness initiatives has become an important part of the strategic conversation. Deb Gold, Senior Vice President at Quantum Health, moderates a panel discussion with business leaders to hear how they developed their respective wellness programs; the challenges they faced when first establishing wellness initiatives; and what well-designed wellness programs can ultimately deliver.

Wellness in your organization

Many companies take great pride in creating a safe workplace for their employees, but believe it is equally important to focus on improving overall employee health and well-being both at work and at home. For some companies, however, just signing up for a wellness program isn't enough.

LHP Hospital Group offers partnership opportunities that provide hospital funding, financing and acquisition services to not-for-profit hospitals and hospital systems, with which it forms joint ventures to own, operate and manage acute care hospitals.

LHP Hospital Group's wellness initiative, which began in 2012, is a biometric outcomes-based program with the goal of preventing Metabolic Syndrome—a group of risk factors that can lead to diabetes, heart disease, and stroke. To avoid premium surcharges, employees and spouses must meet three of the five biometric targets (HDL Cholesterol, Triglycerides, Glucose, Blood Pressure, and BMI) during their annual biometric screening, and be tobacco free. According to the results of the most recent screenings, 70 percent of LHP Hospital Group's population is considered to be healthy; 20 percent are not and account for nearly 80 percent of the annual health care cost; and 10 percent do not participate. LHP Hospital Group's strategy is to move the 20 percent into the low-risk, low-cost, or in others word, "healthy" category—and to keep them there.

The number of businesses imposing such outcomes-based wellness plans is expected to increase. "Wellness-or-else is the trend," said Health Care Researcher, Ryan Lore of Towers Watson.

Implications for Employers

Return on Investment

Return on investment (ROI) is an important but limited measure of program success. There are no generally accepted "wellness" principles, as Ryan cleverly phrased it, so methods for measuring wellness success vary, especially in regards to computing ROI. In addition to ROI, programs often measure changes in medical costs or utilization, others are more outcomes-based (i.e., health-risk assessments and biometric screenings), while others focus on participation rates.

Participation

Engaging employees is key to program success, but can be challenging. Research indicates employers are increasingly using incentives to encourage employee participation. Incentives are often both extrinsic and intrinsic rewards designed to motivate individuals to modify their behavior. Studies show, however, that financial incentives prompt more employees to participate in wellness programs. Framing incentives as penalties, such as premium surcharges, tend to have an even higher participation rates. Jason Whitehair, Vice President of Human Resources at LHP Hospital Group, credits their unusually high 90 percent participation rate to the financial penalties imposed on those who fail to participate in the program.

Senior Leadership Support

Research consistently shows that a supportive corporate culture is one of the most critical factors affecting program success. A supportive corporate culture includes not only a commitment to the wellness program from senior leadership, but also extends to middle management. One of the biggest challenges larger companies face is selling the long-term financial benefit to senior leaders. The return on investment is measured in years or even decades, not quarterly. Many companies note that building their program and creating an atmosphere of wellness in the workplace took years to successfully implement.

Results

Jason acknowledged it is too soon to tell if LHP Hospital Group's wellness initiatives have reduced health care claim costs. But it is clear that the company is benefiting financially from the penalties. 30 percent of employees, or about 1,800, did not meet specified biometric outcomes or did not participate in the program, resulting in significant additional "income."

Ryan said that it can take at least two to five years to realize the impact of wellness programs on health care cost trends and other financial outcomes. "In fact, employers who institute wellness programs shouldn't be surprised to see an initial spike in health care costs, as some workers will learn of new health problems through initial screenings and are often placed on maintenance drugs."

Takeaways

- There is more to measuring the effectiveness of a wellness program than return on investment alone.
- Wellness programs operate in many ways. Some offer rewards to employees who participate or impose penalties on those who do not.
- Wellness initiatives that lead to better health outcomes and subsequent lower health care costs take time.
- Not all programs are created equal. There is no one solution as every organization is unique.

Session 308
TALKING IN PICTURES: EFFECTIVE STRATEGIES FOR COMMUNICATING IN THE 21ST CENTURY

Speakers:

- Brian Septon–The Terry Group
- Douglass Stewart–Vanguard Institutional Advisory Services
- Jake Burkett–Column Five Media
- Session Assistant: Melissa Kemmer Verguldi–Lockheed Martin Corporation

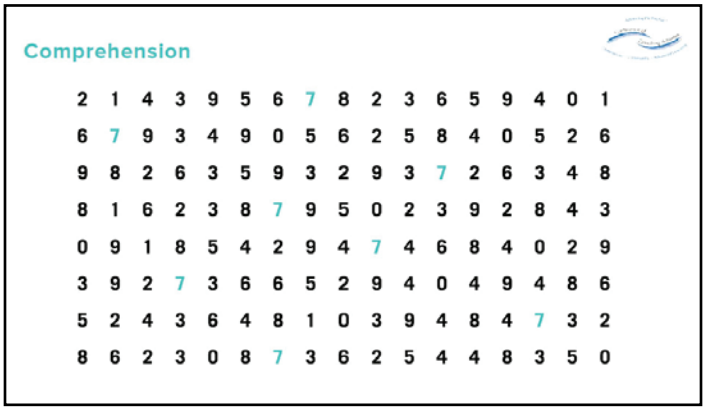
Are you communicating complex topics with a number of points, or presenting information with mountains of data? In today's world of information overload, having your audience understand your points quickly and easily is critical to effective communication. In this session, presenters share modern communication methods, often using pictures to tell a story. Participants leave with new ideas on how to share their story with clients.

Data Visualization

Data visualization is the intersection of information and storytelling. Graphics are a global language that can convey complex topics to a wide array of audiences. Graphics enhance comprehension, aid information retention, and help gain the attention of the audience.

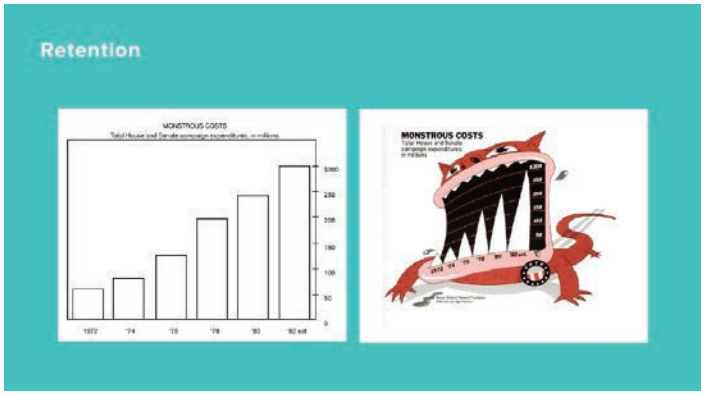
Comprehension

A primary goal of data visualization is to communicate information clearly and efficiently through graphical means including visual objects such as graphs, tables, and charts. Effective visualization helps the audience analyze data by uncovering trends, telling stories, and discovering sources. The design principle of the information graph should support the task. For example, simply changing the color of one number in a series of data allows the audience to more quickly count its occurrence. A picture may allow the reader to reach a conclusion in seconds whereas detailed analysis of the underlying data may require hours. Graphic displays make data more coherent.



Retention

Graphics aid in the retention of the message that is being conveyed to an audience. A historical pattern of significant increases in expenditures can be depicted with a routine bar chart. Alternatively, the same pattern can be shown within a graphic of a monster to illustrate the "monstrous costs." The audience will continue to speak of and recall the picture of a monster but not the bar chart.



Get Attention

Data visualization has a rich history and examples of several pioneers who delivered powerful messages and gained the attention needed on significant events. Florence Nightingale ultimately gained attention to the topic of avoidable deaths during the Crimean War with the use of graphics. John Snow's cholera map was a founding event in the science of epidemiology; identifying with his map the source of an outbreak that could not be seen in data driven reports.

Why is Data Visualization Important in the Financial Services Industry?

The topic of financial services is complex and therefore communicated to audiences with varying levels of sophistication and limited time to devote to the topic. The subject matter expert needs effective tools, such as data visualization, to equip the consultant with the right materials to convey the important messages to their stakeholders. There is risk that the key messages and concepts are not conveyed if presented as an abundance of data. Presenting your audience with an infographic in place of a white paper will foster their understanding and better ensure they absorb the critical points.

Tips for Practitioners

Practitioners, including consulting actuaries, are encouraged to make design a priority when communicating information and results; a skill most need to invest in and little developed from many years of experience, actuarial exams, and education. The use of data visualization will change, and may improve, upon traditional conversation with clients. Consultants and subject matter experts are encouraged to invest in data visualization capabilities, outsourced (Column Five Media is a recommended resource) or internal, and use a template to define the work in advance.

Some initial best practices for data visualization with bar charts include using horizontal labels, spacing bars and ordering data appropriately, using consistent colors and starting the Y-axis at zero. Other tips include focusing on what is being compared and starting the graphic with the story you are trying to tell. There are also websites and resources to explore including flowingdata.com, Professor Edward Tufte and Stephen Few.

Session 401
PENSION DERISKING: NEW FRONTIERS

Speakers:

- Michael S. Clark – P-Solve
- Richard McEvoy – Mercer
- Ryan McGlothlin – P-Solve
- Russ Proctor – Pacific Life
- Session Assistant: Steven R. Pribis – Dietrich & Associates

Background

Recent returns on pension plan assets haven't proven to be able to close the gap between plan assets and liabilities; in addition, improved mortality – both with respect to actual longevity as well as mandated mortality tables – has tended to exacerbate the lack of closing the gap. Plan sponsors have employed various techniques to address this, using various risk transfer strategies such as LDI (liability driven investments) and offering lump sum windows. Lump sum window opportunities have somewhat been thwarted by the recent ruling denying the option to offer participants in pay status a lump sum. Also, participants seemed to have taken a different perspective in evaluating the lump sum option with lower "take rates." Plan sponsors also had to deal with accounting and cash flow issues in moving forward with derisking strategies.

Recent plan sponsor surveys indicate that about 80% have considered or begun derisking strategies. Among such strategies is the lump sum window, especially in light of the recent announcement of significant increases in PBGC (Pension Benefit Guaranty Corporation) premiums and mandated recognition of mortality improvements. Not surprisingly, roughly 50% of surveyed

plan sponsors expect to terminate their plans within 10 years.

Recent annuity activity has seen about $10 billion shifted from plan sponsors to insurance companies with the expectation that this amount will keep increasing, perhaps to $15 billion per year. However, there has been a recent trend on the part of insurance companies to avoid or delay quoting on plans with any sizable deferred liabilities. This lack of willingness has created a concern that plan sponsors wanting to terminate their plans may not find an easy or short-term solution. In addition, plan sponsor perception is that the "cost" of buying annuities represents about a 10% -15% premium as compared to the liabilities "on the books" (i.e., projected benefit obligation or PBO). In actuality, the "premium" is closer to 5% when expressed as a gross cost. Also, in order to execute an annuity buy-out, plan sponsors have to be aware of the time intensity associated with ensuring the cleanliness of the census information.

Insurance-based solutions

Three options were discussed – the buy-out, the buy-in and a guaranteed or insured LDI.

The annuity buy-out has historically been the most popular and understood by the plan sponsor. It still requires an analysis of the economic cost and has more recently been an option to derisk a portion of the plan's obligations, as opposed to the entire plan, e.g., retirees only. Communication to participants remains a critical concern, as well as making sure the plan sponsor understands that the full cycle of a plan termination can take anywhere from 6–18 months.

The annuity buy-in is a more recent phenomenon with sparse activity in the U.S. to date. and the features of the annuity buy-in that differ from the annuity buy-out are: the assets stay in the pension plan, the trust continues to pay the benefits and no participant notification is required. Conditions under which a buy-in may be more practical include a sudden spike in interest rates, the need to retain the AFTAP (Adjusted Funding Target Attainment Percentage) at its current level and the desire to defer any settlement accounting.

Two case studies were reviewed: a plan with multiple entities (not quite a multiple employer plan, but with similar cash flow and exit strategy issues), and a Supplemental Executive Retirement Plan (SERP) with mostly all retirees addressing issues of constructive receipt (avoidance) and the issue of longevity risk. Observations included similarities to the buy-out, the short-term oriented aspect of the buy-in, retention of administrative expenses (including PBGC premiums), as well as the need for due diligence as part of U. S. Department of Labor (DOL) Interpretive Bulletin 95-1.

The traditional LDI hasn't been able to precisely match assets and liabilities which gave rise to insured LDI. Insured LDI has reduced volatility by improving the match of liability and asset performance. The case study showed cash flows, primarily targeted for current retirees, and the notion of front loading the liability. An advantage of the insured LDI cited was funded status stability as demonstrated in the second case study. The case study was a reminder that the price was not meant to be a "full price" option; rather, it retained the idea of a pay-as-you-go solution.

Investment-based solutions

One of the primary points raised as the focus of investment-based solutions was the emphasis on the cash contribution risk as opposed to the balance sheet risk. This encompassed a review of the plan's current and desired funding status (AFTAP as opposed to PBO accounting based), as well as a review of the plan's asset allocation strategy, which is centered around the expectation of future short and long-term returns. Liability-driven investing led to a contribution volatility/risk which may not be appealing to certain plan sponsors.

One of the choices of investment-based solutions included equity index options with call and put options. Examples of institutional investors executing successful strategies were shown with acknowledgment that such practices were not as common in the U.S. as they are in the U.K. The hedging strategy included an example of an "actual" 15% downturn in the market as well as an 8% positive return, and the muted impact on the plan's funding status after having implemented the hedge strategy. There are numerous rules and constraints associated with this approach including documentation, the notion of "permanency," and the importance of education and buy-in on the part of the plan sponsor. One of the conclusions of this approach acknowledged that funding relief came at a cost.

Case Studies and Questions from the audience

Several case studies were offered, demonstrating the need to identify specific types of organizations (public vs. private; industry-specific), the demographics of the plan (frozen vs. active; retiree only vs. all categories of participants), as well how well funded the plan was – looking at both the AFTAP and the PBO funded status. Also pointed out was the need for identifying the availability of cash to terminate the plan, which may require a wait-and-see approach.

Questions from the audience included the recent restriction imposed on plan sponsors with respect to current retirees' ability to elect a lump sum and the notion that it could extend to plan terminations, the "price" of insured LDI vs. an annuity (considerations of mortality and more "drilling" into participant specifics); the ability to convert a buy-in contract to a buy-out contract, as well as considerations as to when DOL Interpretative Bulletin 95-1 would apply, and charges, if any, to convert. Finally, a general question as to how or if insurance companies would be ramping up their resources to accommodate the rapid demise due to pending plan terminations.

Session 402

MERGERS AND ACQUISITIONS: INDUSTRY DIFFERENCES, DIFFERENT PERSPECTIVES

Speakers:

- David Scharf – Buck Consultants, a Xerox Company
- Christine M. Kong – Drinker Biddle & Reath LLP
- James A. Stewart – Buck Consultants, a Xerox Company
- Kenneth E. Levine – United Technologies Corporations
- Raphael E. Newman – Duff & Phelps LLC
- Session Assistant: Ruth Schau – TIAA-CREF

This informal panel discussion brings together a variety of merger & acquisition (M&A) experts to discuss the various functions of advisors that a plan sponsor might amass as advocates during a merger/acquisition event. While we are aware that there are more than just expert actuaries at work during the M&A process, it is interesting to hear their point of view and understand their roles. We will hear from David, the session moderator and an actuary; Chris, the Employee Retirement Income Security Act (ERISA) attorney; Jim, an actuary and M&A expert, Ray, an M&A advisor, and Ken who shares the plan sponsor perspective from an actuary's point of view.

As actuaries, we may not experience the full breath of the merger/acquisition experience unless we are inside an organization, like Ken Levine at UTC. Generally well before the actuaries are contacted, there are attorneys and others at work performing the early deal work. This session reviews the different actions that occur as well as offering insight into where roles may intersect.

Ken is likely the earliest person involved in merger/acquisition as he is the corporate insider. When his corporation is involved, he works to ensure the finance group understands human resources and the impact of their decisions. Conversely, he works to ensure HR understands finance and the related implications. As an in-house actuary, Ken plays a rare role in merger/acquisitions. If a DB (defined benefit) plan is involved, he can consider liabilities, funding and options. Ken has had multiple M&A experiences within his organization to apply his talent with unions, defined benefit plans and addressing the fairness of the deal.

While Chris is an attorney, she is not an attorney found in the early part of the deal. Chris arrives later, possibly near the time an actuary becomes involved to work through benefit plan issues from the legal aspect. Chris has worked with Healthcare and Tech industries lately, and with more than 50% of healthcare sponsoring DB plans, it is likely that an actuary or two are also involved. Actuaries are quite adept at reviewing valuation reports and cost projections to opine on whether an appropriate set of assumptions was used. However, Chris provides information beyond what actuaries can provide. She is asked by clients to take a deeper dive into benefit plans to identify any cost adjustments that should be made to the purchase price. Chris deals with the relatively common situation found in the market today where a buyer states they do not want the defined benefit plan. There may be occasion to work closely with an ERISA attorney in such as cases where it is not clear whether PBGC (Pension Benefit Guaranty Corporation) forms are due, in cases where plan documents may not be clear and in cases where the question at hand appears more grey than black and white. According to Chris, the bottom line is that the purchase agreement should contain direction regarding the benefits. If these are found in appendices, make sure the appendices exist within the document you are provided. Ask for them if you don't receive them with the agreement.

Options for the deal structure are driven by the tax structure of the entities involved. Alternatives in dealing with benefit plans are found in the purchase agreements. In a case where no advisors are involved and an agreement is signed at the CEO level, there can be resulting angst among employees since there is no agreement directing the benefits. Chris has experience with this. It is not likely the perfect deal and should be avoided if possible. It is best to have agreement on the benefit provisions stated in the agreement as part of the deal.

From Ray, we gather the broader business perspective. A business is typically bought for what a business will earn in the future – plain and simple. What is not so simple is to estimate what future earnings will be. Buyers need to understand assumptions used in projections that have been performed by the seller and understand past history, too. Ray warns that a buyer should always perform their own due diligence since the seller's due diligence report is positioned for the benefit of the seller.

A question on why reverse diligence would be performed is posed to the panel. Ray responds that reverse diligence is performed when a transaction is not all cash. When stock is received by the seller, it is beneficial to ensure the correct value of the stock is known.

Transfer pricing is a critical issue in merger/acquisitions. Transfer pricing schemes are generally found at large companies because the tax liability could be astronomical. Full disclosure and understanding is needed since no one wants a surprise tax bill.

Benefits may need to be addressed in post-closing covenants. It is important to ensure that benefit issues translate down to the purchase price and can be addressed as indemnities or clarifications. It is also very important to list what programs or plans are not being assumed or taken as part of the deal.

Towards the end of the session, Jim covers executive benefits in merger/acquisition deals. Supplemental Executive Retirement Plan (SERPs) and other agreements with executives are common,

and it is important to understand the triggers. Chris states that she tries to specify double triggers; the second trigger may be a substantial reduction in pay or responsibilities. In this way, triggers are not enacted solely because of a merger/acquisition occurrence. Retention agreements and transaction agreements may be needed to support the desired outcome in regards to the employment of the executives. Tax gross up agreements are not commonly found in today's market.

In summary, merger/acquisitions are complex and take teamwork between the buyer, seller and the expert advisors. We learn that due diligence is key in understanding the current position and eventually moving forward appropriately regarding benefits and other details involved in the transaction. Additional questions such as:

- Will you be able to collaborate with one of the other experts during your next merger/acquisition project?
- Will interaction between some of the experts make M&A deals better understood by all? More successful?

The session provides a key message to all of us, but especially plan sponsors – hire the right team to support you.

Session 403
BENEFIT CALCULATION CHALLENGES

Speakers:

- Martin Einhorn – Consulting Actuary
- James Turpin – The Turpin Consulting Group, Inc.
- Ellen Kleinstuber – The Savitz Organization
- Session Assistant: Dan Lucas – The Newport Group

Mr. Turpin and Ms. Kleinstuber filled the session with information relating to benefit calculations and the challenges encountered by benefit administrators. Among these challenges are issues relating to Qualified Domestic Relations Orders (QDROs), multiple annuity starting dates, and Qualified Joint and Survivor Annuity (QJSA) rules.

When it comes to benefit calculations, there should be no assumptions. All aspects of the calculation should be clearly identified in procedures blessed by the plan administrator. Questions to and answers from the plan administrator regarding methodology should be well documented.

QDROs

Ideally, provisions relating to benefit administration associated with QDROs are clearly stated in the order. However, poorly written orders containing ambiguous or missing provisions can often be a source of benefit calculation challenges. We can help minimize these challenges when reviewing domestic relations orders. Refer to ASOP No. 34 – Actuarial Practice Concerning Retirement Plan Benefits in Domestic Relations Actions – for guidance when performing actuarial services in connection with a QDRO.

Is the order written for a shared interest or separate interest payment? Shared interest is when an alternate payee (AP) shares in the participants monthly payments (with no actuarial adjustments). The alternate payee's share usually reverts to the participant upon the death of the AP. The QDRO must be a shared payment if the participant is already in pay status.

A separate interest payment occurs when a portion of the participant's benefit is awarded to an AP. This awarded portion is actuarially adjusted for the AP's age. The alternate payee may commence benefits before any distribution is made to the participant, even if the participant is still accruing benefits. APs typically have a choice of optional forms of payment in a separate interest arrangement.

Does the Plan provide a subsidized early retirement benefit? The AP does not receive the subsidy if the QDRO does not contain a provision awarding the subsidy to the AP. An AP's benefit cannot include the subsidy if the participant has not commenced benefit payments.

What does the order say about death benefits? The QDRO should be clear on what portion of the death benefit is payable to the former spouse. Specific provisions as well as a review of state law will help eliminate disputes over death benefits between a former spouse and a current spouse.

Current and potential IRC §436 benefit restrictions and High-25 restrictions should also be addressed in a well-drafted QDRO. APs are subject to the same rules as participants.

MASD, QJSA, & COLA

Multiple annuity starting date (MASD) challenges can arise from a number of situations. These include actual retirement after in-service commencement, lifting of §436 benefit restrictions, additional accruals while still employed, and rehired participants with a prior payout. How do QJSA rules apply? David MacLennan's award-winning paper, "Benefit Adjustments for Multiple Annuity Starting Dates", is an excellent resource on MASDs.

Plans with a guaranteed cost-of-living adjustment (COLA) must take care in determining actuarial equivalence. Although a pre-retirement COLA can be eliminated, automatic post-retirement COLA benefits are §411(d)(6) protected. Reasonable assumptions are needed when converting a COLA benefit to a lump sum. The IRS takes a position against assuming a 0% COLA increase for future years.

Session 405
THE EXCISE TAX

Speakers:

- Trevis Parson – Towers Watson
- Barry Carleton – Towers Watson
- Audrey Im – Lincoln Financial Group
- Daniel J. Dotzert – Towers Watson
- Session Assistant: Piotr Krekora – Gabriel Roeder Smith & Company

CCA Editor's Note: Within two months of this session, new legislation was passed delaying the implementation of the excise tax to 2020 and making it tax-deductible to employers.

Introduction

This session focuses on the Excise Tax on High Cost Employer-Sponsored Health Coverage, introduced, among other provisions, by the Patient Protection and Affordable Care Act of 2010 (ACA). Under this provision, if the aggregate cost of "applicable employer-sponsored coverage" provided to an employee exceeds a statutory dollar limit, which is revised annually, the excess is subject to a 40% excise tax. Section 4980I, added to the Internal Revenue Code by ACA, is effective for taxable years beginning after December 31, 2017.

Mr. Parson led the session off with an introduction and a brief overview followed by Mr. Carleton presenting more in-depth discussion of the current guidance and its application to analyzing ranges of pricing scenarios for active employees and retirees. The session concluded with an analysis presented by Mr. Dotzert and prepared by Ms. Im for Lincoln Financial Group for whom the excise tax has been an important element of health care benefit planning.

Background

Once the Excise Tax becomes effective, a 40% nondeductible tax will be assessed on excess in value of employer-sponsored coverage over thresholds calculated per participant based on total cost of participant's selected coverage tiers. For 2018, the ACA established a standard threshold of $10,200 for self-only (SO) coverage and $27,500 for other-than-self-only (OTSO) coverage. Thresholds are increased for members performing high-risk jobs and pre-65 retirees by $1,650 for SO coverage (to $11,850) and $3,450 for OTSO (to $30,950). Furthermore, all coverage through multiemployer plans is subject to OTSO thresholds for all coverage tiers. The ACA also allows for age and gender adjustment and indexes threshold amounts for years after 2018 to inflation represented by Consumer Price Inflation index (CPI), thresholds for 2019 will be increased by CPI+1%, all future increases will be set to be the same as CPI.

The primary objective of this provision is to compel employers to reduce current and future plan costs, and consequently reduce tax exclusions by reducing plan value and/or improving trend performance. According to the Congressional Budget Office (CBO) scoring, this Act will bring approximately $87 billion in revenue through 2025. This projection is very sensitive to a spread of the emerging medical trend over the general price inflation. As the expectations for the trend and projections changed between April of 2014 and March of 2015, CBO revised their projected revenue through 2024 from $120 billion to $66 billion (2014 scoring didn't include revenue for 2025). Projections incorporate an assumption that employers will reduce the value of tax-free health benefits and offset those cuts with increases in taxable pay. It is expected that 75% of the budget impact will come from such increases in taxable compensation.

Available Guidance

Current guidance from the Internal Revenue Service can be characterized as limited at best. Two IRS notices were issued in 2015 offering some clarification and soliciting comments from the interested parties on numerous issues.

IRS Notice 2015-16 lists benefits included in the "applicable coverage" and comments on applicable dollar limits. Generally, applicable coverage includes all benefits paid for by employer or by employees on a pre-tax basis except for limited scope and de minimis coverage.

This notice also seeks comments regarding determination of cost of "applicable coverage." Currently, ACA provides that the cost of applicable coverage is determined under rules "similar to" prescribed by the Consolidated Omnibus Budget Reconciliation Act (COBRA). This is somewhat ambiguous as COBRA regulations are very vague when it comes to rate setting. The notice indicates that the cost of applicable coverage for an employee will be based on the average cost of that type of applicable coverage for that employee and all similarly situated employees with mandatory aggregation by "benefit package." This will allow for a single risk pool rate development currently used by most employers when offering multiple options to the same employees. However, employees would be disaggregated by "self-only" (SO) and "other-than-self-only" (OTSO) coverage tiers which is not consistent with a single pool rating. Disaggregation between different tiers within OTSO coverage would not be required. Groups may be further permissively disaggregated by traditional group market distinctions. It is not clear yet how the mandatory disaggregation by SO and OTSO will impact a common rating approach under which all claims are pooled and rates are determined using projected actuarial relativities. Employers may end up developing 3 sets of rates: excise tax, COBRA and internal budgeting, each with different components, assumptions and methodologies.

Notice 2015-52 supplements Notice 2015-16 with discussion

related to identification of persons liable for excise tax, proposing two options for self-insured plans: a person performing day-to-day functions in administration of plan benefits, or a person with ultimate authority or responsibility with respect to administration of the plan benefits. Many observers have argued for the **employer** to act as the coverage provider for self-insured plans. This notice also comments on details of the cost of applicable coverage by defining "determination period" and "taxable period" and allocating of contributions to Health Savings Accounts (HSA), Flexible Spending Accounts (FSA) and Health Reimbursement Accounts (HRA) as well as on notification and payment requirements.

Actuaries will be most interested in a proposed guidance on potential Age and Gender Adjustments (AGA) contained in Notice 2015-52. It is proposed that AGA is determined separately for SO and OTSO coverage. This will be done by comparing the employer's workforce to the national workforce. The IRS proposes using Table A-8a from the Current Population Survey published by Bureau of Labor Statistics for this purpose. Adjustments will be based on premium costs for Federal Employees Health Benefits Program (FEHBP) under the Blue Cross Blue Shield (BCBS) standard option using population profiles grouped in 5-year bands and made by adding appropriate dollar differences to thresholds. The IRS proposes requiring employers to use the first day of their plan year as a snapshot date for determining workforce age/gender profile but observers noted that this will likely draw a lot of criticism as it would undermine employers' planning process; most employers will need to know the tax impact well in advance of the plan year. There is no guidance yet with regard to a morbidity table to be employed in this process.

Case Studies

In the first case study, a plan sponsor explores how tax liabilities projected for the first five years after it becomes effective are affected by different approaches to rate setting and plan changes. This employer offers self-insured coverage to active employees, pre-65 retirees and Medicare-eligible retirees. Actives and pre-65 retirees can choose between a Preferred Provider Organization (PPO) and an HAS-compatible High-Deductible Health Plan (HDHP) with actuarial values of 90% for the PPO and 80% for HDHP. Medicare-eligible retirees are covered through a Medicare supplement paired with an Employer Group Waiver Plan (EGWP) prescription plan. Rates for active employees are developed by setting a single risk pool under which experience for both plans is combined and then rates for each plan are set according to the ratio in their Actuarial Values (AV). Under this approach, PPO premium rates are 12.5% higher than premiums for HDHP (reflecting the difference in actuarial values) while the average claim cost for PPO participants based on the actual plan experience is 50% higher than for HDHP. A similar procedure is used for pre-65 retirees. Projections are performed assuming a 6% health cost trend and a 2% CPI.

The first projection illustrates difference in excise tax assessed under a common practice of developing rates with a single pool rating versus setting rates for each plan separately. The conclusion is that, for this employer, tax liabilities are projected to be lower under a single pool rating. However, it is not clear whether future guidance will allow for single risk pool rating or if rates will need to be developed separately for each unique benefit option.

The second projection examines the effect of tier structure on tax liability. Most employers set rates and contributions on a 3-tier or 4-tier basis. Excise tax thresholds, however, are set on a 2-tier basis: self-only (SO) and other-than-self-only (OTSO). Moving from 3-tier (or 4-tier) to 2-tier rating will generally reduce excise tax liability. Again, it is not clear if regulators will allow employers to adopt 2-tier rating **without** also requiring a shift in contribution structure to a 2-tier basis. It is also shown that the tax liability for a two-tier structure is minimized if the ratio between OTSO and SO premiums is the same as ratio between OTSO and SO thresholds.

The next projection illustrates effects of age/gender adjustments. Baseline thresholds of $10,200 (SO) and $27,500 (OTSO) can be raised if the age/gender composition of the employer's workforce is less favorable than the national workforce. As the covered workforce distribution is a little older and more expensive to cover than the national workforce, this employer is expected to be computing taxes based on thresholds adjusted upwards resulting in a reduction in tax liability.

Like many other employers, this plan sponsor intends to avoid paying the excise tax. This will likely require changes to the benefit package. Generally, plan changes will result in higher out- of-pocket expenses and the employer will likely compensate that loss of benefit by increasing taxable compensation. As after-tax contributions made to HSA accounts are often tax deductible, there is some room for lowering excise tax without heavily impacting the value of the total compensation package. However, CBO scoring assumes that 75% of federal budget savings from excise tax will be due to increases in taxable pay as employers cut the value of tax-free health care benefits. It may not be reasonable to assume that employers will uniformly raise taxable pay to offset any loss of tax-free health care benefit but as the employers migrate towards less expensive plans, the taxable share of total compensation will drift upwards resulting in higher income tax revenues.

Remaining illustrations focus on excise tax relative to retiree coverage. As retiree medical plans tend to see enrollment concentrated in single and retiree + spouse coverage tiers, some employers use a 2-tier approach (single or retiree + family) to recognize this, in many cases with the family rate set at 2 times the single rate. As shown earlier, tax is minimized for a two-tier design if the rates are set at the threshold ratios. Consequently, it would benefit employers (and members) if the regulations allow for that approach as opposed to a mandatory disaggregation by SO/OTSO where employers need to develop ratios closer to 2:1 reflecting experience.

Many employers offer coverage to pre-65 retirees along with coverage for retirees eligible for Medicare benefits. Statute indicates under determination of cost (but not thresholds) that "the plan

may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries." This is commonly interpreted as blending. Projections included in this case study show that blending may substantially delay tax liability for retiree coverage. However, there are some unanswered key questions that would need to be addressed in the future guidance: under what conditions will employers be allowed to blend pre-65 and post-65 retiree costs? Will plans need to be identical except for Medicare coordination? Furthermore, there is no guidance on how will the "cost" be defined under post-65 plans that may be structured under a variety of plan arrangements. Will cost for plans with RDS or EGWP Rx be determined before or after deducting "third party payments" from CMS and pharma? How will cost be determined for retiree-only stand-alone HRAs that are often linked to Medicare exchanges?

Employers offering retiree medical plans to pre-65 retirees are expected to be affected by the excise tax before incurring tax liabilities for active employees or Medicare retirees. This will happen because an average cost for a pre-65 retiree can easily run as much as 50% or even 100% higher than for actives but thresholds are raised only by 13% to 16%. Relative impact on retiree cost share will be even stronger if employers offer capped (fixed dollar) subsidies. Employers offering pre-65 coverage will likely consider exploring ACA coverage options as a way of optimizing financial positioning for both the employer and its retirees. Using employer HRA dollars or federal subsidies, retirees may be able to pay less for a similar coverage on the ACA marketplace.

The second case study examines efforts undertaken by Lincoln Financial Group to avoid paying excise tax for as long as feasible. This employer offers variety of options to active employees, agents and retirees (both Medicare and non-Medicare). Through an aggressive plan management over recent years, Lincoln managed to delay the prospect of excise tax on active employee plans until at least 2026. This was achieved by elimination of the richest PPO plan for 2014, promotion of account-based health plan (enrollment now at 32%), aggressive vendor management, comprehensive wellness program, plan design changes to cut actuarial value and to incent appropriate utilization, and implementation of telemedicine, price transparency and second opinion services.

Exposure to excise tax on retiree coverage is mitigated by closing retiree health plans to new members as of 1/1/2015. Pre-65 coverage was previously offered as a bridge to Medicare (prior to ACA). Availability of ACA coverage allows for gradual elimination of this plan and any tax liability relative to pre-65 retirees within 10 years. Post-65 coverage (also limited to current retirees only) is offered through an employer-sponsored Medicare supplement with an EGWP. Costs for this plan are projected to stay below tax thresholds for many years into the future. It is not clear if Lincoln will be able to lower tax liability by blending costs for Medicare and non-Medicare retirees and whether the cost will be determined before or after receiving third party funding for EGWP.

Conclusions

In conclusion, speakers stressed that what we don't know about the excise tax still far exceeds what we do know. We should expect more proposed regulations in early 2016. It is expected that future guidance will likely require substantial changes to the rate development process for self-insured plans.

Session 406
GLOBAL APPROACHES TO RETIREMENT READINESS

Speakers:

- Douglas J. Carey–Retired
- Wil Gaitan–Aon Hewitt
- Hardev Sandhu–Towers Watson
- Stephen Barry–Voya Financial
- Session Assistant: Al Phelps–Arthur J. Gallagher

Background

This session reviewed average retirement readiness in four distinct countries: Philippines, Chile, United Arab Emirates (UAE) and Suriname. These countries provide a variety of social and private pension practices in emerging economies.

The comparison looked at principal retirement income sources, provision for retiree health, local culture and special factors. Sources of retirement income include the three legged stool for each country: social security and statutory benefits, employer supplemental plans and individual retirement savings vehicles.

The adequacy of social programs, enabling legislation for employer pensions and the availability of a supportive financial services sector (investment and insurance) to promote employer sponsored and individual pension savings accumulation and delivery were evaluated.

Philippines (Grade B)

The Philippines was chosen as an example for a developing country with low life expectancy at retirement in long-term transition to a more mature population. The economy is relatively stable with moderate inflation and a developed local equity market.

The social security system is structured similar to the US, but

with a low cap on earnings (about USD $4,100). Participation in the system is limited to a small part of the population. Retiring employees also receive a mandatory defined benefit (DB) severance payment of one-half month's of pay for each year of service. Modest employer supplemental benefits are common. Total replacement income at age 60 (normal retirement age or NRA) is about 58% for an average earner, but only 33% for a high income earner. All retirees need access to private healthcare alternatives given the inadequacies of the social system.

The social security system, modeled after the U.S. system, and the employer pension legislation, modeled on the pre-ERISA (Employee Retirement Income Security Act) pension system, were described.

A robust market and options exist for individuals to save for retirement via retirement savings accounts known as Individual Personal Equity and Retirement Accounts or PERA and insurance products. Contributions earn a 5% tax credit, realized gains and dividends are not taxed and distributions after age 55 plus 5 years are tax-free. Investments typically include commodities. Family is a diminishing source of financial support in retirement, and costs for long-term care and retiree healthcare add to the future burden.

Chile (Grade A-)

Chile was chosen as an example for its model individual account social security system. Inflation has been moderate with a well-developed equity market and excellent returns for the social security system individual accounts to date. However, the population is aging rapidly with long life expectancy (especially for women).

The social security system is fully funded via employee contributions only with a local earnings cap. Employees also receive a mandatory DB severance of one month of pay per year of service (with a salary cap and a limit of 11 months' pay). Employer supplemental plans are rare without any tax incentives for the company. Total replacement income at age 65 (NRA for men) is about 43% for an average earner, and 25% for a high income earner. The social system is adequate for most healthcare needs following retirement.

Employees are encouraged to save voluntarily for retirement via a capped government subsidy, but the levels are modest.

The financial markets are well developed. Employees typically annuitize most of their social security accounts and lump sum severance payments.

United Arab Emirates
(local nationals Grade A+, foreigners C-)

The UAE was chosen as a small country with 85% of its workforce being foreigners on temporary contracts (primarily male). Foreigners must leave the country at age 61 or termination of their contract. Regardless of age, almost all local nationals work for the government due to better pay, guarantee of lifetime employment, and social status.

The social security system provides close to 100% of pay to local nationals, but nothing to foreigners. Foreigners receive a mandatory DB severance of about one month of pay per year of service with an overall limit of two years' pay. Supplemental retirement contributions are not common, but would be tax-free as no income tax exists in the country.

The financial system is well developed and stable for those who choose to save and invest.

With free housing and healthcare and 100% retirement income replacement, local nationals have a great outlook for retirement income security. However foreigners have a dire need for supplemental retirement income; they have no social programs (retirement or healthcare) at all and can only rely on severance and their own savings for retirement income and post-retirement healthcare expenses.

Suriname

Suriname was chosen for its unique characteristics as an example where a large U.S. employer created a plan subject to ERISA I and II in order to provide a valuable source of local retirement income for foreign employees residing outside the country.

Suriname is a very small country with a young but aging workforce.

The social security system provides a modest retirement benefit and basic retiree healthcare. The financial infrastructure is limited, inflation high and local currency subject to devaluation.

A case study was presented based on experience with Alcoa's Surinamese subsidiary (Suralco). Local currency devaluation in 1992 led to hyperinflation. From 1992 to 1999, the assets of the local savings plan further depreciated in USD from $50 million to roughly $45,000.

To address the 99% loss, Suralco modified its retirement plans as follows:

1) DB plan (1.5% final pay for salaried, flat factor for union). Different classes for retirees with those that reside in Suriname paid in local currency and those outside Suriname paid in USD. This program is qualified in the USA.
2) DC (defined contribution) plan with a 100% company match up to 6%. Assets are held offshore with diversified investment options.
3) Retiree medical plan available only to resident retirees via onsite medical clinics.
4) Global savings plan for additional employee contributions. Also held offshore with diversified investment options. This plan was later extended to other countries, providing cost effective and simplified administration.

Discussion ensued on the plan qualification aspects of the plan:

1) Domicile of the plan.
2) Pay indexation to the USD ensures compliance with U.S. benefit accrual rules.
3) Investment of plan assets.

With the approval of local authorities, the company was able to create plans that provide local employees with the security of U.S. ERISA, diversified investment options, hard currency and stable retirement income.

Session 502
LUMP SUM WINDOW

- Session Moderator: Joe Strazemski – Buck Consultants

Speakers:

- Lorraine Halpin, ASA, EA – Towers Watson
- Donna Westervelt – Buck Consultants
- Matt McDaniel, FSA, EA, CFA – Mercer
- Jim Burke, FCA, FSA, EA, MAAA – Savitz
- Session Assistant: Phil Parker – Buck Consultants

Background

Since 2012, one of the most common methods that plan sponsors have utilized to derisk their pension plans has been to offer terminated vested participants optional lump sum payments in a window program to settle the plan's obligation. This session was designed to look at topics and ideas relevant to the design, administration, communication and GAO (Government Accountability Office) findings of such a lump sum window offering. This session covered the following topics:

- Key Window Design Issues
- Communication Considerations
- Financial Considerations
- Other Considerations:
  * Data
  * Fiduciary
  * Compliance

Key Window Design Issues

There are several important considerations when designing a lump sum window. The plan sponsor and consultant(s) should work together to determine whom to include in the window. Considerations that need to be taken into account include financial implications such as settlement charges, the state of the data, and whether to include: participants with QDRO's (Qualified Domestic Relations Order), deferred beneficiaries, or participants requiring complex manual calculations. Once the population is determined, the plan needs to be reviewed and amended to allow for the window. Plan document Items to review are the definition of a lump sum, the factors to be used to calculate the lump sum, how annuities payable prior to early retirement age are calculated, and anything else that may need to be changed so that benefits can be calculated and paid.

In addition to the population definition and ensuring that the plan document supports providing a lump sum window, the plan sponsor should examine the administration of the plan. Is the current administration robust enough to support a large number of calculations, distributions, phone calls, fulfillment requirements in a short window period? If not, then the plan sponsor will have to take steps to ensure smooth operation of the program such as adding staff or hiring a third party to support the window. In addition to capacity, many of the administrative procedures should be examined, such as the necessity for spousal waivers, determining what documentation a former employee must provide and how the banking information will be acquired and provided to the trustee or pension payroll provider in order to make payments in a timely manner.

Communication Considerations

The success or failure of a lump sum window can be judged based upon the degree to which employees understand the offering and feel confident in their ability to make the best decision. In order to have a successful window, a strong communication strategy should be adopted early in the process and followed to completion. Key points to consider in developing the communication strategy include raising awareness amongst the participants, building an understanding of the offering and the process, providing education and tools to support their decision and ways to remind employees to not miss the opportunity.

Financial Considerations

Plan sponsors often offer lump sum windows based on two objectives: reduce cost or reduce risk. The two objectives lead to many financial considerations for the sponsor.

When looking for cost reductions there are numerous sources of expense that can be reduced, for example, a reduction in administrative costs from PBGC (Pension Benefit Guaranty Corporation) premiums or maintaining participant records. On the accounting side the liability settled is often greater than the cash paid out in the lump sums. Both accounting and funding need to be evaluated when considering cost reductions. Often the funding liability that is settled is less than the cash paid out for lump sum payments and the funding level of the plan may decrease resulting in additional cash contributions or restricted distributions.

The other key consideration is risk reduction for the plan sponsor. All financial risk is removed on the liabilities that are settled by paying lump sums. Sponsors should be careful to maintain an appropriate asset mix after the window to ensure that the payments didn't come solely from a single asset class thus resulting in an inappropriate asset mix. In addition to eliminating the investment risk on the liabilities cashed out, the cash out also eliminates the longevity risk for the plan sponsor.

Other Considerations: Data, Fiduciary, Compliance

The speakers covered an assortment of other important topics.

Data Remediation

The benefits that are being determined and paid must be based on the plan document and be based on accurate information. This can be a problem for many plan sponsors, as terminated employee

records can go back 40 or more years. Clean data may not be available. Plan sponsors should determine if the data can be used for the window, whether to exclude employees with bad data, or to take on a data remediation effort in advance of the window. Data remediation projects can be lengthy and expensive.

The Plan Sponsor is the Fiduciary

Plan sponsors should make all final decisions regarding the window. All decisions, interpretations and procedures should be approved in writing by the plan sponsor. Common fiduciary responsibilities include determining the benefit amounts and lump sum calculations, content of communications, and hiring third party providers.

Compliance

The window must follow the plan document. This typically requires a plan amendment. The plan amendment should define all aspects of the lump sum offer that are not part of normal plan provisions.

Participant communications must include all information required in any retirement election package including relative values, right to defer notification, and applicable forms of benefit at any age that the lump sum is offered. In addition a Summary of Material Modification may be required, but the election kit may meet those requirements.

GAO Report (January 2015)

The panel and the audience discussed the recent GAO report that was issued summarizing the GAO's review of a small subset of lump sum windows. The report generally felt that while communications within the election packets met current federal minimum requirements, the communications needed to be more thorough focusing on eight essential items: benefit options, calculation description, relative values, positive and negative ramification of taking the lump sum, tax implications, PBGC protection, instructions on how to elect, and where to get assistance.

Conclusion

Lump sum windows are expected to continue to be a major tool for plan sponsors to manage their defined benefits plan from a cost and risk perspective. In doing so plan sponsor have a lot of considerations from plan design to compliance.

Session 503
NOT-FOR-PROFIT RETIREMENT PLANS

Speakers:

- Mike Horton – Towers Watson
- David Cohn – Sullivan Cotter
- Ross Krinsky – Fidelity
- Session Assistant: Michael S. Clark – P-Solve

Background

Not-for-profit organizations tend to have slim operating margins and depend on donations to fund their work. Because of their constraints, volatility – such as that posed by defined benefit plans – can be extremely harmful. In addition, participants tend to request or require a higher level of hand holding with their retirement decisions. Finally, the types of plans available to not-for-profit companies also vary from traditional corporate entities.

The two largest sectors of not-for-profit companies are healthcare companies and higher education institutions. Healthcare companies have been faced with numerous changes over the past several years including: Affordable Care Act regulations and their complexity, aging workforce, changing distribution channels, consolidation, technology's expanding role, physicians' evolving roles, emerging consumerism, etc. Higher education institutions have also experienced changes as a result of decreases to their endowments, real estate/urban growth prohibiting expansion, overseas expansion, competition for students, massive open online courses, and competition for qualified personnel.

Defined contribution plans

Not-for-profit organizations have several options for providing defined contribution retirement benefits to their employees. For employee deferrals they can use 401(k), 403(b), or 457(b) plans. Each of these plan types has different contribution limits, testing issues, and catch-up provisions. In addition, organizations can provide contributions through 401(a) or 457(f) plans; however, there are rules regarding taxation and when benefits are no longer subject to a substantial risk of forfeiture.

Fidelity data shows that trends in defined contribution plans tend to lag in the not-for-profit space. For example, features like auto-enrollment, auto-escalation, and Roth contributions are much less likely in a not-for-profit organization's plan compared with their for-profit counterparts.

There are also issues related to 415 benefit limitations. As healthcare organizations consolidate these benefit limits become complex, especially as they relate to physician groups, separate HRIS (Human Resource Information System) systems that are not integrated or having multiple plans for various groups of employees.

Executive retirement plans

These types of plans go by various names (SERPs [Supplemental Executive Retirement Plan], non-qualified deferred compensation,

Top Hat, or 457(f)) but essentially all boil down to deferring compensation to a future year. These arrangements also defer taxation of the executive deferred compensation until there is no substantial risk of forfeiture. These benefits tend to face immediate taxation in the year that they vest. They also appear on an organization's Form 990 which is available to the public.

In healthcare organizations, executive retirement plans have become universal. Organizations use these benefits to attract and retain talent, provide market competitive benefits (especially in absence of stock options), and to overcome statutory pension limitations. Typically C-suite executives are covered under these arrangements. While structures vary by organization, there is a trend towards design simplicity.

Vesting provisions are important to get "right" since it drives retention, taxation and cash flow, disclosures, and compliance. As with contribution design, trends in vesting are toward simplicity

Healthcare retirement plans

Sullivan Cotter survey results show several key findings as they relate to healthcare organization retirement benefits. The shift from defined benefit to defined contribution plans has generally slowed. Thirty-one percent (31%) of survey respondents still maintain open, ongoing defined benefit plans and two-thirds (2/3) of this group have not considered freezing the defined benefit plan. For those sponsors with frozen defined benefit plans, the vast majority are not utilizing risk management strategies. Some have considered lump sum windows or changing asset allocations, but many have not implemented these considerations.

The last key finding from the survey indicates that defined contribution plan benefits are evolving. The majority of respondents indicate that they provide some sort of matching contribution and almost 50% provide a fixed or discretionary contribution as well. While lagging the for-profit industry, features like auto-enrollment and auto-escalation are starting to gain ground among these plans.

Higher education retirement plans

Colleges and universities tend to align plans to be competitive within their industry resulting in little differentiation. They are also improving the balance between university cost objectives and employee needs. As a result, the organization's finance function is becoming increasingly more involved in plan design discussions. Higher education organizations are also looking at better meeting the needs of different population segments (faculty vs. staff) and ensuring long-term cost sustainability.

In many cases these trends have resulted in modest benefit reductions and gradual transitions to new plan designs. Plans are also providing different contribution levels based on pay. They also are providing additional employee retirement planning and communication support.

Regarding plan prevalence, while matching-only contributions are most common in the broad market, only 6% of higher education organizations have these designs. Instead the majority of higher education organizations tend to provide automatic contributions (69% compared to 3% of the broad market based on Willis Towers Watson survey data).

Session 507
RISK SHARING PLAN DESIGNS FOR PUBLIC PLANS

- Moderator: David Driscoll, Buck Consultants

Speakers:

- Pat Beckham, Cavanaugh MacDonald
- Phyllis Chambers, Nebraska Public Employee Retirement System (NPERS)
- Dana Woolfrey, Gabriel Roeder Smith & Company
- Session Assistant: William Fornia, Pension Trustee Advisors

Background

Public Employee Retirement Systems are responding to pension reform efforts to some extent by considering and implementing plans which transfer risk in varying degrees from plan sponsors to plan participants. Traditionally, public plans were Defined Benefit (DB) with the plan sponsor bearing all of the risks. A few jurisdictions have introduced Defined Contribution (DC) plans, these are not common. Some jurisdictions have even abandoned their DC plans and reverted back to DB plans. What has been more common is some type of hybrid design. The format of these designs and the degree of risk transfer has varied extensively.

Summary of Session

Mr. Driscoll began by discussing various risk sharing plan designs. The Center for Retirement Research (CRR) from Boston College has studied the shift toward DC-type coverage both before and after the financial crisis. Five factors were analyzed, from Republican control of state government and Social Security coverage to benefit levels, unfunded liabilities, and teacher coverage.

Cash Balance (CB) plans were defined (DB plans based on notional DC-type accounts) and two (Nebraska and Kansas) were discussed in great depth by Ms. Beckham and Ms. Chambers, respectively. CB plans are attractive because of the preservation of the DB paradigm with their higher expected returns and the ability to adjust the degree of risk sharing through plan design features of

interest crediting and annuity conversion calculations.

Ms. Woolfrey, filling in last-minute for Joe Newton, discussed the Colorado Fire and Police Pension Association (FPPA) innovative hybrid plan model in great depth, describing its 35 year history and how it has responded to various market forces and trends.

FPPA has many features which make it responsive and risk sharing. Total plan contribution rates are fixed at 16% of pay, shared equally between members and employers. During the strong 1990's, the 16% rate was more than sufficient to fund the DB component of the plan and individual DC accounts were credited the difference.

Very little has been allocated to the supplemental DC accounts post 2000; and, in an additional risk sharing feature, the FPPA board has granted minimal cost of living allowances (COLAs). The discretionary COLAs are another risk sharing feature of FPPA. In response to the uncertain COLAs, FPPA members have voted to increase their contributions, which increase their likelihood of receiving COLAs more in line with inflation. The member vote prompted the Board to look at intergenerational equity issues and ways of most equitably allocating the COLAs across generations.

Woolfrey's presentation also demonstrated how mature pension systems (unlike FPPA, which began only in 1980) have much of the actuarial liability attributed to older members. This makes discretionary COLAs a powerful cost control tool. However, some purchasing power protection provided by COLAs is a needed benefit feature.

Ms. Beckham discussed many of the actuarial nuances of valuing a CB plan. Because CB plans are technically DB plans, they are typically valued using the entry age normal (EAN) cost method. Because CB plans crediting rates are typically lower than the actuarially assumed rate of return, the actuarial liabilities are generally lower than the accumulated cash balances.

Interest crediting rates are a critical variable in determining the plan costs and the amount of risk sharing. For example, Kansas Public Employee Retirement System (KPERS) credits a minimum of 4% plus 75% of the excess return over 6% on a rolling 5 years average. In order to value this, an assumption must be made as to the long-term average crediting rate. The assumption was set by simulating 1,000 total interest crediting returns (including the variable credit) over 40 years based on the underlying expected return and standard deviation of the portfolio.

Other actuarial ramifications which must be considered include the election of refunds (versus annuities) and annuity conversion basis. Plan annuity factors must be unisex, because individual benefits are based on them, although the actuarial valuation would reflect a sex-distinct mortality basis.

Plan designs can vary widely. KPERS, for example, has a CB plan for members hired beginning in 2015. Their pre-retirement refund is the member contribution balance only, while Nebraska Cash Balance Plans refund both the member contribution and the employer contribution balances. The KPERS annuity conversion interest rate is 2% less than the actuarially assumed rate of 8% while the Nebraska Cash Balance Plans use the valuation interest rate (7.75%) for the annuity rates.

Phyllis Chambers discussed the State and County Cash Balance Plans in Nebraska, which switched from a DC plan to CB in 2003, following a benefit adequacy study that showed that members covered under the DC Plan did not have balances which provided an adequate retirement income. All new hires after January 1, 2003 became members of the CB Plan and existing members in the DC Plan had an election where they could voluntarily elect to move their account balance and participate in the CB. Only about 25% of DC members transferred to the CB when it was first offered in 2003. Although billed as a one-time choice, the legislature subsequently permitted additional transfer windows in 2007 and 2011. About 20% of those who were in the DC plan are still covered by that plan, while the remaining State and County employees are covered by the CB. School employees, Judges and State Patrol employees have always been covered by a traditional DB plan. Since their inception, the Nebraska CB plans have maintained a funded ratio close to 100% which has enabled them to provide a "dividend" credit in many years. NPERS is a risk sharing CB plan in that both the employee and the employer contribution amounts are credited to the notional CB accounts, which is credited with a guaranteed rate equal to the greater of 5%, or the Federal Mid-Term Rate plus 1.5%. In recent years, the guaranteed interest crediting rate has been 5%. The Nebraska Public Employees Retirement Board has adopted a formula for dividend calculation that is based on funded levels. The maximum crediting rate, including dividend, is the assumed rate of return of 7.75%.

For the Nebraska CB plans, account balances are converted to annuity amounts using the actuarial assumed rate of return of 7.75%, but Ms. Chambers indicated that very few members are electing annuities (about 10%). With the plan's inception in 2003, account balances for many members may be relatively small, so the low annuitization election is not necessarily unexpected and may change over time. The CB plan has been an effective retirement plan alternative in Nebraska.

Session 601
UNDERSTANDING PENSION RISKS THROUGH SCENARIO TESTING

- Moderator: Barry Freiman – Principal Financial Group

Speakers:

- Michael E. Clark – Principal Financial Group
- Nathan Zahm – The Vanguard Group
- Jodan Ledford – Legal & General Investment Management America
- Session Assistant: Barry Freiman – Principal Financial Group

Background

The current economic environment is uncertain and volatile. Sponsors of defined benefit plans are expected to navigate through this turbulence the best they can. They look to their consultants to help them understand their risks and the options available to mitigate them. This session focused on the current methods and strategies being used by consultants and the best practices around scenario testing the relationship between plan assets and liabilities.

Summary

Mr. Clark led the discussion noting the process of helping sponsors understand risk is akin to telling a story. Mike contends that while the work we do is very complex and hard to fully convey in short amounts of time, telling the story effectively will more likely lead to action. Similar to a book or even a movie, storytellers that allow the reader or audience to place themselves in the stories get the best reviews. This is particularly more challenging for complex topics, like pension risks.

Mike questions how best to tell this story. Whether using deterministic models, where you can show sponsors what happens if certain events occur, are better than stochastic models, which show sponsors the probability of certain outcomes given a set of assumptions and correlations. Providing a stochastic analysis has challenges; it is complex, it requires a lengthy learning curve for its users, the results are harder to visualize and the audience must understand and accept the underlying assumptions (what Mike calls "Assumption Obstruction"). On the other hand, Mike thinks deterministic models have many advantages; it is simple, sponsors are familiar with this type of analysis, it is easier to visualize, and sponsors are able to insert themselves into the story and understand the key lessons (what Mike calls "Best Seller Syndrome").

Mike's conclusion is fourfold. First, models, whether deterministic or stochastic, are tools we use to tell a story. Second, the correct model to use depends on the audience and the story you are trying to tell. Third, the use of a combination of models can also be effective. Finally, Mike makes the important point that the actuaries are the storytellers and they should put their thought and energy into making sure the story is told effectively.

Mr. Zahm led the next part of the discussion. His presentation hit on the major considerations for plan sponsors as they look at derisking strategies for their defined benefit plans. First, Nathan explains when performing projections of plan assets and liabilities, there needs to be consistency between those measurements. Not only do you need to understand how different asset classes behave in different economic environments and how they are correlated with each other, but you also need to consider how the plan liability is impacted by those economic environments as well. The two, assets and liabilities, should not be projected into the future in isolation, but they should be projected into the future with consistency, making sure the same economic environment you are modeling is used for both measurements.

Next, Nathan hit on concepts that defined benefit plan sponsors are looking at to help derisk their plans; investment glide paths, lump sum payments and group annuity purchases. Investment glide paths, built to derisk a pension plan, generally shift a higher portion of assets toward fixed income holdings as the funded status improves. Nathan shared how a sample plan's funded status faired under different economic scenarios; but he emphasized that the type of rate movement (parallel or non-parallel yield curve shifts) have an impact on the behavior of assets and liabilities and any immunization strategy should consider this.

Nathan continued by discussing two derisking techniques; lump sums and annuity purchases. With lump sums, Nathan shared that it is important to be aware of the interest rates used to pay the lump sums and how the underlying asset values may change from the time the lump sum values are determined and when they are actually paid out. For pension plans, the timing between determination and payout could be several months or longer. If the lump sum values are locked in (it is very common for pension plans to be locked in for a yearlong period), it is important for sponsors to understand how their asset values change with changes in interest rates during the waiting period. Scenario testing is a great way to show this sensitivity to sponsors. Regarding annuity purchases as a derisking technique, Nathan says sponsors should understand the cost drivers and they should scenario test those drivers to understand the potential impact to their plan. Insurance companies base their purchase price on many factors, including credit spreads, supply/demand, specific plan demographics and market attractiveness. When scenario testing a possible annuity purchase to alternatives (such as immunizing the liability), it is important to keep the relationships between these facts consistent.

The third speaker, Jodan Ledford, led us through a case study that used scenario testing to help a defined benefit sponsor to decide on an appropriate asset allocation strategy. Mr. Ledford presented a case study for a plan that is about 83% funded with 65% equity/high yield exposure and 35% invested in liability hedging assets (long bonds). Jodan provided the sponsor with a

deterministic projection, showing the sensitivity in funded status to changes in interest rates and changes in equity values. From those results, Jodan and the sponsor were able to determine which scenario results were acceptable for them and which were not. Using that input, Jodan was able to recommend a solution to the sponsor that included more sophisticated holdings, including swaps, futures and swaptions. These new holdings mitigated funded status volatility (per the sponsor's objective). In this case, the sponsor is willing to swap the high end "good" scenarios with the low end "bad" scenarios and protect against downside risk, dampening volatility.

Session 602
CASH BALANCE/401(K) PLAN COMBINATIONS FOR PROFESSIONAL SERVICE ORGANIZATIONS

- Moderator: Richard O. Goehring

Speakers:

- Jonathan E. Joss – Fidelity Investments Consulting Services
- Kevin J. Donovan – Pinnacle Plan Design, LLC
- Session Assistant: Brian Kane – Kane Pension Design & Administration

Introduction to Cash Balance Plans

The qualified retirement plan landscape is split between Defined Contribution designs and Defined Benefit designs. A Defined Contribution plan provides a participant with an account to which the benefit is based solely on the contributions and gain/loss on that account. A Defined Benefit plan is any type of retirement plan that is not a Defined Contribution plan.

A Cash Balance Plan is a Defined Benefit Plan in which the benefit is defined as a Theoretical Account Balance which receives pay credits and interest credits. This is not a Defined Contribution plan since interest is not based on actual gain/loss (at least not entirely). Cash Balance plans are used in favor of traditional Defined Benefit designs as:

- they provide participants with a benefit whose value is easier for participants to understand,
- the benefit is defined as the Theoretical Account Balance, and
- professional organizations can easily allocate the benefits and cost of the plan across multiple partners.

Since Cash Balance plans are Defined Benefit designs, they must provide an annuity benefit. This benefit is determined by projecting the Theoretical Account Balance to the participants Normal Retirement Date and converting the projected account balance to an annuity equivalent. It is this amount that is used to satisfy nondiscrimination and compliance testing requirement. Subsequent accruals are based on the change in the annuity benefit.

Cash Balance plans for Professional Groups

Professional Group Cash Balance plans are generally designed to provide a large benefit for the owners of the organization. Additionally, dependent on the size of the group, the Cash Balance plan will often need to cover certain employee groups with a minimum benefit in order to satisfy 401(a)(26) participation requirements. Based on the structure of benefits provided in the Cash Balance plan, these plans are typically paired with a 401(k) plan under which the employees of the organization receive the bulk of their benefit through a Profit Sharing feature.

These Cash Balance/401(k) Combinations must satisfy additional restrictions on contribution deductibility. Professional employers who have a Defined Benefit plan with not more than 25 active participants are not subject to PBGC (Pension Benefit Guaranty Corporation) coverage. While not having PBGC premiums to pay may be a positive event there is a trade-off, these plans become subject to certain combined maximum deductible contribution limits:

- 31% of compensation for participants, or
- the maximum deductible defined benefit contribution and 6% of compensation for the 401(k) plan.

Due to the above mentioned deduction limits, designs of Cash Balance/401(k) combined programs will follow one of two patterns. The first pattern is to maximize the benefit under the 401(k) plan for the owners and then provide the owners with a generous Cash Balance benefit that in total stays under the 31% of compensation limit. This is done as the 401(k) limit is an annual limit that if unused will be lost for future years. The second pattern is to maximize the Cash Balance benefit and provide a 6% of compensation limited benefit in the 401(k) plan. This design typically provides for a larger annual contribution but will reach the 415 limit more rapidly.

Minimum Benefits

In order to satisfy 401(a)(26) participation requirements, staff must earn a meaningful benefit in order to be considered benefiting under the plan. While there is no formal guidance on what this minimum is, the IRS (Internal Revenue Service) has given internal guidance that the annual benefit accrual must be at least 0.5% for a participant to be considered benefiting. Since Cash Balance plans are not defined as an annuity, staff benefits must be converted. Since the Theoretical Account Balance are projected

from the participant's current age to their retirement age, older participants may require larger benefits to meet the meaningful benefit threshold.

Nondiscrimination Testing

Cash Balance/401(k) Combination designs must satisfy 401(a)(4) rate group testing. Typically, the Profit Sharing benefits provided to the non-highly compensated staff must satisfy the minimum gateway requirements which allow the profit sharing benefits to be converted and tested on a benefits basis. These benefits, much like the Cash Balance plan's Theoretical Account Balances, are projected to the testing age and converted to annuities. This projection and conversion is based on the testing interest and mortality assumptions.

Interest Crediting Rates

Cash Balance plans may not credit interest at a rate that exceeds a market rate. There are many options for interest crediting but most plans for Professional organizations credit either a fixed rate (not more than 6%) or credit the return on the plan's assets. This second approach is becoming more popular as the organization just has to fund the pay credit each year. However this does pose some unique testing issues.

Recall that the accrued benefit is based on a projection of the Theoretical Account Balance. When the return on assets is used to credit interest on the accounts, the projection uses the current interest crediting rate. Since the 415 maximum lump sum is determined based on this accrued benefit, this can lead to situations where the 415 limit is greatly exceeded when the return on assets is strong. This means the maximum distributable benefit can be significantly less than the Theoretical Account Balance. On the flip side if the actual return is low, there may be additional issues with determining a meaningful benefit under 401(a)(26) for the staff. These issues can be resolved by limiting the interest crediting rate for owners and including a minimum crediting rate for the staff.

There can also be issues that arise under 411(a)(9) when asset returns are used to determine the interest credit. Since Cash Balance plans typically have an immediate lump sum option, there is a possibility that the immediate annuity at an earlier date is larger than the annuity at the current date. This situation would arise if the return on assets were to suddenly have a very bad year for a long time participant such that the preservation of capital rule did not come into play. The annuity payable at an early age could be much larger than the current annuity and guaranteed if the participant elected the annuity. Interestingly the lump sum amount would still be the current Theoretical Account Balance.

Other Issues

New regulations in 2014 introduced the idea of sub-pools of assets to be used to determine the interest crediting rate. This rule was designed to allow the segregation of assets between those assets that cover a traditional defined benefit liability and the assets used to determine the interest crediting rate. The regulations also allow this separation to be used to determine separate asset pools for different participant groups' interest crediting rates. This could be used to create "lifestyle" sub-pools as is common as a default investment option in Defined Contribution Plans. However, the IRS has indicated that any use of age as a criterion to determine the interest crediting rate will cause a loss of the age discrimination safe harbor. This could also expose the plan to age discrimination claims.

The IRS is in the process of reviewing Cash Balance Plan Documents to be Pre-Approved Documents. This deadline for submission of documents for review was October 31, 2015. It is anticipated that the process of reviewing these documents will take multiple years and may be completed in 2017. The IRS has indicated that certain design features will not be approved, including any plan that credits interest based on the return on plan assets.

Session 603
DEALING WITH THE PBGC

Speakers:

- Michael S. Clark – P-Solve
- R. Joseph House – Palisades Capital Advisors
- Scot McCulloch – Palisades Capital Advisors
- Session Assistant: Michael S. Clark – P-Solve

Background

The Pension Benefit Guarantee Corporation (PBGC) is a government agency tasked with protecting retirement benefits of more than 41 million workers and retirees. The PBGC insures two main types of defined benefit pension plan programs: single employer and multiemployer.

The Office of Negotiations and Restructuring (ONR) within PBGC is the group that works with companies, both in and out of bankruptcy, to preserve their pension plans by monitoring, conducting financial, legal, and actuarial analysis, and negotiating protections for plans and their participants. When plans cannot be preserved, ONR pursues claims to recover additional assets that help PBGC pay benefits. The group's analysts and actuaries work with plan sponsors and their actuaries to understand projected minimum

funding contributions as well as the plan's underfunding to reach successful outcomes.

The PBGC regularly monitors its universe of pension plans in order to fulfill its mandate to protect the retirement income of pension plan participants. This monitoring tends to focus more on sponsors that are experiencing distress or engaging in reorganization. The main sources of PBGC's monitoring include reportable event filings or through their own proactive reviews of financial news, media reports, and press releases.

Recent Changes

New updates to reportable event filings went into effect on September 1, 2015. These changes are meant to cut down on the amount of filings that the PBGC receives and focuses more on those entities that pose more risk to the PBGC. To this end, many of the new filing waivers relate to low default risk companies and well-funded plans. One area where PBGC is providing greater focus is when there is a corporate transaction involving private equity firms.

While the PBGC is reducing the amount of reportable event filings it receives, for those filings where the PBGC decides to engage the plan sponsor for additional information the data requests have become more onerous. These requests now typically include 10-year funding projections and often require various hypothetical contribution scenarios.

In July 2014, the PBGC issued a moratorium on Section 4062(e) enforcement. Section 4062(e) has been a part of ERISA (Employee Retirement Income Security Act) since its inception, but it wasn't until the mid-2000's that the PBGC aggressively enforced its provisions. A 4062(e) event happens when a plan sponsor has a major shutdown of operations (e.g. reductions in force or plant closures). In situations where 4062(e) applied, PBGC had the authority to pursue additional contributions to the pension plan which it could do through liens and other aggressive negotiations. In late December 2014, Congress largely re-wrote the 4062(e) provisions which now limit PBGC's ability to pursue shutdown liability against a plan sponsor.

Regulatory Focus

The PBGC's early warning program (EWP) helps PBGC assess corporate transactions that may impact the credit worthiness of a plan sponsor. PBGC analyzes a plan sponsor's capital structure and financial projections pre- and post-transaction to better understand if the pension plan may be adversely impacted and what, if anything, should be done to protect the plan. PBGC is particularly interested in transactions that: involve significant debt (especially secured) or are highly leveraged; move a company or sponsor from a controlled group with a strong corporate credit to a weaker credit; and involve private equity firms or hedge funds.

The PBGC may pursue several different tracks with respect to an EWP case:

- The plan sponsor and/or its professionals submit requested data to PBGC with limited to no follow-up.
- PBGC reviews the information submitted and follows-up with the plan sponsor via letter, email or telephone to resolve any outstanding questions it may have.
- PBGC reviews the information submitted and reaches the conclusion that a pension plan is exposed to additional risk as a result of the transaction that triggered the EWP case.

Under this last scenario, protracted negotiations may occur and PBGC will likely "ask" the plan sponsor to consider providing additional protection for its pension plan. If an EWP case reaches the stage where PBGC is seeking additional protection for the pension plan, negotiating a mutually agreeable settlement can take considerable time and may have the effect of delaying the transaction.

PBGC is also currently focusing on situations that involve controlled group liability. PBGC looks at controlled group liability as it relates to multiemployer withdrawal liability, underfunded single-employer pension plans, minimum funding obligations and PBGC premiums. In situations where a plan is struggling with any of these items, PBGC is reaching out to other entities that it considers joint and severally liable to try to bolster protections for the pension plan and its participants.

Conclusion

Mr. House shared a case study from a recent client that highlights what practitioners and plan sponsors can do when faced with scrutiny from PBGC. The big takeaway from the case study is that PBGC is always willing to negotiate to reach successful outcomes. In that light, practitioners should not hesitate to propose creative or out of the box solutions to resolve any negotiations with PBGC.

Session 605
WHERE DID YOU GET THAT HEALTHCARE TREND?

Speakers

- Michael Taggart–Standard & Poor's Dow Jones Indices
- Dale Yamamoto–Red Quill Consulting
- Session Assistant: Steven Draper–Ernst & Young LLP

We have grown used to an environment where trend surveys are available and each client has a different trend indicating that their own experience has been different. We now have two clear measures of recent health care cost trends that can be used to benchmark the trends of our clients.

S&P Healthcare Index

With the S&P (Standard & Poor's) health care indices, we now have an objective measure of health care cost trend transforming what used to be a fuzzy measure. The indices are based on data submitted by national carriers who can then evaluate whether they themselves beat the average trends. Twenty-five large plans submit data monthly including Aetna, Cigna, Health Care Service Corporation (HCSC), and 20 other Blue Cross Blue Shield (BCBS) plans that represent in total over 57 million covered participants. The data is reported monthly by the carriers, but S&P reports the results on an incurred basis with about a three month delay so the data can be more complete. For example, the data to be reported October 29th is based on incurred data through August. The data is further completed using an average monthly claim lag development.

The reported data includes ASO (administrative services only), small group, large group insured, and individual market including public exchanges. The data is split into medical and drug with drugs split into generic and brand. The data is available at the three-digit zip code level assuming that one carrier does not represent more than 65% of the data in a specific cut of the data. About 16,000 of a possible 32,000 indices are published. S&P does not publish reasons for trends or commentary. Only the facts are published. Due to seasonality, October and March are typically high months; there is no adjustment for seasonality in the published trends.

The index allows for studying trends in areas with high ACO (Accountable Care Organization) penetration. No projections are included, only historical data. Kaiser data is not included, but some of the data is aggregated at the capitation level so procedure codes are not provided.

What can you do with the S&P health care cost index?

Primarily, you can track your insurance provider against the market. Key performance metrics could be tied to trend results. With a published benchmark the adversarial nature of trend comparison calculations are removed. Actual trend is compared to the benchmark, not against a moving target of what trends would have been. Of course there will be a need to adjust for geography, networks, and plan designs.

A futures market is possible. Approval has been granted by the exchanges, but a market needs to be identified, i.e. who will take the risk of these contracts? It is possible that hedge funds will see market return opportunities?

Hospital costs include unit charges by day and number of days but do not go into further detail. United Healthcare and Anthem are not currently participating.

Consultants can receive a 12-month subscription to the indices at no cost. S&P would like the indices to be well used and accepted in industry and among consultants. As they gain acceptance and are used, S&P will begin to generate licensing fees other than subscription fees.

HCCI–Health Care Cost Institute

The website for the HCCI is healthcostinstitute.org

The desire of the institute is to gather data for researchers to review. It is a non-partisan, non-profit organization dedicated to providing complete, accurate, and unbiased information about health care utilization and costs. Kaiser, United Healthcare, Aetna, and

Humana are all HCCI supporters.

Over the past five years HCCI trends have tracked fairly well with S&P trends, but have been slightly higher on average.

The HCCI includes adjustments to make the data reflective of the natural market since in some areas the Blues plans are dominant, but the HCCI does not include Blues plans data yet. Inpatient, outpatient and other service categories are all available in the HCCI by age/gender, geographic region, and service categories. Part of the value of the index is to see how the composition of trend and costs by service category has changed over time. For example, the HCCI shows the generic drug penetration in the market. Most recently generic utilization is up to 86% when looking at 30-day equivalent fills.

Consultants from pharmacy benefit managers (PBMs) publish forward looking pharmacy trends that take pipeline into account. CMS (Centers for Medicare and Medicaid Services) develops the National Health Expenditures (NHE). The data shows a spike in recent trends that is not yet quite explained.

Conclusion

The tools available to health care actuaries to measure trend are more comprehensive and detailed that have been available at any time. Both the S&P index (with licensing) and the HCCI offer data on historical trends and patterns that health care actuaries and benefit consultants can use to augment their work.

Session 606
RECENT DEVELOPMENTS IN CANADA

Speakers

- Kevin Tighe – Towers Watson
- James Jones – Deloitte Consulting LLP
- Session Assistant: Gordon B. Lang – Gordon B. Lang & Associates Inc.

Recent Developments in Canadian Public and Private Pension Plans

Unlike the U.S. and U.K., pension plans in Canada are primarily subject to Provincial rather than a single Federal jurisdiction and therefore are somewhat complex in nature. Whereas there are many similarities between various Provincial and Federal registered Pension Legislation, each jurisdiction has certain differences from the majority of the other jurisdictions.

The New Ontario Retirement Pension Plan (ORPP) is not currently being adopted by either the Federal Government nor any of the other provinces. All employees who are residents in the province of Ontario, unless employed in a Federal jurisdiction (e.g., banks, interprovincial transportation etc.) will be required to join this Plan unless they are members of a "Comparable Plan." Contributions will be 1.9% of earnings from each of the employee and employer up to indexed earnings of $90,000 (Canadian). The ORPP is intended to provide an indexed pension over a 40 year career of 15% of earnings up to the indexed limit.

Whereas the ORPP is similar in many ways to the Canada Pension Plan (CPP), it will be registered as a Multi-Employer Pension Plan (MEPP). Instead of a tax credit to employees contributing to the CPP, ORPP contributions will be fully deductible. "Comparable Plans" will be DC (Defined Contribution) plans with minimum contribution rates of 8% (at least 50% of which will be contributed by the employer) or a DB (Defined Benefit) plan with a minimum formula of 0.5% containing all the bells and whistles of the ORPP (e.g., full CPI post-retirement indexing). Flat Benefit DB Plans will require special testing. Depending on the size of the employer, membership in the ORPP will be phased in between January 1, 2017 and January 1, 2020. Contribution rates will also be phased-in over three years. The ORPP is designed to improve the Target Replacement Ratio of government pension programs, in particular for pre-retirement earnings up to $90,000 (indexed).

The implications to pension consultants and their clients were discussed, in particular with respect to pension plans which do not meet the "Comparable Plan" standard.

New Ontario Successor Plan Rules

The Financial Services Commission of Ontario (FSCO) which has jurisdiction over pension plan members in Ontario (unless they fall under Federal rules), recently has reversed its stance and permitted a pension plan to be wound up despite the existence of a successor plan, as long as the employer "ceases contributions" to the original plan. This policy change will permit the wind-up of the DB component of a plan once future DC accruals for current active members are moved to another DC plan.

Quebec Bill 57

As a result of the 2013 D'Amours Report, Bill 57, which has received a favorable response from unions and employers, is expected to be adopted with effect from January 1, 2016. Bill 57 will remove the requirement for solvency funding but require a stabilization provision (STAB) of between 5% and 25% (depending on the investment policy). Total normal cost contributions will be increased by STAB. There will be a three-year transition period for STAB requirements. If the solvency ratio is under 85%, annual valuations are required; otherwise valuations are required every three years. There are a number of additional rules including: annual notice of plan's financial situation before April 30, partial valuation for plan amendments or contribution holidays, plan amendment funding, employer reserves, surplus use on plan wind-up, members consent regarding plan surpluses, transfer values, partial indexing and member contributions towards deficits.

Canadian Group Annuity Marketplace

The past and current annuity purchase markets in Canada were compared. There has been a substantial increase since 2012. Fifty-three percent (53%) of employers with DB plans are contemplating annuity purchases in next two or three years. The main triggers are DB exit strategy or right-sizing, pension asset diversification and longevity risk mitigation. Also the relative advantages or disadvantages of buy-outs and buy-ins were discussed as well as limitations on the size of the Canadian annuity marketplace.

Session 703
REVIEWING RESULTS OF ANOTHER ACTUARY

Speakers:

- Michael Altilio – Towers Watson
- Seth D. Chosak – Towers Watson
- Gary H. Rothy – PricewaterhouseCoopers LLP
- Session Assistant: Joseph M. Kim – Deloitte Consulting LLP

Background

The purpose of this session is to help the consulting actuary understand who might be reviewing their work, under what circumstances it might be necessary for their work to be reviewed, how the work might be reviewed, and what the actuary can do better in order for the review process to go efficiently.

Summary

There are many parties that could potentially be reviewing the actuary's work. These include, but are not limited to, an internal actuary who is performing a peer review in order to meet internal quality control policies and an external actuary who might be assisting "the other side" in M&A (mergers and acquisitions) deals or taking over your role as the successor actuarial service provider. In these cases, the work is generally reviewed by someone who meets the Qualification Standards promulgated by the American Academy of Actuaries. Sometimes, an actuary's work product can be questioned by others who generally do not have a sound actuarial background: attorneys, auditors, clients, plan participants, media personnel or personnel within government /regulatory agencies. Examples of government/regulatory agencies cited in the session include U.S. Securities and Exchange Commission (SEC), Public Company Accounting Oversight Board (PCAOB), Internal Revenue Service (IRS), Department of Labor (DOL) and the Pension Benefit Guaranty Corporation (PBGC).

The scope of the review can be different depending on the purpose of the review: for example, a review of individual benefit calculations or an assessment of the reasonableness of the assumptions and methods used to determine the benefit obligation. The reviewing actuary will keep in mind professional skepticism and validate both inputs and outputs of the actuarial deliverables in order to get "comfortable" with the results. When the person reviewing the actuarial work does not hold sufficient knowledge/background to perform the review, s/he may invite another qualifying actuary to review the work (e.g., an actuary who supports audit engagements that involve defined benefit plans).

Many times, a review may be limited to a "high-level" or a "gut check" review, but in other circumstances the reviewing actuary may ask for more details depending on the situation (e.g., review of individual benefit calculations or match of prior actuary's work in the case of take-over). In these circumstances, it is important for both the preparing actuary and the reviewing actuary to act with professional courtesy in order to avoid any contention or confrontation.

In order to make the process as efficient as possible, the preparing actuary needs to keep a few things in his/her mind when preparing an actuarial communication:

- Compliance with relevant Actuarial Standard of Practice (ASOPs) and Code of Professional Conduct as well as internal standards and policies
- Balance flexibility with consistency/efficiency
- Provide appropriate details and document what you considered in reaching your conclusion
- Clearly define the scope of your work and be clear on the limitations of the analysis
- Write with the audience in mind.

When responding to a request from someone who will be reviewing your work, it is important to not assume anything and to provide only the information requested. For example, auditors are prohibited from obtaining irrelevant information such as "Personally Identifiable Information." The actuaries involved should work collaboratively in an effort to serve the client better. Sometimes, having a conversation with the information requestor and setting the right expectations up front can increase the efficiency of the overall process.

If a mistake is found by the reviewing party, the preparing actuary first determines whether it is truly a mistake – perhaps, the scope of work has not been communicated appropriately or a preparing actuary uses a computational shortcut to arrive at a different estimate. If it is truly a mistake, then the preparing actuary has a responsibility to inform the principals and take appropriate actions to remedy the mistake.

Session 704
HOW DO WE MEASURE UP?

Speakers:

- Jack Bruner – Change Healthcare
- Ryan Wilson – HealthSouth Corporation
- Gerry Smedinghoff – KPMG
- Session Assistant – Jennifer Milstein

Background

Healthcare lends itself to a lot of different types of numbers, trends and analysis. This session aims to help the consulting actuary understand how to build a transformational analytic strategy, using two case studies – one of a healthcare technology company and one of a provider – who followed such a strategy and conducted analyses to help drive business results.

Building a Transformational Analytic Strategy

Change Healthcare, a healthcare technology company, uses the following five-step process for their analytic strategy and the study detailed below. In the study, Change Healthcare focused on leveraging available data and connectivity to broaden consumer engagement in their healthcare.

Step One: Quantify the full opportunity – Identify those items that should be considered in your study. Consider other secondary opportunities that may be interrelated and pursue all opportunities in conjunction to optimize ROI. In this particular study on engagement, Change Healthcare knew that focusing on transparency and provider pricing presented a 10% opportunity, but that also including prevention, decision support, chronic condition management and pharmacy management could enhance results.

Step Two: Map the process – Determine what your future state will look like. Map out the tactics/steps that need to be taken to get to the future state process. In this study, Change Healthcare mapped out the various touchpoints that a particular consumer would experience – from communications to biometric results to nurse coaching.

Step Three: Analyze each activity and intervention – After employing the process, collect data on each of the tactics and steps and analyze the outcome. Was the result what was intended? In this study, Change Healthcare was able to determine what actions impacted drug adherence and engagement in decision support/cost of care tools.

Step Four: Use data dynamically to optimize results – One you have the results from step three, you can determine changes that can be made to the process defined in step two to optimize results, either on an individual or a group level. For Change Healthcare, they were able to adjust interactions with members, based on demographics, as they had collected data that showed different groups respond to different styles of communication.

Step Five: Demonstrate results and return on investment – Using the data obtained from the study, calculate savings associated with the process employed. Change Healthcare was able to quantify chronic condition savings resulting from improved drug adherence.

HealthSouth Comparative Effectiveness Study: Inpatient Rehab Hospital vs. Skilled Nursing Facility

HealthSouth is dedicated to comprehensive rehabilitation medicine in both a hospital setting and at home. They operate over 100 inpatient rehabilitation hospitals (IRH) in the U.S and Puerto Rico.

HealthSouth became interested in their data due to several factors:

- Attention to the Post-Acute Care sector, with federal cost-cutting interest,
- Confusion between segments of the Post-Acute Care sector. Little knowledge of difference between long-term acute care hospital, skilled nursing facilities (SNF) and IRH, and
- HealthSouth also believed that their IRHs may be a better alternative to SNFs, from both a cost and quality perspective. Numerous clinical journals documented the superiority of clinical and functional outcomes achieved – but does this translate to lower cost of a total cost of care basis?

HealthSouth selected KPMG as their partner for the study. Together, they tested the following hypothesis:

Compared to SNFs, IRHs focus on rehabilitative care, which results in patients:

- Being discharged from the acute care setting earlier
- Showing higher functional improvement during rehab
- Having a shorter length of stay in rehab
- Having a lower acute care hospital readmission rate
- Having a lower average total cost of care

Obstacles for HealthSouth include the fact that there are no valid industry-wide metrics to evaluation cost and quality of post-acute rehabilitative medicine and there is a need to create valid metrics that avoid the two most common quality control definitional errors (assuming that use = value, and failing to control for inputs). Datasets used for the study were the HealthSouth internal patient records and the BHI (Blue Health Intelligence) dataset.

The study design focused on one specific condition, stroke, to control for inputs. Target patients were those admitted to an IRH or SNF following discharge from an acute care hospital for stroke. Quality/total cost of care of all health of all health plan expenses, as well as LOS and readmission metrics, were defined in three periods – pre-stroke (90 days prior to hospitalization), stroke (from hospital admission through rehab facility discharge) and post-stroke (90 days

following rehab facility discharge).

After analysis of the data, it was found that IRF costs are comparatively lower in each of the three care continuum phases. The lower costs in the post-stroke period are driven by the fact that IRF readmission rates are approximately half of those of SNFs. There was some concern that the favorable results were due to differences in the patient cohorts that were discharged to an IRH versus a SNF. The study was refined to normalize for this, and the 90 day period post-stroke cost advantage for IRHs held.

The study clearly demonstrates that IRFs have a cost advantage over SNFs. The study findings can help to re-orient a provider's understanding of rehab options, assist patients and their families in medical decision-making, improve payor's decision-making algorithms for IRHs and SNFs, promote wise use of limited health resources and fulfill the promise of patient access to appropriate care – all of which can help drive business results for HealthSouth.

Session 705
RISK SCORE BASICS AND MECHANICS

Speakers

- Christine Bach – Wakely Consulting Group
- Kelsey Stevens – Wakely Consulting Group
- Joel Menges – The Menges Group
- Session Assistant: Karen A. Shelton – UnitedHealthcare

Medicare Risk Adjustment

Risk adjustment mechanisms can be used to adjust payments to health plans based on the health risk of the covered population relative to an average population. These adjustments dampen the impact of anti-selection and "level the playing field" for participating insurers.

Risk adjustment models are either prospective or concurrent. Prospective models use prior year diagnoses to predict future expected costs. Concurrent models use current year diagnoses to predict current year costs. These models produce individual-level risk scores typically based on each member's diagnosis data, claims detail and demographic information such as age and gender.

The Centers for Medicare & Medicaid Services Hierarchical Condition Categories (CMS HCC) risk adjustment model is a prospective model used to adjust payments in the Medicare Advantage market relative to the average Medicare beneficiary. This model considers items such as age, gender, Medicaid dual eligibility, disabled status, income status and health status. The model is additive and hierarchies apply so that those with a more severe case of a condition receive a higher risk score than someone with a well-managed condition. Disease interactions are also considered, where the presence of two conditions may be more costly than the sum of the individual condition costs.

The CMS HCC risk adjustment model was created under the guidance of 10 principles, which could be applied to the creation of any risk adjustment model.

- Principle 1 – Diagnostic categories should be clinically meaningful (International Classification of Diseases, 9th Revision [ICD-9] grouping should relate to a common disease or condition).
- Principle 2 – Diagnostic categories should predict medical expenditures.
- Principle 3 – Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures.
- Principle 4 – In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate.
- Principle 5 – The diagnostic classification should encourage specific coding.
- Principle 6 – The diagnostic classification should not reward coding proliferation.
- Principle 7 – Providers should not be penalized for recording additional diagnoses (no condition category should carry a negative payment weight).
- Principle 8 – The classification system should be internally consistent.
- Principle 9 – The diagnostic classification should assign all ICD-9 codes.
- Principle 10 – Discretionary diagnostic categories should be excluded from payment models.

Under this risk adjustment model, higher risk scores translate into greater revenue for Medicare-advantage plans. There are member approaches, provider approaches and data approaches that can be used to increase risk scores. Member approaches can include ensuring the member is seen by a doctor annually so that all conditions are being recorded. Provider approaches may include educational sessions on coding or entering into risk-sharing arrangements with financial incentives aligned to coding accuracy. Data approaches ensure permanent conditions are captured each year.

Medicaid Risk Adjustment and Capitation Rate-Setting Dynamics

There is an abundance of opportunities for actuaries to be involved in Medicaid managed care.

Risk adjustment has given Medicaid managed care organizations (MCOs) more influence over their payments in recent years, contributing to the growth in capitated Medicaid MCOs. In 2016, it's projected that 45% of total Medicaid expenditures will come from capitation. This varies considerably by state with some states in excess of 85% capitation to some states not using this type of reimbursement model.

Several challenges exist within the Medicaid population, one being the diversity of the population with very different clinical needs. The population includes low-income children and adults, dual-eligibles (Medicare & Medicaid) and non-Medicare disabled. As may be expected, the disabled and low-income elderly (dual-eligibles) have considerably greater needs than low-income children and adults. Not only are the needs very different, the ability to coordinate care varies greatly among these populations. Low-income adults and children are prevalently in coordinated care whereas this is much less the case for the elderly.

Medicaid MCO payments cover members retrospectively which can create a pricing challenge for a transient population like the low-income children and adults.

The aforementioned challenges with this diverse population contribute to a risk adjustment model that has its own challenges in getting accurate data to reflect that actual population. Impacts of policymaking and specialty pharmacy add to the challenges of appropriately setting capitation rates. Medicaid often has managing care as its only means to control cost, making it an area ripe for actuarial innovation.

Session 708
INTEREST RATES DECONSTRUCTED

Speakers:

- Brett Dutton – PNC Institutional Asset Management
- Andrew Patterson – Vanguard
- Gordon Enderle – Towers Watson
- Session Moderator: Tammy Shelton – Towers Watson
- Session Assistant: Christy Trang – Towers Watson

How do CFOs and Treasurers think about interest rates? How do you break down Treasury rates and corporate bond rates into components? Why are interest rates where they are now, and where are they headed?

Treasury Rates and Corporate Bond Rates

If we look beyond actuarial context, there are varying perspectives and interactions with interest rates. Per Investopedia, the definition of an interest rate is the "amount charged, expressed as a percentage of principal, by a lender to a borrower for the use of an asset." In the financial world, interest rates are primarily associated with bonds, the contractual borrower and lender relationship and specifically with how the market reprices bond value. The term interest rate is somewhat interchangeable with bond yield – a rough measure of a bond's return. A more general context in which interest rates are considered are risk-free rates or Treasury yields. Ninety percent of the time, the shape of a yield curve is seen as upward sloping and concave.

A corporate bond index, such as the Citigroup Pension Discount Curve, is a hypothetical spot rate curve of zero coupon bonds derived from existing bond yields. The "spread" or additional yield of a corporate bond on top of the Treasury, represents the reward required by corporate bond holders for bearing risk. In the bond investment industry, corporate bond returns are typically expressed as Treasury + X%. Fundamentally, interest rates are derived as the equilibrium yield or price between investors and sellers that sufficiently compensates the investor given the risk of the asset.

The two building blocks for a Treasury's expected return are inflation and real interest rate. There are many imperfect approaches to determining a Treasury's yield. Treasury Inflation Protected Securities (TIPS) which provide automatic inflation protection are an estimation for inflation. The Federal funds target rate is an overnight or short-term borrowing rate that has a direct influence on short-term yields and observable impact on long-term rates. Beyond those two variables, a Treasury's return builds in a premium that depends on the maturity term of the security.

Steep yield curves characterize bullish markets whereas flat curves denote bearish markets. The yield curve can be used to derive forward rates, the market's expectations for future interest rates. However, forward rates are not purely market expectations because the market does not expecting rising rates 90% of the time. The positive slope of a curve is related to the bond-risk premium, or additional compensation expected for longer duration and higher price volatility; whereas the concave nature of a curve is the price protection property of the bond, also known as convexity bias.

In general, spreads are less volatile than the yields themselves, thereby volatility in rates predominantly stems from Treasuries. Historically, there is a negative correlation between Treasury rates and corporate spreads such that a lower Treasury yield tends to lend to a higher corporate spread. Spreads are influenced widely depending on individual issue characteristics, such as the type of

bond issuer, the perceived creditworthiness (credit rating), term to maturity, inclusion of options, interest taxability, and liquidity. BBB-rated issue bonds dominate the U.S. investment grade corporate bond market and are associated with the highest spreads and spread volatility. In fact, in the context of pension plans, the scarcity of AA bonds makes it difficult to estimate AA yield curves in which to invest a portfolio of bonds to hedge the pension obligation.

Current and Forward-looking View of Interest Rates

Where we are today

Fixed income is mathematical in nature. There is a stable relationship in Treasuries with regard to time and yield. Treasuries are currently yielding approximately 2%, and are not so bright on the bond yield front. A bear-flat curve refers to an upward sloping, not quite parallel, yield curve. As mentioned, federal fund rates more so affect short-term rates than long-term due to inflation. Using the curve, forward rates are the market-derived expectation of interest rates and informative starting points to pinpointing the market view. The only problem with the market view is that the market view is always wrong. It may be more reasonable at longer maturities but definitely divergent with reality in the short-term. Rates rarely evolve as expected but nevertheless are a reasonable starting point.

The possible building blocks or drivers of interest rates are outlined below.

1. Inflation expectation – has a larger impact on longer maturity yields
2. Risk premium – risk involved with investing for a longer period of time
3. Federal policy – has implications on shorter end to avoid rate rises
4. Client demand – e.g. institutional or foreign investors flight to safety, foreign hedging have negative implications on yields
5. Deficit – difference between fiscal policy and tax and spending; has upward pressure on yields
6. Economic activity – expectations for growth policy rates
7. Other – preferred habitat theory, liquidity theory

Banks respond to global crises in varying degrees; the U.S. Federal Reserve ("the Fed") and U.K. have come out with guns blazing. Euro and China banks lag in their response and continue easing policy. Monetary policy is driven by breakeven inflation expectations (particularly Europe and Japan). The driving factors cannot be looked at in isolation; they are connected in a symbiotic relationship. Keep in mind that the Fed is more so reactionary rather than the driving cause.

Where Treasury bond yields are going

The Taylor Rule model is often used to approximate the Federal fund rate and is the sum of:

1. Neutral interest rate – real interest rate present assuming no gaps in inflation and unemployment
2. Gaps in inflation – Fed's target Consumer Price Index (CPI) (2.0%) versus actual
3. Gaps in unemployment (5.0%)
4. Target CPI

Given the principles outlined above and current interest rate levels, there is belief that there is a pending interest liftoff, but one likely to be a more measured, staggered rise than rather than a steady march to the end game. Also, the terminal rate is not likely to return to historical levels, but more along the lines of 2.0%–3.0%.

Bond bear market

Bond-bear markets are centered around the fear of losses and less concerned with liability-matching. In terms of equity, a bear market is defined as a 20% loss. An increase of 300 basis points, which means a 3% change in yield, would be the largest ever one-year increase in relative terms. That would result in the second worst 12-month return for bonds or a 13.1% loss, which is difficult to stomach but would not meet the 20% threshold definition. Also keep it mind, income would result in a positive cumulative return by year four.

Interest Rates and Benefit Plans in a Client's Financial World

A universal nugget of advice is that you want to be good at what happens a lot and a definite recurring theme within the pension industry is investment-grade corporate bonds. All companies run debt, even small ones. CFOs and Treasurers think about a lot about "hard debt," such as loans from banks or commercial paper. They are continuously aware of where Treasuries and spreads currently are. And yet, it's interesting to think that the trillions-of-dollars pension industry sits on the pinhead of AA corporate bonds.

CFOs and Treasurers come from varied backgrounds – accounting, operations, and finance – and thereby we cannot assume they have mastery of interest rates, valuation and discounting. Despite their background, they are all generally concerned with positioning of the balance sheet, credit rating and debt/equity ratio. There is a 15-20% annual turnover among CFOs, so generally their vision and goals are short-term. Furthermore, their compensation is weighted towards short-term financial performance, which thereby lives in natural contention with pension plans that have a long-term horizon. The macroeconomic issues and challenges of pension plans (where rates are going) are constantly colliding with management's quarter earnings priority.

We are operating in an age of uncertainty and yet still need to make business decisions. This is especially difficult for actuaries who like concrete answers (math, exams, models) and can lead to analysis paralysis. Rather than a right versus wrong mentality, we need to evolve and change the nature of the conversation – what is going to promote the organization's objectives. An investment policy is successful if objectives are met. Define what the objective is and if the interest rate helps the outcome, we should consider that good, rather than what is necessarily "right." Interest rates are not a single monolithic thing. We need to recognize that there is no such thing as normal interest rate. Being able to consult and move forward in an evolving economy are essential skills. Perhaps the current interest rates we live with are the "norm."

A few key market developments have changed the game for pension actuaries, the first being plan freezes. Frozen pension plans have made plan sponsors more aware of the legacy liabilities they hold. Investment strategies are being rethought. Finance has become a larger presence in the conversations while HR has become more removed. The second game changer has been the lump sum opportunity. A natural arbitrage, we have had to help our clients understand corporate rates, spreads, and smoothing mechanisms. We also have to become more knowledgeable on how transactions happen and how Treasury and bond markets affect these conversations.

Thank You To Our Session Assistants

A special thank you to our Session Assistants who provided the following summaries:

Deborah K. Brigham – Segal Consulting

Michael S. Clark – P-Solve

Steven Draper – Ernst & Young LLP

William Fornia – Pension Trustee Advisors, Inc.

Barry L. Freiman – Principal Financial Group

Eli Greenblum – Segal Consulting

Michael I. Helmer – Segal Consulting

Brian Kane – Kane Pension

Joseph A. Kim – Deloitte Consulting LLP

Piotr Krekora Gabriel Roeder Smith & Company

Gordon B. Lang – Gordon B. Lang & Associates Inc.

Daniel P. Lucas – The Newport Group

Andrew Marcus – Fidelity Investments

Jennifer Milstein – Lockton Companies

Michael Muir – Quantum-Health

Philip M. Parker – Buck Consultants, A Xerox Company

Albert Phelps – Arthur J. Gallagher & Co.

Steven Robert Pribis – SR Retirement Consulting LLC

Derek Ray – Willis Towers Watson

Ruth E. Schau – TIAA-CREF

Vinaya Sharma – Quantitative Risk Management

Karen A. Shelton – UnitedHealthcare

Christy Trang – Willis Towers Watson

Melissa Verguldi – Lockheed Martin Corporation

Would you like to be a Session Assistant at this year's Annual Meeting?

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

Serving as a Session Assistant is an excellent way to network into other continuing education opportunities, gain exposure within the profession, and potentially participate in speaking opportunities. New actuaries are especially encouraged to consider serving in this capacity to build contacts and experience in coordinating an educational session.

Sign up now to volunteer for this year's Annual Meeting, October 23-26 in Las Vegas, Nevada. Hope to see you there!

CCA Bylaws Ballot Results

By an overwhelming margin of 95% in favor, the CCA's membership has endorsed the Bylaws amendments proposed by the CCA Board of Directors. These changes to the Discipline section of the Bylaws were required to comply with changes that are being made to the profession's Joint Discipline Agreement, to which the CCA is a party.

The CCA thanks everyone who took the time to vote.

To view the newly amended Bylaws, please visit our site at http://www.ccactuaries.org/governance/bylaws-of-the-cca.

The CCA Announces Bylaws Update, New Committees and Volunteers

The CCA Board of Directors has launched three new committees: the Member Engagement Committee, the Continuing Education Scan Committee and the Social Media Committee (formerly the Social Media Community).

The Member Engagement Committee focuses on identifying member engagement opportunities and placement of volunteers into suitable roles. The committee creates communications about opportunities and establishes and maintains follow-through of communications through various channels to appropriate chairs regarding opportunities that might match the identified volunteer. The committee ensures that volunteers are appropriately placed, and if unable to do so, the committee fully communicates back to the member the challenges encountered. The goal is to ensure a member's volunteer offer is welcomed and managed by establishing an appropriate opportunity that makes use of that volunteer's talents, which also benefits the CCA members at large through specific volunteer efforts.

The purpose of the Continuing Education Scan Committee is to provide semi-annual reports to the Board of Directors regarding current CCA offerings, as well as outside opportunities and offerings: a) among the actuarial associations; b) other closely related professional associations (e.g., IFEBP and other appropriate healthcare associations/professional groups), and c) other groups the committee feels are appropriate to determine other potential methods for delivery of CE content.

The Social Media Committee develops and implements social media strategies to enhance the value of CCA membership to consulting actuaries and to promote the activities of the CCA and its membership to the general public.

The CCA welcomes volunteers for these and other committees. For more information, visit our website and view our Volunteer form at http://www.ccactuaries.org/Portals/0/pdf/CCA_Volunteer_Form.pdf.

CCA Welcomes New Members and New FCAs

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

Matthew P. Avery, FCA
Mark A. Barrett, FCA
James G. Berberian, FCA
Mark William Birdsall, FCA
Charles W. Bloss, FCA
Gary H. Ceppos, FCA
Seth D. Chosak, FCA
Kelly Conlin, FCA
Matthew A. Cowell, FCA
Dean M. Crawford, FCA
Rebecca Crowley, FCA
Jason A. Denton, FCA
Thomas M. Donlon, FCA
Steven D. Draper, FCA
Lisa Marie Engler, FCA
Bernon R. Erickson Jr., FCA
Edward F. Groden, FCA
Robert Grider, FCA
Thomas A. Harrigan, FCA
James M. Hechler, FCA
Andrew B. Hodges, FCA
LeRoy House, FCA
Marcus Howell, FCA
Katherine Huang, FCA
Kelly Lynn Karger, FCA
Yassir Mohamed Khalid, FCA
Melissa Conklin Kolle, FCA
Brad Kopcha, FCA
Yi-Ling Lin, FCA
Yi Chieh Liu, FCA
R. L. Masselink, FCA
Matthew Wayne McDaniel, FCA
Gary J. Miller, ACA
Melissa Lee Nicholas, FCA
Carly Nichols, FCA
Jeffrey Grant Passmore, FCA
Christopher M. Place, FCA
Moshe Radinsky, ACA
Narendra R. Ramdass, FCA
Timothy K. Robinson, FCA
Ernesto Rosas, FCA
Ruth E. Schau, FCA
Lisa Schilling, FCA
Gregory Schoener, FCA
Enrique Schulz, FCA
Aaron Shapiro, FCA
Matthew Smith, FCA
Christopher Snell, FCA
Kevin Scott Spanier, FCA
Mark F. St. George, FCA
Tanya E. Sun, FCA
Molly A. Thompson, FCA
Philip M. Trick, FCA
Deborah A. Tully, FCA
Martin Weiss, FCA
Teresa Ellen Wolownik, FCA

In Memoriam

Douglas C. Borton, FCA, a CCA member for more than 50 years, and the editor of The Consulting Actuary, died recently. In 2005, Mr. Borton was honored with the inaugural Lifetime Achievement Award presented by the Conference of Consulting Actuaries. Mr. Borton is remembered for his thoughtful interaction with colleagues, and his generosity of time and attention to projects he supported as a volunteer. The CCA benefited greatly from his service as TCA editor for more than two decades, as well as his activities on the CCA Membership Committee for over 25 years, and on the Board of Directors.

CONTINUING EDUCATION

CCA Remaining 2016 Audio/Webcast Schedule

Keep up with the latest developments and earn your CE credits by participating in CCA's Audio/Webcasts. You may participate online or by phone. Registration is available by annual subscription–which includes any "pop-up" programs to address late-breaking issues – or à la carte. All sessions are presented from 12:30 PM–1:45 PM ET. Upcoming programs include:

2016 Schedule*

Programs are broadcast at 12:30 – 1:45 PM ET

Are Health Population Programs Worth It?
May 11 – 12:30 – 1:45 PM ET

Gain/Loss Analysis: Uniting Current and Traditional Methods
June 8 – 12:30 – 1:45 PM ET

Public Sector Plan Headlines
July 13 – 12:30 – 1:45 PM ET

Presidential Politics and Policy: Benefits under Debate
September 14 – 12:30 – 1:45 PM ET

Healthcare Risk Adjusters: Medicare, Medicaid and the ACA
September 28 – 12:30 – 1:45 PM ET

Data Mining
November 9 – 12:30 – 1:45 PM ET

Ethics (Special 100-minute Session)
December 7 – 12:30 – 2:10 PM ET

Capital Market Update
December 14 – 12:30 – 1:45 PM ET

** This 2016 schedule is preliminary and subject to change.*

Now you can take advantage of significant savings on CCA-hosted audio/webcasts, including all currently scheduled and late-breaking presentations. Register now and you can stay on top of the latest developments, the same way many of your peers do, with a subscription to CCA's audio/webcast series. As a CCA member (current dues must be paid before or at the same time as purchasing a subscription) your yearly subscription rate is only $620. All participating CCA members receive a continuing education certificate at no additional charge.

Subscribe for the Entire 2016 Series of CCA-Hosted Audio/Webcasts Exclusive CCA Member Savings with a 2016 Subscription:

As a member you save up to $100 on each CCA-hosted audio/webcast, or subscribe to the full year to enjoy a members-only deep discount on the full series of 2016 audio/webcasts. Nonmembers should consider applying to CCA for just $425 more to take advantage of these savings and benefit from all the other aspects of CCA membership.

2016 Subscription

CCA Members – $ 620

CCA Member and U.S. Federal Government Employee – $ 310

The cost of any previously purchased session is not applicable toward the purchase of a 2016 subscription.

Single Session Rates	
Individuals	**Groups** *(includes two non-CCA member certificates)*
Registrations received one week prior to the event are charged a $50 late fee. Fees listed are applicable for participants in the U.S. only. Participants outside the U.S. will incur additional phone line charges payable by the participant.	
CCA Members – $ 165 Nonmembers – $ 270 CCA Member and U.S. Federal Government Employee – $ 85 Non-member and U.S. Federal Government Employee – $ 135	CCA Members – $ 370 Non-members – $ 720 CCA Member and U.S. Federal Government Employee – $ 185 Non-member and U.S. Federal Government Employee – $ 370

For more details visit the CCA website or review the document "Audio/Webcast Options and Fees for 2016".

Please note: No portion of these live audio/webcasts may be recorded by any third party. Registration for these events acknowledges that you are aware of and agree to uphold the "Code of Professional Conduct." Member rates are only applicable for those who have paid their 2016 membership dues. Cancellations received in writing more than one week prior to the seminar will be refunded the full fee minus a $50 processing fee. Within one week, no refunds are issued.

2016 Enrolled Actuaries Meeting Highlights

Over 800 actuaries and guests attended the Enrolled Actuaries Meeting from Sunday, April 10 to Wednesday, April 13, at the Marriott Wardman Park Hotel in Washington, DC.

Continuing education sessions covered timely and relevant topics to keep Enrolled Actuaries up-to-date and well-informed on issues impacting specific areas of interest to pension actuaries. Attendees shared this feedback in the evaluation when asked what they liked about this year's meeting:

> *"I thought this year's meeting was excellent. The sessions had a good balance between technical with consulting issues. All the logistics and the location worked very well (as usual)."*
>
> *"Good value for the money. Speakers are top notch. Lots of government participation. Love being in DC."*
>
> *"I appreciate that the program committee works really hard to fill out the tracks with subjects that are relevant to all attendees. In other words, everyone from the small plan actuary to the corporate actuary can find sessions of interest to them. In fact, there are many times when I would have liked to attend two or even three of the sessions during one time slot. We certainly aren't running out of things to talk about."*
>
> *"I appreciate the thoroughness of the speakers for the various topics."*
>
> *"Truly one of the best."*

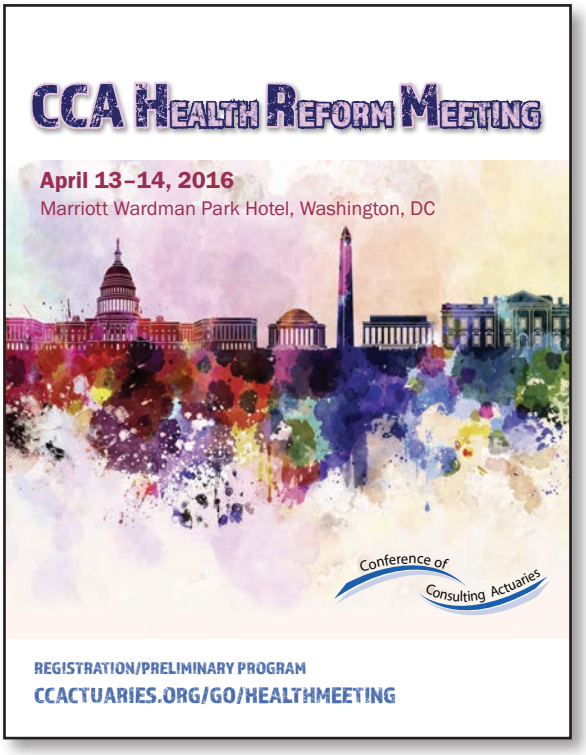
There were several sessions during which representatives from the IRS, PBGC, DOL, GASB, and JBEA offered insights for participants.

Attendees also enjoyed the opportunity to network with colleagues, exchange ideas, and catch up with long-time friends and speak with company representatives at the various exhibits.

Handouts from the meeting remain available to attendees through the CCA's Community platform at http://www.ccactuaries.org/go/eameetingcommunity through Friday, May 20th. CCA members may also access these materials through the Archives section of the CCA website.

Mark your calendar now for the 2017 Enrolled Actuaries Meeting, returning to the Marriott Wardman Park Hotel in Washington, DC over the dates of April 2-5, 2017.

CCA Health Reform Meeting Wrap Up



The Conference of Consulting Actuaries hosted the 2016 Health Reform Meeting on April 13-14, at the Marriott Wardman Park Hotel in Washington, DC. The meeting was held concurrently with the Enrolled Actuaries Meeting.

CCA's Health Reform Meeting provides health actuaries and other healthcare professionals the chance to hear the latest developments on the Affordable Care Act, and it affords the opportunity to discuss with peers what's happening on the home front of healthcare reform. The meeting featured a variety of sessions on healthcare reform issues, providing relevant education for healthcare providers, carriers and employers such as:

- The Current and Future Health Reform Landscape
- Size Still Matters: Challenges Ahead for Small, Medium & Large Employers
- Perspectives on Rate Filings and Review
- Is ACO-Led Payment Reform Working?
- Is It Working? A "Presidential" Debate on the ACA's Impact on IHI's Triple Aim
- Excise Tax
- 3Rs: Risks and Rewards
- Healthcare Cost Trends

Here are some of the reviews from attendees:

> *"I like having a broad spectrum of topics and involving non-actuaries as well as actuaries. Having representatives from government [IRS and CCIIO] is a great benefit."*
>
> *"Great meeting—learned a lot."*
>
> *"Good details and dispelled a lot of rumors."*
>
> *"Excellent session speakers."*
>
> *"Good topics, good networking."*

We hope to see you next April in Washington, DC for the 2017 CCA Health Reform Meeting. Details are expected to be released through the CCA website in December.

OTHER PROFESSION-WIDE NEWS

CCA Past Presidents Elected as New Leaders

Two past presidents of the CCA hold prestigious positions of international leadership for 2016. Thomas S. Terry is President-Elect of the International Actuarial Association (IAA), and Margaret Tiller Sherwood is Chair of the International Association of Consulting Actuaries (IACA). Congratulations to Tom and Margaret! The CCA is pleased to know you are leading the profession on the global stage.

CCA Member Matching Gift to The Actuarial Foundation

Through the CCA Matching Gift Program, CCA member donations to The Actuarial Foundation may be matched, dollar for dollar*. Your donation can be of any amount. All donations are 100% tax-deductible.

Programs administered by The Actuarial Foundation which may benefit from the CCA Member Matching Gift include: research, awards, prizes and scholarships; consumer financial education; and youth education (K-12) for math skills and financial literacy.

As an example, click here to learn about The Actuarial Foundation's impressive program, Data Sampling: Making Effective Inferences. This program highlights the newest cutting edge digital math program intended to provide extra math practice in important areas for students in grades 6, 7, and 8.

Double your impact and help expand financial literacy; make your CCA matched donation today at http://www.actuarialfoundation.org/donate/index.shtml.

* Donations are matched up to an annual cap approved by the Board of Directors ($10,000 cap in 2016).

News from The Actuarial Foundation

The Actuarial Foundation announced Jason Leppin, CFRE as its new Executive Director. Leppin fills the vacancy created by Eileen Streu's retirement in October. The selection was made after a local search and selection process.

Jason Leppin

Jason Leppin, a Certified Fundraising Executive (CRFE), brings more than 10 years of non-profit management and leadership experience to The Actuarial Foundation. Prior to joining the Foundation, he served as the Vice President of the JourneyCare Foundation, one of the largest non-profit hospice and palliative care organizations in the Chicagoland area. During his tenure, he successfully implemented several community engagement programs.

Nomination Deadlines for Foundation Awards are Fast-Approaching

Nominate yourself or a colleague for The Actuarial Foundation's **John Hanson Memorial Prize** or the **Wynn Kent Public Communication Award**. The **John Hanson Memorial Prize** recognizes the best paper on an employee benefits topic. The **Wynn Kent Public Communication Award** acknowledges an actuary who has highlighted the profession's role in financial security issues benefitting the public. The nomination deadline for each of these awards is **June 1, 2016.**

The John Hanson Memorial Prize:

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

Wynn Kent Public Communication Award:

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