

2023 CCA Annual Meeting Session Summaries



Session 001

Social Security and Medicare – State of the System

Speakers:

- Stephen Goss, ASA, MAAA – Social Security Administration
- Frank Todisco, FCA, FSA, EA, MAAA – Government Accountability Office
- Craig Rosenthal, FCA, FSA, EA, MAAA – Mercer
- Dale Yamamoto, FCA, MAAA – Red Quill Consulting

Moderator: Ellen Kleinstuber, FCA, FSA, EA, MAAA - Bolton

Session Host: Tim Sullivan, FCA, ASA, MAAA – Aetna

Background:

Social Security and Medicare are the primary financial safety net programs upon which millions of seniors rely. The Social Security Act requires that the Board of Trustees provide information on the financial and, more specifically, the actuarial status of the Medicare and Social Security Trust Funds every year. The most recent trustees' reports indicate that the trust funds for Social Security and Medicare are projected to be depleted by 2034 and 2031, respectively. The speakers discuss the key drivers leading to the depletion of the funds, what would happen under current law, how these programs fit into the overall federal budget, and why near-term action is desirable.

Summary:

Under current law, when the trust fund reserves are depleted, scheduled benefits for a given year will be reduced to align with the revenue coming in that year (primarily via payroll taxes). The current projection has the combined Social Security trust fund becoming depleted in 2034, at which point payroll taxes will only be able to cover about 80% of scheduled benefits, then gradually decreasing to 74%.

From 1982 to 2022, Medicare spending increased significantly, from \$47B (1.39% of GDP) to \$911B (3.58% of GDP in 2022). The Hospital Insurance fund, which covers Medicare Part A services such as Inpatient services, is expected to be depleted in 2031. Medicare Parts B and D benefits are paid from a separate trust fund (SMI Trust Fund) financed through general Federal revenue and beneficiary premiums and therefore is not at risk. However, the law does require that a warning be issued when short-term funding from general revenue exceeds 45 percent of Medicare expenditures, which has been triggered in each of the last six years.

It is important to note that any projections indicating that the costs of these programs will increase federal debt, or add to publicly held debt after trust fund reserve depletion, assume that the benefits will continue to be paid in full, which would require a change to the current law.

Of course, Congress could act at any time to adjust benefit or funding levels, but any changes to the programs would be unpopular among some segment of most politicians' constituents. By acting sooner than later, it will be possible to phase in tax increases and/or design changes as opposed to having a sharp cliff, where payroll taxes would either have to increase several

percentage points from one year to the next, or retirees would immediately begin to receive a significantly lower level of benefits.

Who provides these projections and how are they used?

The Social Security Administration (SSA) and Centers for Medicare & Medicaid Services (CMS) are both part of the Executive branch of government. SSA actuaries develop all the population and economic projections (such as employment level, earnings growth and program revenues from taxes and interest) under the Trustees' approved assumptions that are utilized for Social Security and Medicare. SSA actuaries' population projections are also used for any long-term projections in the President's budget. CMS actuaries provide Medicare cost projections utilizing the population projections and the underlying economic assumptions approved by the Trustees. In addition, the CMS actuaries develop projections of total national health expenditures not included in the Trustees Reports.

The Government Accountability Office (GAO) is part of the legislative branch of government. GAO provides Congress with fact-based non-partisan information that can help improve federal government performance and ensure accountability, and prepare projections related to financial security programs on a unified basis as they relate to the broader U.S. fiscal outlook. Projections from the GAO are "what if" simulations that include the hypothetical assumption that future Social Security and Medicare benefits would continue to be paid in full even after trust funds would otherwise become depleted (again, which would require a change to current law). The GAO simulations show public debt as a percentage of GDP continuing to increase over time.

What led to the depletion of the Medicare and Social Security Trust Funds?

1. Demographic shifts – largely anticipated when the 1983 changes were implemented
 - a. Changing age distribution of the US population
 - b. Higher Aged Dependency Ratio (US population over 65 as a percent of those at working ages), moving from 20% in 1990 to 30% in 2020, and projected to exceed 40%
 - c. Had birthrates stayed at "baby boom" levels, the age distribution would have remained more level, even with increased longevity
2. Redistribution of earnings from 1983 to 2000 – unforeseen
 - a. Much higher wage increases for the top 6% of earners resulted in taxable share of earnings decreasing from 90% to 82.5% between 1983 to 2000
 - b. Real wage growth was 62% for the top 6% of workers, while the remaining 94% of workers only saw a 17% increase over the same period
 - c. Only applicable to Social Security, as there is no applicable threshold for Medicare taxes
3. Depth of the 2007 to 2009 recession and the slow recovery

Proposed changes to fix the Systems

Revenue Levers - for Social Security and Medicare:

1. Increase tax rates

- a. Concerns that any large increases to payroll tax rates would have broad economic impacts, which is why it is suggested that any increases should be phased in over time
 - b. Medicare proposals could include increasing corporate tax rates so that individuals would not be directly impacted
2. Broaden covered earnings/income
- a. Only 6% of the U.S. population has income above the Social Security Wage base with that excess being 17.5% of total covered earnings
 - b. Increase taxable wage base: applying Social Security taxes to higher wage levels to achieve more than the 82.5% of earnings currently being taxed.
 - c. This approach might include a “doughnut hole” where earnings between the current taxable maximum and a new fixed threshold aren’t taxed, but that gap would narrow in the future as the current-law taxable maximum increases each year
 - d. Apply taxes to other forms of income beyond wages, such as investment income
 - e. Medicare taxes are not capped at any applicable maximum level, so these options do not apply to Medicare

Program Design Levers:

1. Social Security
- a. Change the cost of living (COLA) basis
 - i. Some argue that CPI-W overstates inflation, others that it understates inflation for the elderly
 - b. Modify retirement ages, to reduce benefits and encourage later benefit commencement
 - i. Social Security – increase normal (“full”) retirement age above 67 and the earliest retirement age of 62 to reflect life expectancy increases beyond those reflected in current law by the 1983 amendments.
 - ii. Reconsider the late-retirement adjustments, both in amount and/or by extending the ages to which late retirement factors apply
 - c. Modify benefit formula
 - i. Reduce benefit level for all, or all but lowest earners
 - ii. It was also noted that the poverty rate amongst seniors has been increasing (whereas the overall US population has seen a decline in poverty rates). Some argue that any comprehensive reforms should also address this issue, such as by increasing the minimum benefit.
2. Medicare
- a. Modify payments to Medicare Advantage (MA) plans
 - i. Via risk adjustment and MA benchmark rebalancing
 - b. Simplify program design
 - c. Promote price competition
 - d. Align the Medicare eligibility with Social Security normal retirement age

Session 101

Market-Based Cash Balance Plan Accounting

Speakers:

- Steve Eisenstein, FCA, MAAA, FSA, EA – KPMG
- Larry Sher, FCA, MAAA, FSA, EA – October 3

Moderator: Scott Hittner, FCA, MAAA, FSA, EA – October 3

Session Host: Brian R. West, FCA, MAAA, AFSA, EA, MSPA – Newport Group

The objectives of this session are to introduce the concepts for accounting for market-based cash balance plans and create awareness of the activities of the Cash Balance Plan Accounting Working Group.

History and Current Practice

The session begins with a description of why cash balance plans are defined benefit pension plans under Accounting Standards Codification (ASC) 715 definitions (which follows those within ERISA), provides a brief history of cash balance plans and follows with a history of cash balance plans in accounting standards, from Emerging Issues Task Force (EITF) 03-4 to ASC 715.

For accounting disclosures, the two main alternatives used, today, are:

1. Project notional balances forward at a fixed or assumed rate and discount back at the discount rate.
2. A hybrid approach that treats fixed interest credit cash balance plans the same as Alternative 1 from EITF 03-4 and for market or market related plans measured by reference to the notional account.

In the end, the Financial Accounting Standards Board (FASB) decided that the hybrid approach was appropriate but did not provide any specific codification.

While the “project and discount” method works well for a plan with a fixed interest rate, a quick example demonstrates why this method does not work for a plan which applies a market-based interest credit to the notional accounts.

The dilemma boils down to this question; “if the notional account is market-based and the liability is mark to market, why isn’t the PBO equal to the value of the notional account?” The underlying promise is the account with the right to future interest and the current economic value of that promise is the account value, regardless of market-return interest crediting rates.

A better approach is to set the discount rate at the assumed interest crediting rate or vice versa.

Cash Balance Plan Working Group

To address this issue and propose rules to the FASB, the Corporate Qualified Pensions Community of CCA formed the Cash Balance Plan Working Group. The purpose of the working

group is to analyze the accounting treatment of market-return cash balance plans with the following goals:

1. Gathering information on current practices.
2. Developing a “white paper” discussing alternative approaches and recommendations to the FASB.
3. Present findings and recommendations to the FASB potentially leading to clarification of the accounting rules.

This group narrowed the scope of their work to cash balance plans that provide an interest credit equal to real market return. The white paper from this working group is expected to be published in the 1st Quarter of 2024.

For more information:

- EITF 03-4: Determining the Classification and Benefit Attribution Method for a “Cash Balance” Pension Plan”
- ASC 715: Compensation – Retirement Benefits. Specifically, ASC 715-30 (Defined Benefit Plans – Pension), ASC 715-20-25 (Defined Benefit Plans – General – Recognition) and ASC 715-30-55-127A (Defined Benefit Plans – Pension – Implementation Guidance and Illustrations – Example 8: Cash Balance Plan

Session 102

What's New in the Annuity Purchase Market?

Speakers:

- Michael S. Clark, FCA, FSA, CFA, EA – Agilis
- Ruth Schau, FCA, FSA, EA – Pacific Life Insurance Co.
- Richard McEvoy, FSA, EA, MAAA – Athene
- Amanda Egan – Mutual of Omaha
- Mellissa Lim – RGA RE

Session Host: Jacob Schneider, FCA, FSA, EA – WTW

Background

The pension plan annuity purchase market has evolved significantly since 2012 when the GM and Verizon deals ushered in a new era in pension risk management. We've had new entrants into the market, new innovations, and new issues. The speakers discussed what's new in the annuity purchase market from the insurer perspective to ensure that consultants understood how to best approach the market to optimize results for their clients.

Summary

The speakers discussed their respective insurance company's backgrounds and their target market for Pension Risk Transfers ("PRTs").

- Mutual of Omaha – known for smaller PRTs, quoting a heavy volume of cases with an average size of \$5 million, and will quote on immediate and deferred annuities.
- Athene – Insurance arm of Apollo started quoting PRTs in 2017 and focuses on larger sized PRTs.
- RGA RE – focuses on larger transactions above the \$500 million threshold.
- Pacific Life Insurance Co. – Long history of working in the PRT market since 1941 and will quote on immediate and deferred annuities.

The panel then was opened for discussion of topics effecting the annuity purchase market.

Bidding

Data quality is a big driver of getting a competitive price in the PRT market. The panel agreed that making sure necessary data is provided including the payment information, participant demographic information, location of the participant including the 9-digit zip code, and any other relevant plan information about the population. The larger the transaction the more important the mortality data is for the transaction. Mortality studies can provide the insurance companies with better information on the population's mortality profile. For smaller transactions, insurance companies focus on general mortality information and less on the population's specific mortality study.

Lump Sums, Hybrid Plans, and Plan Designs

Unlimited lump sum provisions are not preferable but some insurance companies will still bid on the transaction, but pricing may be more expensive for larger lump sum limits included in the plan. Insurance providers will ask for the history, structure, and prior take rates of the lump sum windows during the bidding process to understand selection bias from the underlying population being transferred. Early retirement subsidies can also add additional risk premium to terminated vested transactions.

Transition Period

Smaller transactions can be quicker to transition to the insurance provider in some cases only taking six weeks to complete. While large transactions happen on a case by case basis. Any cases with a large terminated vested population can extend the length of the transition to the insurance company.

Timing Considerations

Human capital considerations for insurance companies can lead to some limits on the number bids provided but more activity is expected and planned for by the insurance companies in the market in the coming years. The longer the time to transaction the more likely the insurance companies can fit the bid into their schedule. The fourth quarter of the calendar year can be more difficult for insurance companies to bid on a transaction but not impossible.

Advice for consulting actuaries

Insurance companies recommend that consulting actuaries reach out to the insurance market early in the process. The longer the transaction period the more likely the insurance company can submit a bid on the transaction. Clients and participants are very happy post transaction and the insurance companies view their relationship with the participants as important. More insurance companies offer buy-in contracts but the panel was surprised how few buy-in contracts are being presented to insurance providers for bidding.

Session 106

ROI of Benefits / Total Rewards

Speakers:

- Gary Watts – Fidelity National Information Systems
- Kristina Santos – Arxada
- Phillip A. Merdinger, FCA, MAAA, ASA – October Three (moderator)

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

Total rewards is one of an employer's largest cash outlays. Is it a cost of doing business or is it an investment in the business? Senior HR leaders share their thoughts on how they maximize the value of their total rewards programs.

The session opened with Phillip Merdinger (PM) posing the following question to speakers: "Total Rewards (TR) is the one of the largest expenditures of any organization – is it viewed as investment or expense?"

Kristina Santos (KS) opened the discussion stating that TR is part of the employer total value proposition and is an investment into an organization's success. Rewards encompasses the tangibles as well as the intangibles, which include such items as recognition, mobility and career progression.

Gary Watts (GW) added that TR is used as an attraction tool by employers. It's not just compensation, it's equity, benefits, recognition, well-being and performance management that is being addressed. GW also mentioned that it is helpful if actuarial analysis of TR is part of the solution and discussion when some aspects of TR are being planned.

Q from audience: TR vs. Total Compensation – how do the extra elements of TR translate to money? Specifically given that finance department needs to be involved and budget planning and pay equity to be considered.

A from PM: Organizations are working with the finite amount of money – the allocation will come down to both business and people factors.

Q: How do you manage rising healthcare costs given that not all of them have same risks attached?

A KS: Orgs need to identify whether they are trying to achieve a short-term or long-term solution. Also understand where the people in Finance are coming from – likely from a cost perspective with P&L considerations. In addition, consider creating wellness programs based on the specific prevalent issues (e.g., diabetes, mental health) that drive the majority of the claim spend to bring down costs over time.

A GW: Think about how you can protect downside too – consider stop-loss insurance and if self-insuring makes sense.

Q: What is more important – attraction or retention?

A KS: Attraction. Too much retention might hurt organization in long run. Employer's reputation is important, so in addition to exit interviews, orgs are suggested to do stay interviews and use that to attract employees.

A GW: Both attraction and retention are important, and employee optics are important, too. Employers need to keep up with quickly evolving roles and change in skills necessary to do the work, and pivot accordingly.

Statement from audience: There are surprising under-the-radar benefits that make a big impact, such as providing pet insurance to attract people to organization, and adding benefits that address people's daily needs can act as great retention tool.

Comment from Casey Shork (CS): Another under-the-radar approach is targeted benefits – for example, be clear about existing benefits for parents with kids in different age groups. It's a high perceived value that costs nothing since benefits is already being offered; it's just a change in communication.

Q: How do you come up with allocations? And how do you address generational differences and expectations?

A GW: We are noticing that the younger generation is transient and doesn't have as much loyalty to a company vs. the work they are doing - and we are taking that into account by using age-specific customization in our communication strategy. Also, we utilize focus groups with understanding that organizations can't assume what employees want. We try to offer flexibility in benefits and create signature reward programs that can't be replicated somewhere else. This can be difficult when it comes to international operations, as dealing with small population size and data privacy laws limit available information.

A KS: Our approach is to reward in meaningful ways. We recognize that definition of "meaningful" varies by age and we use employee surveys to hone this definition. From the global perspective we see care giving support, mental health support and flexible work arrangements as continuing trends.

Q: Regarding ROI on Retirement benefits – how do you bring awareness about this benefit given that it is a long-term benefit and many employees won't think about it until mid-career or later?

A GW: Early and ongoing education is key; ideally start with college graduates joining the workforce.

A KS: Including guidance on retirement in mentorship / sponsorship programs; recognize that the approach varies by industry

A CS: Consider plan design that is more understandable to younger employees (defined contributions as opposite to defined benefit); rely on opt-out approach rather than opt-in.

Q: What do you think about involving not just employee but family member in the benefits decision making?

A KS: Address communication to the decision maker in the family, might not be the employee – therefore print communications may be helpful.

Q: How do you keep benefit transparency?

A KS: Stick to list / summary, avoiding too much specifics, but do focus on signature programs

A GW: Bring focus and awareness to how much employer is contributing to benefit program – leveraging total rewards statements and other tools.

Q: How do you influence perceived value of benefits?

A GW: Include video and written testimonials from participating employees.

Q: What psychological factors need to be taken into consideration?

A KS and GW: Colleagues need to understand what business the company is in, how it operates and generates income, so they can appreciate the investment their company is making in rewards.

Statement from audience: Often TR information is overwhelming – we need to do much better job in simplifying employee communications and making them memorable.

Q: What changes [in TR] did you notice in past 3 years?

A GW: Transparency is expected now more than ever. What used to be “private” rewards communications to employees is now frequently shared publicly by colleagues via Fishbowl, Glassdoor and similar websites. Employers and employees are now monitoring those postings. We are seeing AI coming into play – companies are using this to respond to questions and assist in decision making.

A KS: Mental health is now high on employer radar, not just an employee “issue” anymore. Mental health is considered by some a 2nd pandemic. Call to transparency presents great opportunity to show fair practice – organizations going for “fair pay” certification. Employees are more vocal in their inputs in what benefits they want to see. Organizations are doing TR 101 trainings so employees can understand costs for both employees and employers.

Q: How do you handle older employees?

A KS: Non-US employees have mandatory retirement age – there is not much you can do. For US employees – keep if they still bring value and can learn new skills / adopt to changing environment.

Q: ROI on TR – is that a number or not?

A KS and GW: It depends to whom you are telling the story.

In conclusion, the ROI of Benefits and Total Rewards is a multifaceted concept that requires a deep understanding of a company’s workforce and the strategic alignment with its true organizational goals. By exploring these topics and sharing our experiences, we can collectively develop strategies that not only measure ROI effectively but also unlock the full potential of our employees as investments in our future success. It is both an investment and an expense.

Session 107

The CCA White Paper v.2.0

Speakers:

- Paul Angelo, FCA, MAAA, FSA, EA
- Jody Carreiro, FCA, MAAA, ASA, EA
- Wendy Ludbrook, FCA, MAAA, FSA, EA
- Jordan McClane, FCA, MAAA, FSA, EA

Session Assistant: Elizabeth Wiley, FCA, MAAA, FSA, EA

The session updated the Public Plans Community (PPC) of the Conference of Consulting Actuaries (CCA) on the ongoing effort to update “Actuarial Funding Practices and Policies for Public Pension Plans,” commonly referred to as “the White Paper” (WP) that was published by the PPC in October of 2014.

The 2014 WP was produced following four years of committee work and developed a funding model described as a Level Cost Allocation Model (LCAM). The paper systematically introduced policy objectives and policy elements for funding public pension plans as well as categorized practices for such use along an ordinal spectrum from what were labeled as “LCAM model practices,” through acceptable practices, with or without conditions, to non-recommended and unacceptable practices.

The PPC initiated an effort at the beginning of 2022 to update and refresh the White Paper, to both make updates to reflect emerging practices and experiences, as well as changes to the Actuarial Standards of Practice applicable to pensions, and improve and enhance the document, and its readability, to further enhance the relevance and credibility of the White Paper. Further, there was recognition that the syllabus for candidates taking exams in the pension track of the Society of Actuaries syllabus does not currently provide any readings related to public sector pension funding, a deficit that an updated version of the White Paper might address.

A working group of 11 CCA PPC members was thus convened and have been working on developing what is lovingly referred to as WP2.0. The process of this work group has been very systematic, including working through the paper in detail as a group, discussing the history and discussions that inform the original paper, and developing “drafting instructions” used in drafting the updated paper. This approach is intentionally very deliberative, designed to seek a balance between deference to the original paper and not holding the original text as sacrosanct, ensuring updates are made where appropriate and beneficial. Finally, it was noted that another objective of the WP2.0 effort was to have an updated foundational document upon which additional guidance on related funding topics, currently being referred to as “side papers,” could be built.

The session focused on the three core elements of the paper: Actuarial Cost Methods, Asset Smoothing Methods, and Amortization Policy. On Actuarial Cost Methods, it was noted that the primary change for WP2.0 is the addition of a new appendix that provides detailed descriptions and examples of cost methods designed to ensure a common understanding of what is meant by the discussion of specific cost methods in the body of the paper. It was also noted that it is

anticipated that the exposure draft of WP2.0 anticipated in spring 2024 will moved both the Aggregate and Frozen Initial Liability methods from Acceptable to Acceptable with Conditions.

Related to Asset Smoothing Methods, Actuarial Standard of Practice No. 44 provides significant guidance, which is reflected in the drafting of WP2.0, but it is anticipated that the exposure draft will reflect some changes related to evolving practices around asset smoothing, with the proposed test reflecting a balance between historic methodologies and emerging practices. Specifically, it is anticipated that WP2.0 will reclassify use of an unsmoothed, market value of assets from Acceptable to Acceptable with Conditions. A second method, the use of a rolling, or asymptotic, period of more than five years may be reclassified to Acceptable with Conditions from Acceptable as well. While the working group has noted that a move away from longer smoothing periods has been seen in recent years, it is anticipated that the periods referenced in the classifications will remain unchanged.

The intricacies of amortization polices was another focal point, reflecting on the guidelines from the original WP and their continued development. This included discussion on the debate on the appropriateness of level dollar versus level percentage methodologies, underscoring the diversity of approaches and alignment with overarching policy objectives. The influence of emerging practice, particularly related to surplus and tail volatility management was also noted.

In addition to these discussions of specific sections, it was also noted that throughout the drafting work for WP2.0 there has been a focus on making sure that the material is not just comprehensive in its guidance for actuaries, but is also more widely educational, ensuring that the document is accessible and informative for a wide range of stakeholders. Particular examples of this aspect of the work that were noted were the addition of “short names” for the five policy objectives, explicitly linking discussion in the paper to the objectives using these short names, the addition of the cost methods appendix, updating language to be consistent with Actuarial Standards of Practice, and efforts to make the document more timeless.

The sessions then opened to questions and comments from the audience, further enriching the discussion on this topic. This discussion raised additional practical challenges and considerations in public pension plan actuarial practices, including a significant discussion on considerations related to level dollar and level percent amortization.

The session concluded with a reminder that the WP, both the current version and the forthcoming WP2.0, do not represent actuarial standards, but are intended to support understanding of funding policies and their implications on public pension plans. And while the WP is used by a variety of stakeholders, there is an explicit intent for the paper to be a tool for actuaries to apply with their professional judgment to their practices.

Session 201

ASOP 27/35 Review

Speakers:

- Sarah E. Dam, FSA, EA, MAAA – BPAS
- Julie M. Ferguson, FCA, ASA, EA, MAAA – Mercer

Moderator/Session Host: Suzanne Hughes, FCA, ASA, EA, MAAA – Buck

Background

ASOPs 27 and 35 address the selection of assumptions for measuring pension obligations. ASOP 27, adopted in December 1996, addresses the selection of economic assumptions while ASOP 35, adopted in December 1999, addresses the selection of demographic assumptions. The current revisions bring these two ASOPs into one amongst other minor changes. ASOP 35 will be retired upon the finalization of the revisions to ASOP 27.

Summary

The latest exposure draft for ASOP 27, which will be renamed “Selection of Assumptions for Measuring Pension Obligations” and will incorporate ASOP 35, was issued in December 2022. Notable changes from the exposure draft are the exclusion or deletion of several definitions that have been deemed unnecessary (Merit Adjustments, Productivity Growth, Assumption Format, and Assumption Universe), revisions that were made to incorporate guidance from ASOP 35, and the addition of “Reliance Sections” and the modification of “Documentation” to align with recently updated ASB practices. Comments to the exposure draft resulted in language being added to ASOP 27 to confirm that it is applicable to ASOP 6, “Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Plan Costs or Contributions.”

The definition of materiality and the concept of significance from ASOP 1, “Introductory Actuarial Standard of Practice” are applicable to ASOP 27, as is the distinction between when an actuary “must” do something versus “should” do something.

The scope of ASOP 27 covers the performance of actuarial services in both selecting assumptions and providing advice in the selection of assumptions. The selection process involves identifying the types of assumptions that will be used in the measurement and other general considerations. The selection of reasonable assumptions means that the actuary has considered whether the assumption is appropriate for the purpose of the measurement, is reflective of both current and historical data, reflects the actuary’s observations and estimates, and is expected to have no significant bias. ASOP 27 also provides guidance for assumptions that are not set by the actuary but are set by either another party or by law. With limited exceptions for assumptions set by law or where the actuary is unable to assess, actuaries generally need to assess the reasonableness of all assumptions used. In addition, the actuary

should provide support for how they reached the conclusion that an assumption is reasonable or does not significantly conflict with a reasonable assumption. The disclosure should include the information and analyses that were used to make such determination (the “rationale”).

The concept that an actuary is “unable to assess without performing a substantial amount of work beyond the scope of the assignment” is no longer included within ASOP 27, although ASOP 27 still allows for some exceptions where the actuary is “unable to assess” any particular assumption. Therefore, the actuary will need to consider under what situations “unable to assess” may be used when assessing assumptions selected by another party. Actuarial standards provide guidance around these concepts but leaves the determination to the actuary’s professional judgment and the facts and circumstances appropriate to the assessment. Opinions will likely vary between different actuaries.

The actuary should disclose each assumption which significantly conflicts with what they consider to be a reasonable assumption. In these cases, the actuary will need to ensure the plan sponsor understands potential implications of such disclosure(s) before the actuarial report is issued; however, no rationale is required to be disclosed when the actuary believes the assumption significantly conflicts.

When there is a change in actuary, the new actuary becomes responsible for assessing those assumptions and determining whether an update is appropriate. Therefore, it is a best practice for the new actuary to request relevant support for those assumptions, including prior experience studies. This includes holding a discussion with the prior actuary if the new actuary has questions around the rationale for those assumptions.

When setting or recommending assumptions commonly based on plan-specific experience, ASOP 27 only requires the actuary to consider whether an experience study should be performed. Regular reviews of the sources of liability gains and losses can often alleviate potential concerns around a lack of a formal experience study or reliance on an older experience study.

Session 202

SECURE 2.0 – What’s in it for DC Plans?

Speakers:

- Jeremy P. Olszewski FCA, FSA, EA, MAAA – Fidelity Investments
- Dominic DeMatties – Thompson Hine LLP
- Stacey Marie Schmid, FCA, FSA, EA, CERA, MAAA – Empower

Session Host: Ryan Potter, FCA, FSA, EA – The Standard

Overview

The SECURE 2.0 Act has continued the themes and reforms of the SECURE Act of 2019, which were getting more participants into the retirement system, providing participants ways to accumulate more assets and ensuring participants are connected with those assets when retirement comes. Speakers provide an overview of the key SECURE 2.0 provisions affecting DC plans, including guidance available on such provisions and any provisions that still are in need of guidance.

Key Provisions

The Secure 2.0 legislation includes over 90 substantive changes to retirement plan law. The majority of these changes affect only defined contribution (DC) plans while some affect only defined benefit (DB) plans and others affect both types of plans. Some of the changes took effect immediately upon passage of the legislation while others are becoming effective over the next several years.

Changes to Plan Features

There are several changes to Roth contributions to highlight. The first is that employers are now able to make matching contributions on a Roth basis. It should be noted that this feature may not be popular as sponsors still have the option to allow in-plan Roth conversions, which may be easier to accomplish. Additionally, there is a new mandatory requirement for catch-up contributions for employees earning \$145,000 (indexed) to be made on a Roth basis. This provision was due to be effective for plan years beginning after December 31, 2023 but has now been delayed for 2 years.

There are two optional provisions to note related to emergencies. The first allows employers to facilitate an increase in employee savings by creating an Emergency Savings Account (ESA) that allows non-highly compensated employees (NHCEs) to save on a Roth-like basis for emergency expenses. The second provision allows people to take a single distribution up to \$1,000 per year from their defined contribution accounts to pay for an emergency, and permits repaying that distribution within three years.

The law also includes a provision allowing employers to match “qualified student loan payments”. Although this subject has been a hot topic in the industry for several years it was noted by some in the room that sponsors have been more hesitant to implement the option than

expected due to a variety of reasons including outstanding questions regarding how the provision should be administered as well as employee relations concerns.

Eligibility & Enrollment

A new mandatory provision for §401(k) and §403(b) plans requires sponsors to automatically enroll participants at 3% or more (but not more than 10%) and escalate contributions by 1% each year (to not more than 15%). There are exemptions for plans that were already in effect when the law was passed (although the language is not 100% clear) as well as for businesses with 10 or fewer employees, new businesses, and church plans.

Another mandatory provision relating to part-time (PT) employees expands coverage by shortening the 3-year requirement introduced in the prior SECURE Act to 2 years as well as expanding it to §403(b) plans.

Administrative Changes

There are a number of changes to the required minimum distribution (RMD) rules including drawing out the start age to 75 by 2033, reducing the excise tax, optional treatment for surviving spouses, optional increases to amounts that can be used to purchase qualified longevity annuity contracts (QLACs), and 401(a)(9) relief related to partial annuitization of account balances.

Several other changes in law relate to hardships and disasters. Among them are allowing employers to rely on the employees' self-certification of a hardship and allowing special treatment for any federally declared natural disaster.

Finally, a few administrative law changes that are of particular interest to sponsors include an optional increase to the cashout limit from \$5,000 to \$7,000. The final change of note is the change in law allowing discretionary amendments that increase benefits to be adopted by the due date of the tax return.

Regulatory Changes

There are several changes to the Internal Revenue Service's (IRS) Employee Plans Compliance Resolution System (EPCRS) that improve the ability of sponsors to correct compliance problems before the IRS intervenes. The changes include expanding the type of errors allowed to be corrected in this manner and some allowances for fiduciaries to determine that the plan does not need to be reimbursed for plans who have overpaid participants.

Session 203

Window Programs and Workforce Reductions: Design, Administration, and Strategy

Speakers:

- David R. Godofsky, FCA, MAAA, FSA, EA – Alston & Bird, LLP
- Aaron Rothstein, FCA, MAAA, ASA, EA – Buck

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

Economic trends and company-specific needs often lead to workforce changes. Retirement plans can often be used to facilitate a smooth transition for affected employees. Speakers discuss the strategic, logistical, compliance, and accounting aspects of early retirement windows and other workforce management initiatives.

Window programs help employers to provide positive “spin” on workplace reduction, but strategy and planning are crucial.

There are several factors to consider. Maturity of the plan and funded status are important – an overfunded plan will likely have no cash contribution cost but may have an accounting cost. If the employer does involuntary reductions and offers cash severance (not through the pension plan), that will prevent the employee from getting unemployment benefits, or at least reduce unemployment benefits. However, a retirement benefit serving the same function as severance, and often in similar amounts, can be offered through a DB plan, making the employee eligible for unemployment benefits without reduction. While the effect on unemployment benefits is a function of state law and can change over time as laws are amended, as of now we believe that a program can be devised that will enable employees in all 50 states and the District of Columbia to get pension benefits that look much like severance while avoiding the reduction in unemployment benefits.

Different types of windows were discussed: traditional DB formula voluntary, cash balance voluntary, involuntary layoff, involuntary layoff with voluntary benefit.

When to amend the plan for the window program?

- Traditionally – amend the plan first, communicate window after.
- Alternative one – “contract to amend”, similar to collective bargaining. Offer elections first, amend plan once results of elections are known. This results in greater flexibility and simplifies the non-discrimination testing (“NDT”). This approach should be thoroughly discussed with outside counsel and auditors.
- Alternative two – “invitation to offer”. The employer announces the window with certain terms / benefits and asks the employees to submit applications, but provides no guarantee that the employer will accept the employee into the program. This is known as an “invitation to offer” rather than an offer, because, when the employee turns in the application, there is not yet a contract. The employees then submit applications, which are legally considered “offers.” The employer can accept, deny or modify employees’ offers. There are many advantages to the “invitation to offer” approach:

- The employer can control the effect on the workforce. For example, suppose all of the employees in one department, or all of the employees with a particular specialty, submit applications. If the employer cannot afford to lose all of these employees, then the employer can reject some of the applications.
- The employer can control costs by limiting acceptances.
- The employer can manage NDT results by limiting acceptances of highly compensated employees.
- It is often the case that employees begin to negotiate after a window program is rolled out, or the employer realizes after the roll out that there are business considerations that could not be vetted by the small group of employees who were in the “decision circle”. The invitation to offer approach allows for some flexibility even after a program has been rolled out.
- Mr. Godofsky offered an analogy – McDonalds advertisement: McDonalds runs an ad “Cheeseburgers 2 for the price of 1” (invitation to offer). Customer comes and says I want 2 cheeseburgers for price of 1 (offer). McDonalds can do the sale as advertised (acceptance), decline because they ran out of cheeseburgers (denial), or offer 2 chicken sandwiches for the price of 1 (modified acceptance).

Question from Audience: Can “invitation to offer approach” result in lawsuit for discrimination for race, age, religion?

Answer from Mr. Godofsky: You need to be very explicit that you [employer] will not guarantee acceptance of the offer so that the employees understand what is happening when they turn in an application. The decisions as to who to accept or reject are subject to all the usual non-discrimination laws applicable to employment decisions (that is, different laws than NDT as applied to retirement plans). You cannot use discriminatory criteria (that is, race, sex, religion, etc.) to select who is accepted. In addition, you have the retirement NDT rules that are also applicable to the resulting population that gets the enhanced benefits.

Traditional pension benefits (that is, stated in the form of enhanced annuity benefits) / voluntary retirement considerations:

- Under the traditional approach, the window period must be 12 months or less – so keep in mind organizational strategy.
- Early retirement factors are often waived or modified so younger employees will get a bigger bump in benefits – this is not a good strategy if the employer wants older people to leave.
- Early retirement Social Security Supplement, temporary for ages 62-67. Note that under ERISA, these benefits can be eliminated at any time *including after commencement*. However, be careful to avoid breach of contract claims if the Social Security Supplement is modified negatively without other offsetting changes.
- Compliance: you may require a release of claims; you must satisfy non-discrimination rules under §401(a)(4); if plan uses permitted disparity, modified early retirement benefit will likely take you out of the safe harbor for §401(l); A window program that is “too successful” (that is, achieves more than the desired level of downsizing) may be worse than no reduction.
- Accounting: earlier than expected retirements often increase liabilities, may result in increased ongoing net periodic cost (e.g., higher Interest Cost); might result in special accounting (curtailment, settlement, special termination benefits); IAS 19 vs. US GAAP.

- Funding: be aware of potential benefit restrictions applications in year of window adoption (IRC §436). The plan may require additional contributions for §430, IRC §436 contributions, or a combination for window to take effect, depending on AFTAP/presumptions. The value of enhancements includes amended benefits and additional increases in liability for estimated changes in retirement patterns following the window program.

Question from Mr. Godofsky to Mr. Rothstein: Do you review demographic assumptions in connection with window?

Answer: Yes, individually and in aggregate. This is a good time to consider select and ultimate assumptions. Generally, the population demographics may change and this may affect both mortality and retirement patterns in the future.

Question from audience: If you have calendar plan year and July 1 window, do you get new data and recalculate the AFTAP?

Answer from Mr. Rothstein: No, presumption rules apply. But you still need to assess the value of the window and potentially fund it for §436 purposes.

Question from audience: If you have a calendar plan year, and the AFTAP is 85% at the beginning of year; the AFTAP is 83% post-window on 7/1; the assets lose value after and at 8/1 the AFTAP is 75%. What are your steps?

A: It is the same situation if AFTAP goes from 85% to 75% without window – you still have to fund plan based on the 1/1 AFTAP and 1/1 valuation, the cost of the window, and the various presumptions. The difference is that the window itself must be funded, or partially funded, if the window pushes the AFTAP under 80%. But you do not have to do a new valuation of the plan as of 7/1 or 8/1.

Using a cash balance approach / voluntary retirement considerations:

- More effective than severance: can afford it (either plan already overfunded or can fund over 15 years, subject to §436); tax benefit (can leave in plan or roll into IRA, whereas severance is taxable immediately); no FICA tax for both employer and employee; much easier to communicate than traditional defined benefit; can use for employees below early retirement age; effect is more visible than traditional DB benefits.
- Compliance: you may require a release of claims; the plan must be 80% or (“436 amendment” funded); you must satisfy non-discrimination rules under §401(a)(4).
- Cash balance benefits are more likely to result in settlement gain or loss accounting effects; additional administrative complexity to maintaining cash balance account benefits if not already in plan formula; may require additional benefit election form, if layered onto traditional pension benefit; the window program can be “too successful”.

Question from audience: What about employees who are not in the DB plan? Can you open the plan to let them in to be part of the window?

Answer from Mr. Godofsky: Yes, you can add new eligibility criteria to enter the plan in connection with the window (ex. no restriction on age and service), but with it comes additional administrative headaches.

Question from audience: Can the “invitation to offer” provide a choice between severance and DB pension benefits?

Answer from Mr. Godofsky: No, there are rules against the choice of severance vs. pension benefits. These restrictions come under the “cash or deferral arrangement” rules of §401(k) and §401(m). However, you can add language that the employer reserves the right to pay benefits via payroll. This would be important if the program fails NDT testing or if there are other issues, such as §415 limits.

Involuntary reduction / voluntary benefits. Under this approach, the employee will be terminated involuntarily, but makes an election as to whether to take an enhanced benefit. Typically, the reason for the election is to get a waiver of claims from the employee.

- Enhance benefits as incentive for proactive elections. You can require release of claims. The benefit is not subject to FICA tax. The benefit typically can be designed not to affect unemployment benefits.
- Compliance: may require WARN (Worker Adjustment and Retraining Notification) (many states have mini-WARNs that require earlier notice than Federal WARN); the plan must be 80% or (“436 amendment” funded); must satisfy non-discrimination rules under §401(a)(4).
- Accounting: targeted reduction makes it easier to anticipate curtailment; sequential events for voluntary and involuntary phases (is that considered a single event or not?).

Rhetorical Question from Mr. Godofsky: If you let employee leave and then rehire employee as a consultant – is it really a window?

Question from audience: Can you just do “cash balance” with a lump sum option (similar to PTO pay out)?

A: This option can be most attractive for employers with overfunded plans. But if you want a valid age discrimination waiver, you need to give 45 days notice and a seven day revocation period.

Question from audience: Can the “invitation to offer” be contingent on the employee taking a lump sum?

Answer from Mr. Godofsky: No. You cannot force the employee to elect a lump sum from the Plan or require the lump sum election as a condition of employer acceptance. But your “invitation to offer” can include, for example, a lump sum option available only within 6 months post termination, changing to annuity benefits thereafter, to give the employee an incentive to elect a lump sum.

Session 204

Employer Perspective of Point Solution ROI

Speakers:

- Nathan Counts, FCA, ASA, CCP – Amtrak
- Benjamin Hagan, FSA, EA – AT&T
- Scott Ramsay, FSA, MAAA - Prudential

Moderator: Ed Pudlowski, FCA, ASA, MAAA – MorningStar Actuarial Consulting, LLC

Session Host: Samantha Meyer, ACA, ASA, MAAA – Buck

Overview

The digital point solution marketplace has quickly expanded in recent years due to an increase in funding, specifically an influx during the COVID-19 pandemic. Funding fell in Q2 of 2023 to its lowest level since Q3 of 2017, dropping 8% over the prior quarter. Despite the drop in funding, US-based digital health startups continued to account for the majority (65%) of global funding in Q2 of 2023. There has also been an increase in adoption of AI in point solutions, which peaked in 2021 and funding for new healthcare AI deals has begun to slow.

How do employers determine what solutions are needed?

Most employers will begin with looking at the top conditions driving costs within their health plan to determine what needs they could target to find the most impactful solutions. This methodology has likely brought the point solution marketplace to where it is today, as there are multiple solutions for each top chronic condition, many of which may do the same thing. Some employers also will utilize employee feedback and surveys to determine what is of interest. Getting employee buy-in and attention can be one of the biggest challenges when implementing a new solution, and if employees do not see the value or don't trust that the new products being offered have been sufficiently vetted, there may be hesitation to enroll. Most of the point solutions currently in the marketplace rely on employee enrollment and engagement to drive success. With this in mind, employers also look to strike a balance between not offering support and having too many options. Employees can easily get overwhelmed by the plethora of benefits available, so more does not always result in improvements in member health status.

How do solutions get themselves to stand out in the crowd?

It's extremely meaningful to employers for a point solution vendor to be able to describe their vision for solving a specific problem from beginning to end, but also be willing to adapt their product to fit an employer's specific needs or issues. Many plan sponsors may already have an idea for what they are looking for in a solution, so while they are looking for external expertise, they also want to know that their opinions and perspectives are taken into account as the buyer. Finding a solution with the right balance is key to being chosen above the others.

How do solutions fit in with the health plan? Is the health plan treated as the front door?

Employers generally agree that all solutions that are put into place that relate to member health, as well as those that are ancillary, should have a seamless connection to the health plan. The

more steps that members need to take from their health plan/provider to a point solution, the lower the likelihood that they will actually get to the solution, and even if they do, that they will engage and stay engaged longer term. We all need to keep in mind that engaging in these solutions is secondary or tertiary to most employees' day-to-day lives and jobs, so the harder it is, the less likely it will be successful.

What criteria do employers use when deciding which solutions to implement? What hurdles might there be during an implementation and how do you then determine the success of a solution?

One of the bigger roadblocks during implementation are the security and privacy review processes. Large employers have stringent requirements when it comes to data privacy and security, which can end deals with solutions that have not invested time into meeting these requirements or are not willing to be flexible and make changes to accommodate. Many times there is also a disconnect between the sales team and the legal team for a point solution, so it can erode trust when certain terms are agreed to during the sales negotiations that are then struck down during contracting due to reporting/tracking limitations or because the sales lead was not authorized to make those promises. In addition, depending on the size of the benefits team there may be bandwidth limitations that decide how many, if any, solutions can be implemented for an upcoming year. One option that can ease both the data/privacy requirements and the benefits team's lift is to look at solutions with which the health plan already has subcontracting abilities. Going through the health plan, which has already been vetted and meets the employers' requirements, also generally means the health plan is responsible for holding the point solution vendor accountable to the terms that are in place, so then contracting can be quicker. In addition, the relationship between health plan and point solution generally means there is a connection from the member experience side, which should help with engagement. Measuring success of a point solution vendor will depend on the priorities the employer had when picking that specific vendor. Some measures can be seen in the shorter-term, such as enrollment and engagement, while others like health plan savings and improvement in clinical outcomes or indicators will typically need 3-5 years of data.

How important are performance guarantees and what metrics do employers look to have included?

When evaluating point solutions, not only is the product and employee experience important, but also making sure there are metrics in place to hold the vendor accountable to what was promised. Each employer has a different level of accountability they will want put into place, but most can agree to some type of engagement/utilization metric. However, to be meaningful it needs to be more than just registrations or app downloads; this metric should be tied to actions that are expected to influence behaviors that will have an impact on the members' health.

Performance guarantees should be reasonable yet still challenging.

Another important guarantee would be an ROI as it shows the vendor is not making empty promises. However, the ROI model still needs to be fleshed out in more detail. Currently, many of these guarantees are based on averages and there are struggles with plan sponsors to get the raw data that is needed to measure the return independently. This is where external consultants can potentially help bridge the gap between the solutions and the employers and work to develop both mutually beneficial terms and a ROI model for each specific solution that can be clearly articulated as well as measured and audited. For some smaller employers this may not be as easily negotiated since more experience would be needed to make the data credible, plus not all employers have an extended team that has the capacity to monitor the vendor's performance and review/evaluate the outcomes. The desired performance guarantees

will vary by employer size and philosophy, so solutions and consultants should keep in mind the context with who they are working and what is most valuable to them. Some employers may not be as concerned with the hard dollar ROI and more focused on a great employee experience, knowing that an engaged and happy workforce will drive a return in the longer term and keep employees with the company. At a minimum, there is consensus that there should be some general service level agreements in place for all solutions, but input from the plan sponsor/buyer should be taken into account since they will have a better understanding of what to expect from their members.

Session 205

Current Topics in Medicare Advantage and Part D Products

Speakers:

- Dave Tuomala, FCA, FSA, MAAA – Optum Advisory Services
- Jennifer Carioto, FSA, MAAA – Milliman Inc.
- Dan Hoffman, FCA, FSA, MAAA – Optum Advisory Services
- Ward Brigham, FSA, MAAA, FSA, MAAA – United Healthcare Retiree Solutions

Session Host: Diep Stephan, FCA, FSA, MAAA – Deloitte Consulting

Background

Speakers highlight current topics in Medicare Advantage and Part D using an interactive format including presentations, polling, and audience participation. Topics include Medicare Advantage, Part D, and employer sponsored Medicare plans.

Summary

Medicare Part D

The Inflation Reduction Act of 2022 includes a number of changes to the Medicare Part D drug benefit. In 2023, drug companies are required to pay rebates if drug prices increase faster than inflation benchmarks, insulin copay limits of \$35 per monthly supply will be established, and vaccine copays will be eliminated. In 2024, the national average beneficiary premiums used to determine direct subsidy payments will be capped at 6%, beneficiary cost-sharing will be eliminated in the catastrophic phase, and low-income subsidies will be expanded. In 2025, the Part D benefit design will be overhauled resulting in the elimination of the coverage gap, lower member out-of-pocket (MOOP) to \$2,000 for faster progression to the catastrophic phase, and significant cost-shifting from Federal Reinsurance to Part D plan liability within the catastrophic phase. The Part D benefit redesign is not expected to change total program costs, but the intent is to better align incentives to influence stakeholder behaviors. In 2026, the Medicare program will be authorized to negotiate drug prices with manufacturers of 10 select single-source brand drugs. Price negotiations will be focused on qualifying drugs with the highest Part D spend and the number of drugs to be negotiated will increase in subsequent years. Several of these provisions will demand considerable planning for Part D stakeholders to be equipped for the changes ahead. Pre-IRA benefit design incentivizes rebates because plans realize a >2x higher benefit from rebates compared to discounts. Post-IRA benefit design maintains the preference for rebates over price reduction.

CMS Risk Score Model Changes

CMS is implementing a new risk score model in 2024 that includes restructuring of the condition categories using ICD-10 instead of ICD-9. Revisions focused on conditions that are subject to more coding variation. CMS phases the new model in over 3 years. Impact to plans will vary based on the underlying population health risks, plans' current coding efforts. Plans that were

“good” at coding are seeing the biggest decreases in risk scores. Chronic SNPs that were for CHF and Diabetes members likely saw their risk scores drop significantly as they had a higher portion of the higher severity members where the risk scores are now constrained. Plans will look to identify ways they can increase their risk scores under the new model. In 2024 CMS did not update the RxHCC model for IRA impacts.

Employer-sponsored Medicare Plans

The percentage of large employers offering retiree health benefits gradually decreases over the years. However, State/Local Government entities stand out at 70% offering Retiree Health Benefits. 60% of employers offering retiree benefits with 5,000 or more employees utilize Medicare Advantage in 2022. The primary reason for employers to offer Medicare Advantage plans is the lower cost. Some employers still provide retiree choice and offer non-Medicare Advantage and Medicare Advantage plans. However, Medicare Supplement enrollment remains flat despite growing number of new Medicare eligible retirees. Medicare Advantage plans provide tremendous value to retirees with high member satisfaction rating and has high support from members of Congress.

Session 206

Bias: Good, Bad, or a Fact of Life?

Speakers:

- Ellen Kleinstuber – Bolton
- Roosevelt Mosley, FCAS, MAAA – Pinnacle Actuarial Resources
- Becca Trauger, FAS, FCA, MAAA – Bolton
- Shelley Zhao, FSA – Aon

Moderator: David Scharf, FCA, EA, MAAA – Buck

Session Host: Kristi Garrington, FCA, FSA, MAAA – Horizon Actuarial Associates

Background

This session defines different types of biases and presents five case studies with polling responses regarding what type of biases were identified in each case study. The SOA added bias as a requirement for US qualifications to make actuaries aware of other perspectives. There are biases in our work product, especially health and property & casualty. There are multiple places it can creep in and it's not necessarily bad. We need to recognize it and be attentive to it.

Types of Biases

- A. Statistical bias (data driven) leads to a systematic difference between true parameters and statistics used to estimate those parameters (e.g., sampling, omitted variables).
- B. Cognitive bias (think brain) causes systematic and subconscious errors arising from how information is processed, utilized and interpreted. There are two types of cognitive bias; (1) "belief perseverance" – clinging irrationally to previously held beliefs or illogically justifying outcomes, (2) "processing errors" – information is processed or used irrationally (e.g., conservatism, sample size neglect, anchoring, framing).
- C. Social/Emotion bias (interpersonal) leads to unfair or incorrect treatment based on subconscious intuition or impulses related to feelings, perceptions, or beliefs. They can be internal (relating to our own views) or external (our view on the perception of others). Examples are overconfidence, self-control, status quo, conformity
- D. Other bias is anything that does not fit into one of the prior three categories (e.g., cultural bias).

Definitions

There are three basic terms to define for discussing bias. "Bias" is a tendency, inclination, or prejudice to look at a person, object, or event without objectivity. "Heuristic" is a mental shortcut that allows you to decide quickly based on available information (short cuts may or may not lead to the right solution). "Fallacy" is a deceptive, misleading, or mistaken belief (especially if based on unsound argument). Fallacy mental shortcuts may not lead to the right solution.

The following types of bias are defined in this session:

- Affect Heuristic – people make decisions based on the way they feel at that time (e.g., “go with your gut”)
- Aggregation Bias – an assumption that trends in aggregate data are wrongly assumed to apply to individual data points
- Anchoring Bias – favoring or placing too heavy a reliance on the first piece of information provided (or generally information provided early in the decision-making process). For example, in car buying, the first price thrown out is the anchor price and it sets an expectation for negotiations.
- Attentional Bias – people tend to pay attention to some things while simultaneously ignoring others
- Availability Bias – The impact of a person’s most vivid experiences or memories on decision-make (aka Availability Heuristic)
- Base Rate Fallacy – people tend to ignore the general prevalence in favor of the information pertaining only to a specific case
- Confirmation Bias – people tend to look for evidence that confirms their point of view and tend to dismiss evidence that does not justify it. For example, in reviewing work you might see the results you are expecting. A diverse group can help mitigate this bias.
- Framing Bias – the way in which a choice can be affected by the order or way it is presented. This is how you set up what you are looking for in the first place. One issue is framed and others end up getting ignored.
- Negativity Bias – the tendency to pay more attention to negative information than positive or neutral information.
- Ostrich Effect – people avoid or ignore negative information that could cause them emotional distress or harm their well-being
- Outcome Bias – people judge a decision based on its outcome rather than the quality of the decision-making process
- Sample Size Neglect – judging the probability of obtaining a sample statistic without respect to the sample size (aka Sample Size Bias)
- Status Quo Bias – the tendency of people to stick with their current situation, even in the presence of more favorable alternatives

Case Studies on Bias

Five case studies are presented with polling options on which biases apply.

#1 Multi-Year Contribution/Expense Forecasts – You are the actuary preparing a 15-year forecast of pension plan contribution requirements. Historically these projections are based on demographic and economic assumptions from the current year’s actuarial valuation, participant census data and plan assets as of the most recent valuation date, and open group with future new entrant profile based on demographics of the most recent three years of new participants. As part of this process, you look for comparability from year to year. A polling question asks what biases you should take into consideration?

Status and anchoring bias receive strong support (the work was done the way it always has been). Availability bias comes into play with examples of COVID pandemic experience. Did hiring patterns differ, was there more turnover, have demographics changed and how long will

these changes last? Do we have negativity bias due to negative reactions from COVID and how it impacts our projections? Are we avoiding bad news or discounting the impact? Does our framing bias impact how we present the results to our client? Was our sample size credible, did we use the proper weights?

#2 Setting Per Capita Costs or Premium Equivalent Rates – When performing OPEB valuations or setting premium equivalent rates for clients in self-insured arrangements, actuaries have to determine the expected cost of the benefits provided for the upcoming year. This is often done by looking at recent claims experience and developing a weighted-average cost that's trended to the projection period. In doing this, the actuary must make decisions about what experience to include and how granularly they will set the costs (i.e., by plan, benefit type, etc.). A polling question asks which of the following biases come into play in setting these per capita costs or premium equivalent rates?

Audience gave high response to anchoring, confirmation and status quo bias as well as sample size and aggregation bias. The first question we generally ask when reviewing the per capita costs or premium equivalent rates is "Is the result similar to last year's plus trend?". If it is, do we skip a detailed review? Or was it far off but that was expected due to changes in the plan or underlying population? This is an example of anchoring/confirmation bias – if results are as expected we may not do our due diligence. What if we missed something and our expectation isn't correct? Or what if results are correct in aggregate but our assumptions are incorrect and we just got lucky because things offset? Might cause issues next year if we start from the same assumptions. If we are aware of our biases, we can reflect them in our assumptions. Also consider aggregation bias – if we lump plans together, we may not notice a dramatic change in one group. Sample size – if the credibility of the underlying population is not sufficient, how much weight do we use on actual experience? Setting premium equivalent rates – if you have favorable experience, do you drop participant contributions or leave as is? Decreasing rates may be difficult to communicate, as participants may assume they were paying too much in the past – but is this negativity bias and/or status quo bias? It may also make future communications easier as a potential future rate increase will be lower if the base rate is higher, but is it okay to knowingly overcharge participations? If experience was unfavorable, you would be more likely to pass that onto them, so why should favorable experience be different? Actuaries have a tendency to be conservative in their assumptions, but if every assumption is conservative, will the result be too conservative? Do our clients want us to be conservative? Other things to consider – bias is dangerous if we place more value on things more easily quantified. Do fancy models diminish our assumption review?

#3 What is Driving Healthcare Behavior and Spend – In a study to understand how much social determinants of health (SDoH) impacts healthcare spend, a client asks the consultant to look into their key markets with both corporate and factory members to determine strategies that address SDoH (knowing in those key market low/high earners live in different parts of the town). The initial findings were consistent with what they consultant and plan sponsor had anticipated; even in the same city, corporate members tend to live in areas less impacted by SDoH and have lower risk-adjusted spend than factory workers. As a follow-up analysis during union negotiations a year later, the actuaries ran one additional risk-adjustment scenario that controls for SDoH variables. The results were almost identical to the previous study, where a similar magnitude of higher cost among factory members is observed compared to the corporate members. A polling question asks which of the following biases apply in this situation.

Confirmation received the highest vote but it's really driven by our client's confirmation biases. We need to ask how much is impacted, not if there is an impact. In this example, the employer was looking for information in preparation for union negotiations. How much of the difference in medical costs is due to plan design (aka, different benefits) vs SDoH? Aggregation bias is also at play – what if one only looks at averages? They might miss important details about subpopulations. Negative bias – we look for dangers, or things we have to worry about. Ostrich effect - we don't want to look at negative impacts.

#4 Do Societal Biases Impact Property and Casualty Premiums – There are examples in history of times when boarder issues of racism and discrimination have affected insurance. One example of this is redlining, a significant period of time where minorities and low-income communities had limited access to financial services. While the practice of redlining is no longer allowed, the impact of over-a-century old redlining practices is still being felt today in those communities which were discriminated against. The question now being asked is do these continuing effects result in unfairly discriminatory property and casualty premiums. Insurance companies say no; race is not considered and premiums are based on the risk of the policyholder. Consumer groups say yes; the outcome of current practice is that premiums in these areas tend to be higher and those areas tend to be more heavily populated by minorities. A polling question asks which of the following biases apply?

Discussion ensued regarding that regulators and legislative bodies are looking at this and opinions vary widely. Do very diverse opinions mean the answer is somewhere in the middle? Ostrich effect seems apparent. This has been a past concern, is there social pressure to say it's been fixed? Insurance companies say there are no racial issues a race is not a question asked which reinforces framing bias. Or is framing bias in play due to trying to get to a certain outcome? In an example of areas with high incidence of auto theft (such as a minority area with high crime) – to what extent is that bias vs risk of parking a car in a high theft area? Is this outcome bias – a higher premium is charged in a higher risk area? The outcome is logical but is the process used to get there correct? How much of this is causal or a correlation?

#5 Behavioral Economics and Participant Elections – A pension plan sponsor is offering a one-time lump sum widow to terminated vested plan participants. As an alternative to the lump sum, a participant may elect to commence a monthly annuity now. Most participants may also elect to defer payment of their monthly annuity benefit to a later date, at which time a lump sum may not be available as an alternative. The plan sponsor and plan administrator instruct the actuary that the options are to be presented to participants in the following order, based on behavioral economics principles: lump sum, immediate annuity, deferred benefit. A polling question asks which of the following biases come into play in determining how to order the participant's options? Affect heuristic, anchoring, attentional, availability, framing, negativity, outcome. This case study was not discussed other than to state that when we consult to clients, we try to influence them based on a desired outcome.

Summary

Is bias good, bad or a fact of life? Biases are an essential input in the pursuit of success. We deal with bias in daily practice and there are overlapping issues. Bias creates risk that much be managed effectively. As consultants, we bring the sum product of our biases to our clients. Left unchecked or unrecognized, bias endangers the quality and reliability of the analysis and advice we give. We must manage our biases to give our clients sound information. As quoted by

Clayton Christiansen, “Data has an annoying way of conforming itself to support whatever point of view we want it to support.”

There are ways to manage biases in actuarial work. Recognize that they exist and get to know them. Think critically and challenge assumptions and traditions. Build a diverse team for different thought processes and engage in peer review. We need to challenge assumptions and traditions by asking why and why not often. Think of a stone with many facets as opposed to a coin with two sides.

Session 207

Service Purchases in Public Retirement Systems External and Internal Perspectives

Speakers:

- Paul Angelo, FCA, FSA, EA, MAAA – Segal
- Robert (Andy) Blough, FCA, FSA, EA, MAAA – Indiana Public Retirement System
- Koren L Holden, FCA, EA, MAAA – Public Employees' Retirement Association (PERA) of Colorado

Moderator: Elizabeth Wiley, FCA, FSA, EA, MAAA – Cheiron, Inc.

Session Host: Jolene Roe – Deloitte Consulting

Overview

In this session, speakers explore technical aspects and implications of service purchase programs in public employee retirement systems. Paul Angelo and Andy Blough provide a refresher on the basics of service purchase, while Koren Holden covers a case study on Colorado PERA, then Andy wraps up the session with looking beyond the service purchase calculation.

Background

Service purchase is an ancillary benefit in some US public pension plans. Participants or employers exchange payments for service under the terms set forth in the plan. Actuaries may be requested to provide services including pricing the service being purchased, designing, or updating the terms of the plan, and designing or updating the methodologies and assumptions used in the pricing.

Service purchase cost calculations can be performed on either an actuarial or subsidized basis. From there the calculation is either individual or a tabular approximation. The individual calculation uses the change in the participant's actuarial liability to price the service being purchased. Under the tabular approximation, the actuary provides tabular factors as approximations of the individual calculation.

There are a few actuarial issues and considerations for service purchases including cost neutrality, assumption selection, assumption risk including anti-selection, and "true-ups".

Cost Neutrality: Many service programs intend to be "Cost Neutral". This is generally understood to mean that a service purchase does or will not result in an increase or decrease in plan liability or actuarially determined contributions. Because this is largely unattainable, programs can only strive for "expected cost neutrality". Expected cost neutrality measures can change over time given assumption changes, plan experience, and plan changes. It is easiest to maintain expected cost neutrality when service purchase is allowed only at retirement, however, many plans allow service purchases at any time during the participant's career.

Assumption Selection: There are a few options when selecting the assumptions to develop service purchase liability. Funding assumptions are a potential choice, however, participants purchasing service may not behave in the same way as the plan population on a whole and the purpose of the measurement may be considered different than funding. In either case alternative assumptions may be used.

Assumption Risk including Anti-Selection: As previously mentioned, valuation assumptions may not be the best choice for service purchases. It is important to take a close look at the assumption risks particularly associated with service purchase including age at retirement, final pay for benefits, longevity, investment performance, form of payment, COLA, and the proportion of retirees covering a spouse. For some assumption risks, the participant knows more than the plan, such as a participant may be waiting on a promotion, etc. Anti-selection risk also increases with length of purchase eligibility.

True-ups: True-ups are used as a method to achieve the same level of expected cost neutrality as allowing service purchases only at retirement. True-up provisions allow a plan to adjust either the amount of service/benefit purchased or cost of purchase, based on actual participant data at retirement. A true-up compares actual cost (present value) of additional benefit with original purchase cost plus interest. If the recalculated cost is greater, the participant pays the difference or receives a reduced additional benefit. If the recalculated cost is less, the participant receives a larger additional benefit or gets a refund (if legally permissible).

Public Employees' Retirement Association of Colorado - A Case Study

Colorado PERA allows purchased service to be used for both retirement eligibility and to increase benefit amounts. The purchased service also can impact the retiree medical benefits. Under the Colorado Plan there are three ways to purchase service: reinstatement, any employment not covered by PERA, and any sabbatical leave. Colorado PERA's process has improved over time. Pre-1999 service purchase was simply based on subsidized fixed prices, by benefit structure, regardless of age/service. Between 2000 and 2003, fixed pricing continued and cost factors were actually reduced. The Senate Bill 2003-098 passed and caused service purchased prices to increase slightly. The period from 2003 to 2005 was considered a transition period, reflecting the increased service purchase prices, although still subsidized, and based more so on current practices, differentiating by age. In 2006, Senate Bill 2006-235 was enacted, changing the HAS calculation for certain members and mandating that service purchase costs were to be actuarially equivalent. All these changes resulted in the use of an actuarial equivalent tabular approximation for the service purchase cost, based on age, within tier, within benefit structure.

Beyond the Calculation

There are a variety of considerations before and after the service purchase that the retirement system must address, especially when talking to clients or participants.

Communications: Pension rules are complex for a typical participant and service purchase rules add another layer of complexity, thus educational materials on service purchase programs should be developed. Anchoring participant expectations can be helpful to avoid surprises. Potential methods include online calculators, showing ranges, hypothetical purchase examples, true-up mechanism potential outcomes, and participant counseling.

Refunds – Noncontributory Plan: If a plan doesn't require participant contributions, it may still need to issue a refund for money paid for a service purchase.

Data Records: Administration systems will need to track service purchases for both internal and external purposes such as the amount of service purchased, what it can be used for, and transaction details. They should have mechanisms in place to avoid double-counting purchased time and to keep track of legal agreements.

Administrative Expenses: In certain cases, a service purchase calculation may be needed for individuals who are not yet covered under the plan. For example, an employer not yet in the system may be considering joining, but it may depend on the cost of the service. In that case, consider discussing with legal staff which party should bear the expenses.

Session 302 Hedging Pension Liabilities

Speakers:

- Joe Anzalone, FCA, FSA, CFA, EA – Agilis
- Dan Cassidy, FCA, FSA, CERA, CFA – Cassidy Actuarial Services LLC
- Michael Clark, FCA, FSA, CFA, EA – Agilis
- Sweta Vaidya, FCA, FSA, CFA, EA – Insight Investment

Session Host: Jonathan Price FCA MAAA EA – Segal

Background

A pension plan faces many risks to both its assets and liabilities, some of which are linked to capital markets on both sides of the equation and can therefore be hedged. Hedging pension liabilities seeks to create a link between the volatility of the assets and liabilities and reduce a plan's funded status volatility by correlating its asset performance to changes in its liabilities as capital markets move.

The plan sponsor's objectives will dictate how smooth the ride is. Fixed income instruments, such as corporate bonds and Treasuries, will provide returns and diversify risk away from equities. They also provide liquidity for benefit payments and can be used to hedge against liability changes caused by movements in interest rates and credit spreads. For example, a popular use case is for sponsors to protect against a situation where interest rates fall, causing liabilities to increase and funded status to deteriorate. This year has seen interest rates rise dramatically so, ignoring declines in a plan's equity portfolio for the moment, any plans that were not fully hedged against interest rate movements will have seen improvements in their funded status since their assets will have fallen less than their liabilities.

With the continued rise in interest rates this year, many plans have now found themselves in better funded positions than they started the year in, leading to discussions of hibernation, pension risk transfer, and potential plan termination. However, to best understand pension liability hedging, attention is required to determine what definition of the plan's liabilities are the focus of the hedging techniques and measurement. Of course, that definition will be linked to the goal of the hedge. What purpose does the hedge serve for the plan sponsor? Understanding that, will guide the selection of the liability for hedging.

Hedging pension liabilities

Actuarial liability models produce future expected benefit payment streams which, when discounted using a given rate or yield curve (typically based on AA-grade bonds), result in a present value liability. Identifying the appropriate actuarial model for producing the benefit payment stream and selecting the discounting basis, will determine the plan's liability. Ultimately, a plan sponsor will need to consider whether and how to balance various purposes for funded status hedging.

Most commonly, hedging targets intend to remove interest rate risk. Interest rate risk is viewed as uncompensated. Furthermore, forecasting interest rates is challenging, unhedged rates can create a very large single-risk-factor. However, even once it is decided to hedge interest rates,

the plan sponsor still needs to decide on a hedging strategy (all or some of the liability), which factors to hedge and how to implement the hedge. For example, is the sponsor a return seeker (where the risk budget is dominated by contribution of under-hedged rates and return-seeking assets), on a glidepath (where additional incremental hedging can reduce funded status volatility) or moving to an end state (where the level of precision can be impacted by the ultimate objective to terminate versus hibernate).

Current challenges

When implementing a hedge, two common challenges are the current yield curve (i.e., inverted) and lump sum payments (i.e., interest rate-sensitive benefit payments). Specifically with respect to the inverted yield curve, how will the hedging program respond when/if the yield curve normalizes? And with respect to lump sums, how does the hedging program address the increased tracking error?

In summary

The panelists reinforce the critical role for communication amongst all stakeholders – specifically, the plan actuary, hedging manager and plan sponsor. The plan actuary must convey to the hedging manager how best to understand the cash flows (and what uncertainties remain within them). The hedging manager must convey the hedging objectives and potential concerns from the cash flows. The panelists affirm that creating a system for monitoring that include the plan actuary is critical. It is impossible to have a portfolio with zero tracking error, so you should understand how the liability curves compare to the actual universe of available investments and how that affects your funded status. There are many ways to track performance, but success should be evaluated relative to your target and goals, which is not necessarily outright performance relative to industry benchmarks. At the end of the day, the plan's funded status is what matters.

Session 304

Retiree Healthcare – State of the Market

Speakers:

- Christine Kourouklis, President Medicare – HCSC
- Barry Carleton – WTW

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

Retiree Medical Overview (Barry Carleton)

Historical Context

Prior to the passage of the MMA in 2003, there was no pharmacy coverage under Medicare. In 1965 when Medicare was created, prescription drug costs were low and the benefit was not considered essential. The 2003 Medicare Modernization Act (MMA) authorized Medicare Part D to begin in 2006. This was the first step in providing comprehensive drug coverage to America's senior citizens.

Private Medicare plans replacing Parts A/B were first offered in the 1980s, with significant enrollment growth through the 1990s. The Balanced Budget Act of 1997 reduced the funding to Medicare Advantage, leading to insurer market withdrawals or premium increases and benefit cuts. Seniors objecting to these changes made their voices heard in Washington. The MMA created the current Medicare Advantage program with financial incentives for insurer participation, thus triggering substantial enrollment growth with currently about half of those on Medicare enrolled in MA (about 30 million people).

CMS Employer Group Waiver Plan (EGWP) authority provides incentives for employers to continue offering group medical and prescription drug plans to Medicare retirees. Group MA and Part D EGWPs have become a popular means for employers to continue group plan sponsorship.

Prior to the ACA, pre-65 retirees were often unable to get affordable individual market insurance coverage without restrictions on health status. The ACA created a new individual insurance market starting in 2014 with guaranteed issue coverage and substantial premium subsidies based on family income. These subsidies were enhanced by the 2021 American Rescue Plan Act (ARPA) and continued through 2025 under the 2022 Inflation Reduction Act. Coverage is now universally available on a guaranteed issue basis with substantial subsidies that make coverage more affordable for all individuals prior to Medicare eligibility at age 65.

The Inflation Reduction Act of 2022 includes major changes to Part D, especially in 2025, and also extends the enhanced ACA premium subsidies enacted under ARPA.

Current State of Pre-65 Retiree Medical Coverage

Many employers continuing to sponsor group pre-65 retiree medical plans have adopted subsidy caps that shift all future medical inflation to retirees as higher contributions. These caps are generally viewed as a form of extended exit from group plan sponsorship as more retirees

waive coverage under the group plan. With creation of new individual insurance markets under the ACA, employers have a new alternative to group plan sponsorship, enabling pre-65 retirees to enroll in ACA coverage with enhanced premium tax credits based on income. There are several advantages to the ACA market for pre-65 retirees compared to employer sponsored retiree medical plans with capped subsidies.

1. Growing ACA enrollment provides a more stable risk pool than many employer-sponsored group plans with curtailed eligibility, enrollment shrinking due to high retiree waiver rates and adverse selection driving up group plan rates
2. ACA rates in most states are set by age using a 3:1 ratio of costs from oldest (64) to youngest (21); this ratio creates an implicit but substantial rate advantage for pre-65 retirees since their actual claim cost is much higher than 3x the claim cost of younger adults. Group plan rates are based on the actual experience of pre-65 retirees covered under the plan.
3. Federal premium tax credits can increase faster than medical inflation since contributions for ACA coverage are limited to a defined percentage of income. Under an employer plan with a capped subsidy, retiree contributions rise more rapidly than medical inflation. This dynamic is likely to drive higher rates of waiver from employer coverage in favor of cheaper ACA coverage.

Current State of Post-65 Retiree Medical Coverage

Most employer sponsored group post-65 plans were adopted prior to the inception of Medicare in the mid-1960s. 1957 was the peak birth year of the baby boom generation which is now turning 65 at a rapid rate. The political power of the boomer generation has helped ensure bipartisan support for Medicare including MA and Part D programs.

Post-65 individual insurance markets have been stable for many years based on strong federal financial support for MA and Part D programs and the popularity of Medigap plans. Many employers moved from sponsoring group post-65 plans to offering a Medicare exchange approach under which Medicare retirees can elect individual coverage, often with employer financial support through an HRA. Many other employers, however, have elected to retain sponsorship of group post-65 plans via the EGWP route promoting group MA and group Part D prescription drug plans.

Key Provisions of the Inflation Reduction Act Affecting Part D Plans

The 2022 IRA enacts substantial changes to group and individual market Part D plans, with modest changes effective in 2023/2024 and a more fundamental restructuring of benefits and funding arrangements effective in 2025. For 2025, a new \$2,000 member out of pocket maximum applies along with new formulas for determining funding offsets through CMS direct subsidies, CMS reinsurance and pharma manufacturer discounts. Additional changes under the IRA include drug inflation rebates and federal negotiation of drug prices taking effect in 2026.

The new \$2,000 out of pocket limit will substantially reduce the maximum amount a member can pay under Part D. There is currently no limit on total out of pocket costs under standard Part D.

Under Part D EGWPs, the value of enhanced benefits under the employer plan is expected to count toward the new \$2,000 out of pocket maximum (pending regulatory guidance). This

means that EGWP members will pay less than \$2,000 in actual out of pocket costs since their employer plan will pick up part of that cost. For example, assume an \$8,000 drug with a \$100 copay (ignoring the deductible for this illustration). The value of enhanced benefits over the Part D standard 75% coinsurance is \$1,900. Accordingly, the annual out of pocket maximum is met by the plan paying \$1,900 and the member only \$100. This enriches the EGWP substantially more than employers may expect and will also likely drive increased utilization after a member has reached the new out of pocket cap.

The improvements in Part D standard coverage could affect the ability of employer sponsored active health care benefit plans to qualify as “creditable coverage” under which Medicare eligible active employees and spouses can later enroll in Part D without a penalty. Current active plans with Rx benefits that are not as rich as the new enhanced standard Part D could lose creditable status in 2025. Employers with active plans failing to qualify as creditable coverage would need to improve their active benefits or instead offer coverage that is non-creditable so that Medicare eligible active employees and dependents could later face Part D late enrollment penalties. CMS regulatory guidance is required to understand how the new Part D design effective in 2025 will affect creditable coverage testing for an employer’s active health care plans.

Elements for Success in Medicare Advantage (Christine)

When the retiree or associated employer is assessing Medicare Advantage and Medicare supplement plans, it is critical to review all facets of the offering in addition to the actual medical and pharmacy actual benefits. This would include care management, medical and Rx integration, and geographic coverage options available including supplemental benefits. Retirees want plans that will cover them whether they are in a major city environment or in a rural location for where they best should receive services. Retirees today are highly tech savvy and want a partner that will provide easy access to data and overall plan support. For example, they want to be able to review EOBs on their mobile phone or tablet. The number of Medicare enrollees that are in Medicare Advantage plans are a testament to the strength of the Medicare Advantage market which continues to grow. Retirees choose Blue Cross Blue Shield because of the strength of the network, longevity and overall relationship management. Now with the Inflation Reduction Act, retirees can smooth their Rx plan deductible over twelve months by simply making a phone call to the insurance company for a review of what is the best prescription plan alternative.

A question was asked about transitioning from Medicare Advantage back into a Medicare Supplement plan. It can be challenging as most Medicare Supplement plans do not allow enrollment at later ages due to anti-selection concerns. This can be addressed by choosing a Medicare Advantage plan that allows for guaranteed issue into the insurance company’s Medicare Supplement plans if the retiree is unhappy with Medicare Advantage. One participant noted that many of the Blue Cross options under HCSC allow for this option.

A question was raised about the sustainability of the \$0 Medicare Advantage plans in the market today. There is some discussion that risk scoring methodology will change enough to make the \$0 premium plans unsustainable in the long-term. There are also proposed changes in the Low-Income Subsidy.

Session 307

Federal Laws and Congressional Activity Applicable to Public Plans

Speakers:

- Michael J. de Leon, FCA, ASA, EA, MAAA – Deloitte Consulting LLP
- Audra Ferguson – Ice Miller
- Todd N. Tauzer, FCA, FSA, CERA, MAAA – Segal

Session Host: Joe Kropiewnicki, FSA, EA, MAAA, CERA – Deloitte Consulting LLP

This session covers recent legislation and other topics that apply to public pension plans.

Michael opens the session with a brief introduction of the topic and the two speakers, Audra and Todd, who will be covering the material.

Highlights of Secure 2.0

First, Audra walks through highlights of Secure 2.0 and its applicability to public plans. Secure 2.0 contains significant changes for all types of retirement plans, and the IRS is starting to issue additional guidance.

Required Minimum Distributions (RMD)

Secure 1.0 increased the RMD age from age 70.5 to 72 (for people born after July 1, 1949). Secure 2.0 increased the RMD age to 73 for people who turn age 72 after 2022, age 73 before 2033, and age 75 for people who turn age 74 after 2032. Note that a technical correction will be needed for people born in 1959. This impacts all plan types and is a mandatory plan change and operational change.

There are some additional RMD changes: Pre-death RMDs are no longer required from designated Roth accounts; There is a reduction in excise tax penalty on late RMDs from 50% to 25% (10% in some instances); a surviving spouse may elect to be treated as Employee for RMD purposes; and there are new rules for RMD aggregation on partially annuitized accounts.

Increased Participation and Savings

SECURE 2.0 includes higher catch-up limits for older employees.

There is a delay until January 1, 2026 for the requirement that catch-up contributions for those earning over \$145,000 are made on a Roth basis. There is some additional uncertainty regarding this provision, including the applicability to Social Security Replacement Plans.

Qualified Public Safety Employees

There is a new exclusion for disability related retirement payments, effective for plan years beginning after 2026, which applies to benefits that convert to a normal retirement benefit. There are also changes to the early distribution tax penalty under Code Section 72(t)(10), which changes the exemption to the earlier of (i) age 50 or (ii) twenty-five years of service under the plan and expands the definition of a “qualified public safety officer” to include governmental corrections officers and forensic security employees. Additionally, 72(t)(10) is expanded for distributions to private sector firefighters.

Plan Corrections

For recovery of plan overpayments, a new provision is created under Code Section 414 that the failure to correct overpayments will not be a qualification failure. This has been interpreted to create new “flexibility” on correction of overpayments, but more guidance from IRS is expected.

The Employee Plans Compliance Resolution System (EPCRS) is expanded to allow more types of inadvertent errors to be corrected through self-correction, expands to inadvertent IRA failures, and does not require rollovers to be undone.

Additionally, the automatic enrollment correction Safe Harbor under EPCRS is made permanent.

Additional Provisions and Plan Amendment Deadlines

Audra walks through some additional, more minor, provisions of Secure 2.0. She outlines the plan amendment deadlines, which are, in general, December 31, 2027 for governmental calendar year plans or June 30, 2028 for fiscal year plans.

Environmental, Social, and Governance (“ESG”)

Next, Todd walks through the current climate surrounding ESG in Washington DC. First, it is important to understand that the term “ESG” can be used in a variety of contexts:

1. ESG for risk-based disclosures: This pertains to ESG risks that have a “nexus to credit” and communicates the risk of default to investors from ESG-related events (e.g. a hurricane).
2. ESG for procurement or investment parameters: This pertains to policy-directed or policy-prohibited guidelines for ESG as organizations are looking to take on new projects, new investments, or hire contractors.
3. Green Bonds / Social Bonds / Other Labels: While there is no such thing as an “ESG Bond”, organizations can issue bonds related to a particular topic within ESG and include specific ESG disclosures in official documents to potentially increase or diversify investor demand.

Todd references the following site: www.GFOA.org/esg, where the GFOA has published Best Practices for each of the “Environmental”, “Social”, and “Governance” components.

Additionally, Todd references another GFOA Best Practice for Marketing Municipal Bonds as Green, Sustainable, Social, or Other Alternatively Designated Bonds. For governments considering formally designating bonds as having positive social, environmental, sustainable, or other impacts, GFOA recommends they critically evaluate the potential benefits and associated costs. Governments should consider consulting their municipal advisors and bond and/or disclosure counsel who can help them assess whether any benefit of issuing Designated Bonds outweighs the costs and any potential future legal or regulatory risks and consequences if the project goals do not meet the Designated Bond criteria.

Low-Default-Risk Obligation Measure (“LDRM”) and Advocacy Efforts

Todd outlines that while ASOP 4 (particularly LDRM disclosures) have been known to actuaries for a while, many finance officers/members of congress/other stakeholders are still not familiar with the LDRM concept and additional education and communications will be necessary.

Committee on Retirement and Benefits Administration (CORBA)

Todd summarizes recent CORBA projects related to benefits and what might be notable related to public pension plans.

Additional Topics

Finally, Audra covers some additional topics:

- Common problems and concerns for 1099-R reporting
- Areas of inquiry for RMD's: Assuring that benefits begin by the RBD; Assuring that the RMD is made; Procedures regarding missing participants and beneficiaries; Testing survivor benefits under the incidental benefit rules; Grandfathered provisions and/or "reasonable and good faith interpretation" of requirements (Treas. Reg. § 1.401(a)(9)-1, Q&A-2(d)).
- Missing Participants: If the following steps are not completed, examiners may challenge the plan for violation of RMD standards:
 - Search plan and related plan, sponsor, and publicly available records or directories for alternative contact information
 - Use at least one search method (commercial locator service, credit reporting agency, or a proprietary internet search tool)
 - Attempt contact via USPS certified mail
- Designated Beneficiaries: A designated beneficiary must be an individual, can be designated by affirmative action or be default, and contingent beneficiaries receive benefit only if the primary beneficiary dies. Default beneficiaries are the surviving spouse, or if no spouse, to legal representative. And beneficiaries of a trust are treated as designated beneficiaries if certain criteria are met.
- RMD taxation and reporting: RMDs are taxable to the individual in the year of distribution under federal and state income tax laws. RMDs are not eligible for rollover. For nonperiodic RMD's (except RMDs satisfied by annuity payments), 10% is withheld (though the member can change this using Form W-4R). For RMDs made by annuity payments, withholding is in accordance with Form W-4P. Audra also walks through withholding situations for US Citizens versus resident aliens versus nonresident aliens.
- Rollovers: For a Direct Rollover of an Eligible Rollover Distribution from the retirement plan, no required withholding applies, but members may request voluntary withholding via Form W-4R. For an Indirect Rollover of an Eligible Rollover Distribution from the retirement plan, 20% mandatory withholding applies, and the member may not elect out of the withholding but can increase it via Form W-4R. However, withholding is not required for any portion of the distribution that is not includible in gross income (e.g., after-tax contributions), or a distribution of less than \$200. Plans are required to report obligations for outgoing rollovers on Form 1099-R.

The last slide outlines some useful links from GFOA's Committee on Retirement and Benefits Administration. Additionally, Audra noted that a separate handout created by Ice Miller was provided in the session material that contains a useful guide summarizing the IRC provisions applicable to governmental plans.

Session 401

Plan Terminations: Nuts & Bolts and PBGC Input

Speakers:

- Sonja Coffin, FCA, FSA, EA, MAAA – Fidelity Investments
- Meryl Feigenbaum, FCA, ASA, EA, MAAA – Buck, A Gallagher Company
- Sara Eagle, Assistant General Counsel, Pension Benefit Guaranty Corporation
(remarks by PBGC's representative are based on her own opinions and do not necessarily represent the views of the agency, nor are they intended to provide legal advice).

Session Host: Hilja Viidemann, FCA, FSA, EA, MAAA – Buck, A Gallagher Company

Instructions

As preparation starts for a plan termination, the actuary should **download the most recent version of Form 500 instructions** from the PBGC website. If any point in there is unclear, the actuary should call the PBGC for clarification.

Data

The key to a successful plan termination is to start the preparation for it early. Starting data cleanup before setting the plan termination date avoids delays later in the process. Data not normally needed for a plan's valuation will be needed for a transfer to the insurance company, for example, exact dates of birth, Social Security numbers and names for contingent annuitants. Exact indicative data is needed to display on Notices of Plan Benefits that get sent to each participant, beneficiary and alternate payee. If data are not available, the **PBGC will want to see the steps taken to collect the data with specifics on dates and where the sponsor looked**. The PBGC will not accept the inconvenience of getting files back from Iron Mountain as a sufficient reason for missing data on the NOPBs. If the PBGC deems that not enough data was available to make an informed decision on whether the plan paid out all the benefits owed to the participants, they will issue a qualified audit letter. Why should a plan sponsor care about a clean vs. qualified audit letter? Because if a participant claims they never got their full benefit and decides to sue, the clean audit letter could be useful to the plan sponsor.

Annuity Purchase Timing

Notifying potential annuity providers early, especially if you want to transact in the fourth quarter, or if you have a small, complicated or deferred-heavy plan is beneficial to both the sponsor and the insurer. Getting the level of interest ahead of time can avoid the issue where the lump sums to actives have been paid but an insurer cannot be found, threatening the plan's qualification status. The **PBGC advises securing an affordable annuity contract before paying out lump sums to actives** to avoid this issue. No one in the audience had ever done this, and the PBGC's representative said that larger plans normally don't have problems securing annuities. One way to get around this potential problem is to enter into a buy-in annuity contract that can later be converted to a buy-out. This approach will guarantee that an insurer is available when the time comes to buy the irrevocable annuity. The buy-in strategy also helps if the sponsor wants to know the exact cost of the annuity to get approval for the plan termination.

To File or not to File for a D-Letter

We discussed the evolving question of whether it is necessary to file for a D letter with the IRS and if yes, should one wait to receive a favorable letter before proceeding with the benefit distributions. **Lawyers still recommend filing and waiting**, but the majority of plan terminations now file for the D letter but proceed to distribute the assets without waiting to have the favorable letter in hand. The reason for the change has much to do with the amount of time it takes for the IRS to respond recently. The PBGC's representative said in certain cases having a favorable D letter could help upon audit. For example, if the IRS signed off on an amendment that would normally appear to violate IRS requirements, PBGC is unlikely to require correction of the apparent violation. There are rumors that the IRS is prioritizing D letters for terminating plans, but the panelists have not observed the wait times getting shorter, and they still have been in the 1-2 year range.

Plan Amendments

To revert excess assets to the plan sponsor (vs. distributing the excess assets among participants), the **plan needs to have such reversion language in the plan document**. If the provision was to distribute the excess among participants and this is changed, the change must be in effect for at least five years before the plan terminates. If the plan document is silent on the point of reversion it may be defensible, based on facts and circumstances, to assume that any reversion was meant to go the employer, and a clarifying amendment to that effect may not necessarily have to meet the five-year requirement. A transfer of surplus assets to a qualified replacement plan must start in the same calendar year that the terminating plan's assets are liquidated. The surplus assets generally cannot be used to fund a 401(k) match, except for only one to two pay periods, and is usually used to fund non-elective or profit-sharing contributions.

The terminating plan may be amended to eliminate redundant forms of payment, such as pop-ups, if no one has elected them. Some insurers cannot administer pop-ups. To find out which forms can be eliminated, the actuary should review the redundancy regulations, which are very detailed. **Changing the vesting service from hours counting to elapsed time is advised**, as insurers will not administer hours counting. Plan documents should be reviewed for "deemed cash-out" language so that non-vested terminated participants can be excluded from the termination vesting requirements. If no deemed cash out language exists in the plan, the PBGC will force the plan to pay out the non-vested terminated participants regardless of how long ago they terminated. The disability definition should be changed from committee discretion to a Social Security disability eligibility definition to remove ambiguity that insurers do not want to administer.

PBGC Form 501 and Schedule MP

Form 501 is due 30 days after all benefits are distributed; however, there is no penalty if the Form 501 is filed within 90 days of the distribution deadline. **The PBGC will typically grant extensions to file the Form 501** quickly and by email. The PBGC prefers a realistic estimate of the extension; for example, if the plan sponsor anticipates needing 90 more days, the PBGC prefers to grant 90 days all at once instead of being contacted for three separate extensions of 30 days. Facts and circumstances of why the extension is needed will be considered.

Question: At what point are the benefits considered distributed for the purpose of the Form 501 when there is a conversion from a buy-in annuity contract to a buy-out? The date specified in the insurance contract as the date on which the insurance company becomes responsible for all lives under the contract is the distribution date. The date that the insurer makes the first direct

payment to retirees has no bearing on the date that is reported on line 3a on Form 501. The answer is the same if the assets are left in the plan to pay a few months of benefit payments, and the insurer makes bulk payments back to the plan sponsor.

Participants with benefits with present value less than \$5,000 (\$7,000 starting in 2024) can be sent to the PBGC under the missing participant program at lump sum value. **Participants who have not cashed their checks by the check stale date are considered missing participants and can also be sent to the PBGC.** Their values must be calculated based on PBGC's assumptions. The money for Missing Participants should ideally be in the lock box already when filing the MP. This avoids delays in connecting the MP filing with the money. In case of questions on what to report on Form MP: for example, when a participant's identity was stolen and there is no valid SSN/name, call the PBGC and they will tell the filer what to report. When filing Form 501 and there is a discrepancy in final participant counts vs. what was reported on Form 500, this should be explained in the filing. There is no set format for explaining this, as the Form 501 is read by people and not fed into a machine.

PBGC Audit

The PBGC audit letter is not on the PBGC's website; please call the PBGC for a copy of the audit letter anytime during the plan termination process in case you want to collect the documents during the termination process. The PBGC will **audit all plans with more than 1,050 (previously, 300) participants.** Smaller plans are selected for audit based on randomized sampling techniques. The PBGC also audits plan terminations flagged for potential problems. If the Form 501 reports that distributions were made before filing the Form 500 (prematurely distributed) the termination will be audited.

No vested participant's benefits can ever be forfeited per the PBGC's representative. Some plan documents allow for conditional forfeiting for some purposes where the participant will be reinstated should they come forward during a specified period. **PBGC still requires fixed rate premium payments for such conditionally forfeited participants,** and in a plan termination, these participants need to be turned over to the PBGC in the MP program unless the sponsor can demonstrate that they are dead. Benefit waivers are allowed for majority owners.

One of the common issues still found upon audit is that sponsors are buying IRAs for missing participants, such as non-responsive participants whose lump sums are less than \$5,000. (It is allowed to buy IRAs for such participants before a plan terminates, but not after). It is also not permissible to buy annuities for participants not yet in pay that do not include all of the optional forms in the plan, as well as all the plan assumptions. If the PBGC discovers this upon audit, the plan sponsor may be required to buy another annuity for the same participant. Escheating funds to the state is not allowed, and if this is done, the sponsor will still need to transfer assets to the PBGC on the participant's behalf.

Session 402

Accounting for Postretirement Defined Benefit Plans Can be Challenging

Speakers:

- Phil Bonanno, FCA, FSA, EA, MAAA – Grant Thornton LLP
- Andrew Etheridge, FCA, FSA, EA, MAAA – Grant Thornton LLP
- Steve Eisenstein, FCA, FSA, EA, MAAA – KPMG LLP

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

Overview

The postretirement defined benefit plan landscape changes frequently (e.g. lump sum windows, annuity purchases, spinoffs, mergers, business combinations, plan changes, etc.). Clients look to consulting actuaries for guidance on the accounting effects of different events. Clients also look to consulting actuaries for actuarial assumption guidance. At this session, actuaries from accounting firms discuss challenges faced, how they worked with auditors, consulting actuaries, and clients; and resolution considerations based on their experiences and observations.

ASC 715 Discount Rate and Bond Model

There are a number of methods that a company may use to select a plan's discount rate, including use of a bond model. The "perfect world scenario" would be that the actuary would create a hypothetical portfolio of high-quality zero-coupon bonds whose maturity dates and amounts would be the same as the timing and amounts of the expected cash flows (benefit payments) for the plan. The projected benefit obligation would equal the fair market value of this portfolio, and the discount rate would be determined as the single rate at which discounting the each of the bonds to the measurement date would sum to this amount.

A perfect mix of zero-coupon bonds that will exactly match the cash flows is not generally available in the marketplace, and so bond portfolios are constructed with corporate bonds. Corporate bonds may include semi-annual coupons, benefit cash flows that extend beyond the bond maturities (which typically extend to a maximum of 30 years), and may require reinvestment.

In the key facts of the real-life scenario that was presented, instead of setting the discount rate based on the market value of the portfolio, the actuary selected the discount rate based on the internal rate of return for the portfolio. In such a situation, a client is likely following a non-GAAP policy, and the reviewing actuaries would assist in estimating the effect of using this methodology compared to the standard GAAP method described. Luckily, the difference in these two methodologies only results in a 2-3 basis point difference in the discount rate, and so, although there would need to be documentation around the non-GAAP policy, the impact on benefit obligation would not generally be material.

Accounting for a Settlement

Consider a scenario where a plan completes settlement activity. Amount of the settlement is finalized on June 30, but funds for the settlement activity are not distributed from the plan's trust until July 7. The entity's fiscal year ends on December 31 and quarterly financial statements are issued. There is a loss due to the settlement which the entity has reflected through an interim measurement as of June 30.

1. Is June 30 an appropriate date for the interim measurement?
An interim measurement can occur due to a significant event such as a settlement, curtailment, or plan amendment. In case the significant event does not coincide with a month-end. The accounting literature, however, allows the entity to remeasure plan assets and benefit obligations using the nearest month-end as a computational shortcut.
2. When does the entity recognize the loss due to settlement?
A settlement occurs when a transaction (1) is an irrevocable action, (2) relieves the entity (or the plan) of primary responsibility for a pension or OPEB obligation and (3) eliminates significant risks related to the obligation and the assets used to effect the settlement. In this scenario, since the entity is not relieved of responsibility for the obligation until assets are distributed (July 7), the settlement loss would be recognized in the financials during Q3 (even though they were measured as of June 30).

As a caveat to #2, if an entity is a non-public company that does not issue quarterly financial statements, it is common that settlement accounting will be recognized as of the fiscal year-end of the year of payment, because no one is relying on interim financial statements during the year. This is not necessarily a non-GAAP policy as ASC 715-30-35-1 does allow for computational shortcuts if the results are “reasonably expected not to be materially different from the results of a detailed application.”

Annuity Buy-In, Annuity Buy-Out, and Accounting for a Settlement

Annuity buy-outs have been common in the US for quite some time. Recently though, annuity buy-ins have started to gain traction with some large US plans. Historically, buy-ins have been seen primarily for UK plans. Oftentimes, a buy-in is purchased as a preliminary step in moving towards a buy-out.

In this scenario, we consider a plan that is in the process of terminating with the following timeline:

- Q1 2022 – the plan sponsor purchases a buy-in annuity contract with a buy-out conversion option
- Q3 2022 – the plan is terminated
- Q4 2023 – the annuity contract is converted to a buy-out and the all assets and benefit obligations are liquidated

The preparing actuary will need to consider how to reflect these events in the fiscal 2022 year-end measurements (after the plan termination but before the buy-out), and also determine the point(s) at which settlement accounting should be triggered for these events.

For settlement accounting, this goes back to the definition of a settlement, above. Although the plan assets are held by the insurer as of fiscal 2022 year-end, the entity still remains responsible for the benefit obligation until the obligation is liquidated. As such, settlement accounting related to these events will not occur until fiscal 2023.

With the signing of the resolution to terminate the plan and the buy-in annuity contract purchase in 2022, the substance of the accounting for this plan significantly changed, and the company determined that this was a change in accounting estimate under ASC 250. For the fiscal 2022 year-end measurements, the benefit obligation was determined based on the sum of (1) the portion of the benefit obligation expected to be distributed in lump sums during the plan termination process (using estimated IRC 417(e)(3) assumptions) and (2) the benefit obligation for the portion of the plan assumed to not receive a lump sum during the plan termination process, which was set equal to the fair market value of the contract as of the measurement date.

Purchase Accounting

In a situation where a company (the acquirer) acquires another company (the acquiree), and the acquiree sponsors a single employer defined benefit pension plan, the acquirer will need to recognize, as part of the business combination, an asset or a liability representing the funded status of the plan. Further, the acquirer may need to make certain decisions around management of the plan early on following the transaction.

Consider an example where Company A acquires Company B on June 30. Each company sponsors a qualified defined benefit plan (Plan A and Plan B, respectively). Both plans are frozen and both companies' fiscal year ends December 31. The plans will be maintained as separate plans. The actuary for Plan A will become the new actuary for Plan B.

As of June 30, Company B will perform an interim measurement on Plan B, rolling forward the beginning of year assets, liabilities, and AOCI to June 30. As of this date, Plan B's AOCI will be immediately recognized in P&L, and the assets and liabilities from Plan B will be transferred to Company A's balance sheet, completely zeroing out the plan on Company B's balance sheet.

Following the transaction, Company A now sponsors Plan B and is responsible for selecting the assumptions and methods to be used for purchase accounting, expense, and fiscal year-end disclosures at December 31. Plan B may use the same methods as Plan A for selection of discount rate, amortization of gain/loss, calculating market-value of plan assets, etc., but they may differ, and Company A may want to conform these methods for consistency. The same goes for certain assumptions.

In practice, we have seen companies hold off on conforming assumptions and methods until after the first year-end measurement. However, this may create a challenge as the auditors might push back on why, if the company believes these are the best estimates for the plan, would they not have been used in year 1. As such, it is generally recommended that assumptions and methods are reviewed and conformed, if appropriate, in year 1. Assuming the preparing actuary is aware of the transaction, this is a great opportunity for the actuary to advise the company on this timing concern (in addition to recommending appropriate assumptions and methods for the newly acquired plan).

Assumption Selection

Oftentimes while reviewing pension plans as part of an audit, issues that arise revolve around economic assumptions. To briefly summarize some applicable sections of ASOP 27 (Selection of Economic Assumptions for Measuring Pension Obligations),

- If an actuary selects an assumption, the actuary should disclose the information and analysis used to support their determination that the assumption is reasonable.
- In the case that someone other than the actuary selects an assumption,
 - If the actuary believes the assumption is reasonable, the actuary should disclose how they determined that the assumption does not significantly conflict with what, in the actuary's professional judgment, is reasonable for the purpose of the measurement.
 - If the actuary does not believe the assumption is reasonable, the actuary should identify in the report that the assumption significantly conflicts with what, in the actuary's professional judgment, is reasonable for the purpose of the measurement
 - If the actuary is unable to assess an assumption for reasonableness for the purpose of the measurement, the actuary should state such in their report

One of the key economic assumptions that causes auditors/reviewing actuaries a lot of grief, in particular as it relates to ASOP 27, is the Expected Return on Assets (EROA) assumption.

With the EROA, oftentimes the investment manager, plan sponsor, CFO, and/or other parties may get involved and collectively select the EROA. This is then provided to the preparing actuary to use as the EROA. Since the actuary did not come up with the assumption, they need to (a) determine whether or not they believe the assumption is reasonable (or potentially conclude that they are unable to assess the assumption), and (b) provide the appropriate explanation/statements in the report.

In this situation, we sometimes see the preparing actuary just include a statement indicating that the assumption was selected by the Entity (or another party), with no commentary on whether or not they believe the assumption to be reasonable. In this case, the auditor/reviewing actuary may push back for more detail, and the preparing actuary will have to provide their opinion on the assumption.

It is important to note that as a preparing actuary, in case you are using an assumption that are not based on your analysis, you need to be very careful to include the proper statements. In case you are silent on the rationale/reasonability, ASOP 41 (Actuarial Communications), Paragraph 3.4.4 (Responsibility for Assumptions and Methods), states that you will be assumed to have taken responsibility for that assumption or method.

Accounting Standards Update (ASU) 2018-14

ASU 2018-14 was released in 2018, effective for fiscal years ending after December 15, 2020 for public entities and December 15, 2021 for private entities. The main purpose of this ASU was to improve the usefulness of disclosures to users, without creating undue costs for the preparers. This ASU specifically applies to ASC 715 disclosures; however, it can be applied to ASC 960 reporting as well.

A key change that ASC 2018-14 requires is that ASC 715 disclosures must include an explanation of any significant gains/losses (or other significant changes) in the liability since the prior measurement date. There is no requirement to quantify the impact of each significant change. However, reviewing actuaries/auditors will oftentimes request the dollar impact of each significant change as part of their review (for example, if there are multiple assumption changes), so including a breakout of the effect of each significant change upfront can create a smoother audit with less back and forth between parties.

Expected Return on Assets (EROA)

ASC 715 defines the long-term rate of return (LTRR) on plan assets, which is the assumption used in determining the EROA component of net periodic benefit cost. Since the LTRR only affects the EROA and not the plan liability or other figures, it is oftentimes determined to be an immaterial assumption by the auditor for ASC 715 purposes, and follow ups from the reviewing actuary may not make it to the plan sponsor/preparing actuary. As such, it is possible that the selected assumption would not be considered reasonable by the reviewing actuary, and the plan sponsor/preparing actuary remain blissfully unaware.

ASC 960 describes a discount rate that is based on the projected trust returns, adjusted to consider future administrative expenses. Although it is not a requirement, it is common to see the ASC 960 discount rate set equal to the ASC 715 LTRR. Since the ASC 960 discount rate is used in determining the plan's ASC 960 liability, it is a significant assumption on an ASC 960 basis and must be considered carefully.

An issue that can occur is when a plan may be using an ASC 715 LTRR that the reviewing actuary, in their judgment, is outside of a reasonable range for the ASC 715 audit. Due to differences in materiality between ASC 715 and ASC 960 audits, an auditor may deem the impact of the LTRR immaterial to the ASC 715 audit and concern over the LTRR is not brought to the attention of the plan sponsor as well as the preparing actuary. During the ASC 960 audit, if the plan sponsor sets the ASC 960 discount rate based on the ASC 715 LTRR, the assumption may be deemed material due to 1) the lower materiality threshold for ASC 960 audits and 2) the sensitivity of changes to the assumption on the plan financial statements. As such, although the plan sponsor may be responsible for selecting the ASC 715 LTRR, the preparing actuary should consider how this assumption may affect the ASC 960 discount rate and liability, so any potential issues can be addressed before the ASC 960 financials are completed.

Session 403

Latest Developments in Mortality Analysis and Projections

Speakers:

- David Scharf, FCA, EA, MAAA – Buck
- Erik Pickett PhD FIA CERA – Club Vita
- Jim Berberian, ASA, EA, MAAA, FCA – Buck
- Ellen L. Kleinstuber, FCA, MAAA, FSA, EA, FSEA– Bolton

Session assistant:

- Yangyan Hu, FSA, EA, CFA – LGRA

Overview

In this session, speakers give an overview of the various factors affecting how long people live, explaining the two parts of mortality analysis to calculate life expectancy and the interplay between experience studies, augmented mortality models, and credibility analysis. Ellen gives examples of the application of mortality analysis as a Consulting Actuary with a case study. In addition, she discusses how to incorporate the latest thinking on mortality-related questions when consulting with our clients. Considerations of longevity modeling after Covid is also discussed in this session.

What affects how long people live?

Longevity drivers include: Age; Gender; Affluence; Lifestyle; Health; Occupation; Marital Status; Genetics & Smoker. Many of these drivers can be captured in pension administration data: for example, age, gender, and marital status are often provided. Pension or Salary amount can indicate affluence. Address information, in particular the US ZIP+4 code, can provide very granular information that could capture lifestyle and socio-economic information. Normal health retirement vs. disability retirement can indicate the participant's health condition. Collar type such as blue or white collar is used at a high level for occupation. The available data does not provide access to genetics and smoking status.

Part 1 of Mortality Analysis - Baseline

A baseline is a snapshot of current state of longevity, which is an objective measure based on past experience of a given population.

Erik shares Club Vita's analysis on 100 single-employer plans to illustrate that longevity experience of defined benefit pension plans varies widely, thus it is important to try to understand capture differences by plan.

There are two steps to capture these differences:

Step 1: Use common characteristics of plan participants to assign a best estimate base table.

In this step, there are two approaches to reflect plan's prior experience: a Top-Down approach or a Bottom-Up approach.

Top Down approach: average out experience from a large data set and apply uniformly to many pension plans

- Simple to construct and apply
- Need large amounts of data on homogeneous or representative groups of pensioners
- Data demand is very large when using multiple factors, such as gender, collar and affluence
- Not always possible to capture specific characteristics of your plan

Bottom up approach: develop suite of mortality rates that differ based on individual mortality characteristics, and aggregate assumptions based on individuals within a plan

- Generalized linear modeling used to calculate effects of multiple factors simultaneously
- Statistically credible multifactor models developed with much less data
- Specific tailoring even for small plans, or subgroups of plans

Step 2: Fine-tune baseline table assumption to capture any residual plan-specific experience.

Erik went through the details of conducting a credibility-adjusted experience study in conjunction with both a “bottom up” and a “top down” approach to step 1. The key steps are:

- Ensure the plan experience data is relevant, complete and reasonable.
- Conduct Actual / Expected experience analysis split by a range of different data fields to assess reliability, relevance and applicability of possible adjustments.
- Use a credibility analysis to assign a weighting to any appropriate experience adjustment to fine-tune the best estimate base mortality assumption set in step 1.

Part 2 of Mortality Analysis – Future Trends: Mortality Improvement

Future trend analysis seeks a more subjective measure of the expectation of the mortality improvement, or how longevity will change in the future.

It is easier to analyze improvement via the natural logs of mortality rates, here specifically:

$${}^Y\lambda_x = -\text{Ln}[{}^Yq_x]$$

Mortality improvement can be further decomposed into Aging Impact (the mortality increase from being a year older), Cohort Effect (improvement/dis-improvement relative to prior cohort that is a year older), and Yearly Impact - split into Age Effect {long term average at a given age} and Period Effect {short term fluctuations around Age Effect}. This generates an alternative view of the traditional Cohort / Age / Period decomposition.

Erik illustrates pre-COVID components (that might or might not resurface after COVID) predicted by the model using data through 2019, and how adding in a COVID year (2020) distorts the model’s long-term projections into future years.

He also reviews recent CDC excess mortality and COVID deaths data, indicating perhaps a return to “expected” mortality levels so far in 2023 (based on ½ year data).

Application of Mortality Analysis for Consulting Actuaries

Ellen discusses how consulting pension actuaries might incorporate these concepts into their work.

Case Study: Using Augmented Mortality Models (the Bottom Up approach)

This study compared the Pri-2012 tables (with and without collar adjustments) to liabilities determined using the Club Vita “eVitaCurves” to provide the plan sponsor (a regional hospital system) with insights on how these subgroups have different longevity expectations.

- Comparing liability by participant group indicated that while the Pri-2012 tables with no collar adjustment provide a very good match overall, that result is dominated by the large retiree population. For actives, terminated vested, and survivor groups, the Pri-2012 table may overstate liabilities by up to 5%
- Comparing liability by job classification indicated that female nurses are also aligned very well to a mixed collar table, while other classifications match to blue or white collar adjustments as expected (e.g., physicians and executives are white collar, non-exempt workers are blue collar). Somewhat surprisingly, male nurses are projected to exhibit mortality that is worse than blue collar workers despite the mixed collar nature of their work.
- Comparing liability by affluence group (based on salary/pension amount) confirms that:
 - Liabilities overestimated for lowest affluence levels
 - Liabilities underestimated for highest affluence levels

This analysis helped annuity broker negotiate the best pricing for the plan sponsor

- Immediate and deferred lives placed with different insurers, with the immediate going to an insurer that was not using zip-code based pricing models and the deferred lives to an insurer that was using such a model
- Savings realized of approximately 8.8% on the immediate life placement and 5.6% on the total placement, comparing preliminary to final bids

Applying Mortality Analysis Concepts to Ongoing Plans:

While the case study focused on a terminating plan that had access to the Club Vita longevity modeling tools, the concepts discussed in that case study can also be applied to selecting mortality assumptions for ongoing plans; expect to have discussions with a client's auditors about how these assumptions are selected. Key steps include:

- Focus on portions of the population that are most significant cost drivers
- For closed plans, consider qualitatively how the active population may now differ from the retiree population
- Evaluate geographic diversity of the retiree population
- Ask client questions about unknown aspects of participant population:

Actuaries for private-sector plans may also want to take the occurrence of statutory mortality updates for funding purposes as an opportunity to revisit assumptions used for other purposes to assess if a change is appropriate. For example, if ASC 960 accounting uses the IRC Section 430 mortality tables and those tables are updated, consider whether that table continues to reasonably model anticipated mortality experience for the covered participant group.

Longevity Modeling After COVID

The long-term mortality improvement rate should dominate, while taking into account any short-term COVID recovery period adjustments.

Adding 2020 Covid rates for males: Ages 45-85 period effects about -10% to -15%
Adding 2020 Covid rates for females: Ages 45-85 period effects about -9% to -12%

Advice: look to the 2019 model for any trends expected to rise back to the surface and apply annual loads for COVID-related excess mortality until there is a "new normal" basis from which to project long-term.

Session 405

Thinking About OPEB Valuation Assumptions for Medicare Advantage and Part D Plans

Speakers:

- Rebecca Trauger, FCA, FSA, MAAA, CERA – Bolton
- John Grosso, FSA, MAAA – Alight Solutions
- Marty Hill, FCA, FSA, MAAA – PwC
- Dan Hoffman, FCA, FSA, MAAA – Optum
- Jim Whelpley, FCA, ASA, MAAA, EA – Rael & Letson
- Dale Yamamoto, FCA, MAAA – Red Quill Consulting

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

Discussion Summary

Growth in Medicare Advantage plans is continuing. Funding for Medicare Advantage (MA) is based on individual market bids. The most efficient HMOs and PPOs are driving it. Prior to 2018, the bids were separate (two tier); since 2018 it is tied to individual market only. Group plans are not funded based on their own claims experience.

What is CMS' estimate for Fee for Service (FFS) cost in that area? Fee for Service has no care management. Closing gaps in care and managing costs help with plans' star ratings. Carrier reimbursements are based on:

1. Medicare FFS County-Specific Base Payment rate per member;
2. Rebates (driven by the individual plan bid process, a portion of which is sent to each plan based on their Star Rating);
3. Carrier Population-Specific Risk adjustment factors; and
4. Carrier-Specific Star Ratings Bonuses.

Example when setting retiree medical assumptions: If FFS average cost is \$1,000 and the individual plan bids come in at \$750, then CMS takes a portion of the difference in cost and allocates that to the rebates based on star ratings. As local plans become more efficient relative to the FFS plan costs, then more and more dollars will be flowing into the rebates, which are generally used to fund supplemental benefits through the Medicare Advantage plan. However, CMS does not share all of the savings in the form of rebates – the maximum rebate percentage returned is 70% if a plan is rated 5 stars. Will the group MA plans – with open networks and open formularies – be able to compete with optimized local networks?

Risk Scores: An example was given with an MA plan that had a population, based on risk scoring, that is 20% riskier than FFS.

An American Academy of Actuaries practice note that could help with setting assumption for MA plans will likely be available in the second quarter of next year. The goal of the practice note will be to ask the actuary to assess the underlying costs and underlying revenue rather than considering only the fully insured premiums. It is likely that loss ratio percentages in the low 90s

or under will be sustainable long-term in the MA market. However, loss ratios in the mid to upper 90s will likely not be sustainable long term. If the loss ratio is in the low 80s then the premium is too high. The actuary should estimate trend appropriate for each of the components.

The CMS Office of the Actuary indicated that funding increases for MA should keep pace with cost increases in the Medicare fee-for-service market, however that was before the funding reforms announced in the 2024 Final Notice. In addition, it may not be reasonable to assume that the trends for funding and claims will be equal in the short-term when CMS has said that they will be adjusting the normalizing factors for risk scoring. Also MedPAC has estimated that CMS is overpaying MA plans. One of the panelists has seen an insurer with a 5-year projection in which they were losing \$200M during the period. Another panelist suggested that they have seen actuaries project a 0.25% to 0.50% differential between claims and revenue for a few years when projecting MA plan net premiums.

For many plans in recent years, claims have increased less than CMS funding. Plans have an incentive to manage claims. Also, plans have an incentive to find and document diagnosis codes for enrollees to increase the risk score and increase their funding. The key to increasing funding is to push the risk score as much as possible each year. Groups have more success pushing their risk scores because they do not have the same turnover as individual market plans.

MedPAC is often ignored by Congress and by CMS. However, MedPAC has recently advised that they believe that Medicare Advantage is 6% overfunded by CMS relative to standard FFS.

Best practices include asking for all data from the MA plan. Make providing underlying data on claims, funding, and expenses, a requirement that is included in the RFP. However, for small plans getting the claims data may not matter because it will not be credible. One panelist has seen that plans/insurers are re-opening three and five-year contracts due to changes in projected CMS funding.

Compared to Med Supp, MA claims experience is less credible because it has the full claims spectrum which is much more volatile than Med Supp where the Plan's payments are largely capped because Medicare is paying a large portion. Carriers usually maintain the right to re-open contracts if the loss ratios get too high. It is a best practice when bidding to ask the carrier what loss ratios they deem to be sustainable and at what levels they will need to re-open the contracts.

CMS has implemented a "Clawback Program" in which they plan to claim over payments for the years 2011 to 2023 and will have the amount due in 2025. This will result in cash being taken out of the Medicare Advantage system.

Group plans' funding is predicated on the risk scoring. When an employer group first flips to MA it can take a year or two for the population to get fully "coded up" to maximize the risk scoring and associated funding. The level of coding and ramp up will vary by group and by plan.

Under the Medicare Part D provisions effective in 2025 under the Inflation Reduction Act, it is expected that the \$2000 out of pocket (OOP) will be accumulated based on the standard Part D plan parameters. This works out to approximately \$6500 in total spend (\$500 for the deductible + 25% of the next \$6000 results in a \$2000 member OOP). Following this rule will mean that the actual participant share could be much lower for plans with generous cost sharing. For example,

for a plan with a \$100 copay on a \$8000 specialty prescription, it would be possible for the retiree member to hit the member OOP after just the \$100 copay is paid. We are waiting for final regulations to confirm this interpretation.

Part D EGWP funding will depend on the Part D bids. CMS publishes the cost and national average amounts for the following year on or around July 31st. The IRA has the potential to lower the Rx trends long-term due to the drug cost caps.

The ACA allowed for gap coverage to be ignored for purposes of RDS attestations and creditable coverage. Also, retiree contributions could be allocated to medical first. We are still waiting on any regulations that will make passing the RDS or creditable coverage easier in 2025. Also, it was noted that RDS has seen smaller increases than Rx costs overall – in fact RDS payments per enrollee have been relatively flat over the past 15 years. This is because it is only paid based on claims between the cost threshold (typically equal to the Part D deductible) and cost limit– so the high cost of specialty drugs that's driving the high Rx trends isn't impacting RDS payments. Therefore, RDS trend should probably be limited to the increase in the RDS cost limit rather than using the same trend as overall Rx costs.

Session 407

Disaffiliation & With“drawl”

Speakers:

- Alex Brown – NASRA
- Robert L. Schmidt, FSA, EA, MAAA – Milliman
- Todd Tauzer, FCA, FSA, CERA, MAAA – Segal
- Koren L Holden, FCA, EA, MAAA – Public Employees’ Retirement Association of Colorado

Session Assistant: Brett Hunter, ACA, ASA, EA, MAAA – Buck

Overview

Public retirement systems within the United States can be generally categorized in one of three ways. Single-employer pension plans provide benefits to the employees of one employer. Agent multiple-employers plans provide administrative services and pool assets for multiple participating employers, but liabilities and costs are maintained separately for each participating employer. Cost-sharing multiple employer pension plans provide benefits to the employees of multiple employers whose assets and liabilities are pooled, and risks, costs, and investment and plan experience are shared amongst participating employers. The last of these three plan types, cost-sharing multiple employer pension plans, are most sensitive to changes (affiliation and disaffiliation) in the cohort of participating employers, as all resulting employers are subject to the benefits and/or detriments of such decisions.

In this session, speakers discuss points of consideration behind affiliation and disaffiliation of employers, focusing on cost-sharing multiple employer pension plans and examining common practices of public retirement systems across the United States.

Affiliation

Statutes may specify employee types (and by extension, employers) who are required to participate in retirement systems. Such is the case for Missouri state employees’ participation in the Missouri State Employees’ Retirement System (Missouri Statutes §104.330), among other similar examples.

Statutes may also identify employer types that are eligible to join the system on a voluntary basis. For example, Arkansas Code §24-10-302 allows for certain political subdivisions, with a majority vote of its governing body, to participate in the Arkansas Local Police and Fire Retirement System. Idaho Code §59-1321 allows for political subdivisions, through their governing body, to elect membership in the Public Employee Retirement System of Idaho (PERSI). Similarly, Colorado Revised Statutes §24-51-309 allow for any political subdivision within the State of Colorado or any public agency created by the State, or its political subdivisions, to apply to the Board of Trustees for affiliation with the Public Employees’ Retirement Association of Colorado (CO PERA).

In the case of employer affiliation with PERSI, the Board of PERSI commissions a study of excess cost to the system as a result of the new affiliation. Payment of this excess cost by the affiliating employer is a condition of the affiliation. Once the employer joins PERSI, contributions by the employer to the system are the same as other employers.

Disaffiliation

In some public retirement systems, the decision to join a pension plan is irrevocable and disaffiliation is prohibited. For example, disaffiliation from the Oklahoma Public Employees Retirement System is prohibited on the basis of statute (Oklahoma Statutes §74-910). In New York State, a court ruling interpreted statutory silence regarding disaffiliation as the basis of its prohibition. Similarly, the South Carolina Office of the Attorney General characterized the relationship between an employer and the Retirement System as an irrevocable contract and relies on the absence of specific statutory authority to withdraw as the basis for its opinion prohibiting disaffiliation.

In other cases, some employers may be permitted to withdraw from the plan, sometimes in limited circumstances. In CalPERS, state plans cannot withdraw, while municipalities can. In CalSTRS, school districts are not allowed to terminate, while participating charter schools may cease to exist. In that situation, the pool of participating employers covers any unfunded liability, which is likely insignificant. For CO PERA, disaffiliation is only permitted for employers affiliated with the Local Government Division of PERA. Retirement systems may provide for withdrawal within a specified window, as was the case for the Kentucky Employees' Retirement System. Disaffiliation can also be permitted or required as a result of things such as a decline in membership (PERSI) or payroll (CA county plans), or an employer ceasing to be an ongoing financially viable entity.

If voluntary disaffiliation is permitted, certain steps may be required. An employer's decision to voluntarily withdraw may need to be supported by an employee vote to approve the withdrawal decision. An application or notification to withdraw may need to be submitted to the retirement system. Then, generally speaking, the retirement system prepares an accounting of the withdrawing employer's liabilities and determines any amounts due to the system from the employer as a result of the withdrawal (withdrawal liability). The withdrawal liability is the disaffiliating employer's share of the plan's unfunded liability, although it may be calculated on a different basis. Without the withdrawal liability the disaffiliating employer's share of any existing unfunded liability would be re-allocated to the remaining employers, which would increase their funding burden.

The withdrawal liability can be calculated using a lower discount rate or varying other assumptions different than the plan uses for funding purposes, to reflect the severance of an ongoing relationship with the disaffiliating employer. The New Hampshire Retirement System calculates the withdrawal liability using interest rates published by the PBGC for private sector plans in involuntary and distress plan termination situations. Discount rates for withdrawing municipalities participating in CalPERS are based on a combination of 10 & 30 Treasuries (duration matched to the employer's cash flows), and CO PERA uses the plan's assumed rate of investment return minus 200 basis points as the discount rate for disaffiliation cost calculations. Complete withdrawal penalties for PERSI are based on the employer's share of the system's unfunded vested accrued benefits, but the value of the unfunded vested accrued benefits are re-calculated from the latest actuarial valuation to assume 30% of all terminating employees return to work and future COLAs are 2% per year.

Sources of External Information

Practices surrounding affiliation and disaffiliation of employers in public retirement systems vary from system to system. The National Association of State Retirement Administrators has compiled information on disaffiliation policies from more than 50 retirement systems across more than 40 states. This information, which is updated periodically, can be found at the following: <https://www.nasra.org/files/NASRA%20Survey%20Results/disaffiliationpolicies.pdf>

Session 409

Pension Investing: Emerging Issues

Speakers:

- Yubo Wang, FCA, FSA, EA, CFA – Principal Financial Group
- David Murad, FCA, ASA, CFA- NISA
- Ric Ford, FCA, FSA, EA, CFA – Callan
- Jessica Kachur, FCA, FSA, EA- Mercer

Session Host: Emojoy Brown, FCA, ASA, EA - BlackRock

Background

Pension investors are focused on portfolio construction to consider trends such as inclusion of alternative asset classes, liability driven investing and emerging data and regulation around ESG (environmental, social and governance). The key focus areas for portfolio construction, including asset allocation, security selection, diversification, tax efficiency, rebalancing, time horizon, risk management and ongoing monitoring. Each asset class in the portfolio should play a role in either enhancing return or reducing risk.

Summary – Use of Alternative Asset Classes

Using private assets may serve as smoothing agent because they don't mark-to-market, they mark-to-model. Liquidity risk analysis must be evaluated against the use of alternatives. Cash flow management for the pension plan must also be considered alongside the use of alternatives. This would involve review of the pace of employer contribution against the expected outflows from the plan. Private credit as an asset class emerged after the Global Financial Crisis as banks shied away from certain loans. Private credit here refers to high yield credit issued in private markets. Asset managers underwrite the loans and package them for institutional investors. There should be some expectation for defaults within this asset class (50 bps for an average manager). Asset managers of private credit may also support private equity deals involving the same entities. Private credit deals sit above private equity in the capital stack, but if defaults occur in the private credit space it is likely there will also be markdowns in the private equity space. A J-curve illustration shows how it takes time to build up an allocation into the asset class.

With respect to private equity, there's a relatively high expected volatility expressed in most capital market assumptions used for asset allocation purpose. This may seem counterintuitive to the idea that valuations reflect that mark-to-model smoothing. The volatility is modeled to account for the fact that if the holder of private equity is forced to sell, the price they would receive would be at a value lower than the market value represented in the most recent marks. If the plan does not sell, this volatility would not be realized. The higher the allocation to illiquid private assets the more important it is to devote resources to monitor timing of inflows, capital calls and timing of expected capital commitments.

Summary- LDI strategy case studies

Liability driven investment (LDI) strategies have evolved over last 10-15 years, with past 18 months representing significant volatility in rates. Key risks being hedged in LDI portfolios include interest rate risk, spread risk and yield curve risk. This is often addressed by buying Treasury and Corporate bonds which offset these inherent risks present in the valuation of

liabilities. The idea of a completion portfolios is to consider the impact of parallel shifts of the yield curve, impact of changes to credit spreads (also of different tenors) and curve risk to the extent there are nonparallel rate shifts or particular sensitivity to certain points along the yield curve. Completion looks to supplement the exposures to close any gaps between liability risk exposures and portfolio risk exposures.

The process of building a completion portfolio starts with learning about the plan structure or options such as lump sum payments or cash balance design. Then it's important to understand what broad credit and interest rate-sensitive assets already exists in the asset allocation. The completion manager builds a portfolio of bonds or derivatives to supplement the existing fixed income such that assets in aggregate will offset liability risk. The final step of the completion portfolio management is ongoing monitoring and rebalancing to maintain desired hedge. The presentation materials feature illustrations of how this would work. To the extent there are synthetic assets there would be ongoing operational/governance requirements for the completion manager to oversee margin calls and collateral adequacy. With respect to custom credit portfolios, the completion manager evaluates and supplements different credit quality and tenors which could be used to offset the plan liability's sensitivity to changes in high quality credit spreads.

Summary - ESG investing

ESG stands for environmental, social and governance risks. These risks are not necessarily distinct, rather the idea is that these factors impact the risk/ return profile of investing in an issuer's securities. The 2023 Global Risks Report highlights ESG risks as key business risks to manage in both the near term and long term. In particular, climate concerns are the highest rated risks 10 years out, proving it should be important to long-term investor.

Global ESG regulation is increasing, with Europe leading on adopting frameworks for metrics, reporting and risk mitigation. In the US, the SEC has proposed climate-related disclosures mirroring the European standards so investors are informed about climate risk to the entities in a somewhat uniform way. This proposed regulation is currently in comment period and could pass in the coming months. DOL standards require the plan fiduciary to put best interest of participants which "may include effects of climate change and other ESG factors." ERISA plans are slow to adopt ESG factors in their decisions because of changes in the regulatory environment under different administrations (consider 2020 vs 2023 DOL standards). There are no marked differences in historical performance between MSCI ACWI ESG Leaders vs non-Leaders however, this may not be indicative of the future as ESG risks are borne out and come further into focus.

Session 502

Evolving Retirement Landscape

Speakers:

- Lee D. Gold, ASA, EA, MAAA – Mercer
- Tonya Manning, FCA, FSA, MAAA – Buck, A Gallagher Company
- Robert J. Reiskytl, FCA, FSA, MAAA – Aon
- Moderator: Craig P. Rosenthal, FCA, FSA, MAAA – Mercer

Planning for retirement is an important topic for employees, planning their own retirement, and for employers, looking to design retirement programs and benefits that can achieve their business needs. But how do the needs of these stakeholders align and intersect? Based on studies, we will explore what employees want, what employers are doing, and how these two come together.

Retirement programs – the employee perspective

In 2022, the SOA Research Institute sponsored a study to understand what retirement plan features employees really want. A report detailing the results of the study is available along with a dashboard that allows retirement professionals to view and interpret the data. The survey (which had over 2,400 respondents) asked respondents to select amongst various packages of plan features. Fifteen plan features were tested and ranked from most influential to least influential when making a choice among different retirement packages.

The results show that the overall most influential plan feature was receipt of an unreduced benefit at an earlier age. The other features that came in the top 5 most-influential were: Participant contributions, provision of death benefits for surviving spouse/partner, term of payments received during retirement, and the ability to bequeath a benefit. Once overall results were ranked, the survey results were evaluated based on multiple cuts of data. Categories evaluated included: Age, Gender, Marital Status, Race, Education Level, Income Level, Union status, Personal Debt levels, Retirement Savings Levels. The interesting result was that, although some feature's rankings changed slightly, almost universally, the first 5 most important plan features were the same for all categories evaluated.

In addition, the utility or degree of preference was measured for the various plan features. The highest utility was toward retirement benefits that are not dependent on investment returns. If investment returns are a component of the plan design, employees prefer to have professional/fiduciary assistance in selecting the investments while also maintaining the ability to make final decisions. When it comes to payment forms, the highest utility is towards a 20-year certain and life guaranteed payment. Hybrid DB/DC plans may be more appealing to employees than traditional DB or DC plans to meet the desire to receive a benefit that is flexible but with security.

Retirement programs – What are employers offering?

Of Fortune 500 companies, 43% have never offered a DB plan for their salaried workforce, and, of the remaining 57%, less than one-fourth have active DB plans (the rest are frozen/closed or

terminated). A recent trend is pension risk transfer, making the message clear that employers are not looking for a way to go back to a DB-focused retirement system and future plans are likely to be DC in nature.

In DC plans, common features used by employers are automatic enrollment, often combined with auto-escalation, to encourage adequate retirement savings behaviors. In addition, the ability to make after-tax contributions is growing in popularity among plan sponsors. Diversity and inclusion are important elements of retirement plan design for many employers, which may drive plans towards nonmatching contributions, flat dollar minimums, automatic features, and faster eligibility/vesting.

Some organizations may band together to offer retirement benefits, either through multiple employer plans (especially in manufacturing or healthcare) or via state-run retirement programs currently implemented or pending in some states. Pooled employer plans are another way that employers can work together to offer retirement benefits with other employers outside of a common nexus. These types of plans should require less administrative work with less fiduciary risk, and have strong outcomes so it will be interesting to see how many employers will move toward these types of plans.

How are employers responding to the desire to provide lifetime or guaranteed income? Currently less than 10% of employers are offering lifetime income options, with the concerns including fiduciary roles, investment cost and complexity, and usage by plan participants. SECURE helped to reduce these concerns, but it remains to be seen if these options will be more likely to be included by plan sponsors.

Retirement programs – Bringing it all together

Although the studies provided information on what the employees want and what they are planning for, consideration should be given to what they *should* want. Studies show that more than half of current retirees left the workforce earlier than intended, often for reasons beyond their control. Generally, Americans are not well-equipped to estimate their own life expectancy and more than half either cannot estimate or under-estimate their own life expectancy. In addition, Americans are more pessimistic about retirement with fewer viewing their retirement savings as “on-track.” There is a low level of comfort with making retirement and investment decisions and retirees generally do not understand long term care costs and how Medicare will cover (or not cover) those costs.

The desire of employees may not meet up with what is possible. For example, early retirement is favored, but increased longevity, low savings, debt levels, elder-care costs, and postretirement medical costs can make that difficult. Employees want to manage their investments, but may not have the skills, time, or cognitive ability, as they age. Flexible withdrawals and spousal benefits are an important goal, but can be difficult without adequate understanding of the length of retirement, the cost of liquidity, and other late-life costs.

Although employers can work to align what employees want with what they need, many workers do not yet have access to (or do not participate in) retirement plans. For those that do, employers can meet employees in the middle by providing necessary education, considering retirement phase-in programs, adding annuity options or spousal protection to plans, setting guardrails for withdrawals and investment decisions, and establishing bequest account options.

Session 504

Prescription Drug Update: Indications Are Just Guidelines

Speakers:

- Travis Baughn, PharmD, OptumRx
- Sara Martin, FCA, ASA, MAAA – Lockton Companies
- Jon Lewis, FSA, MAAA - Mercer

Moderator: Ian Smith, FCA, FSA, MAAA - OptumInsight

Session Host: Kristi Garrington, FCA, FSA, MAAA – Horizon Actuarial Associates

Overview

In this session, speakers highlight current pharmacy topics as requested in a prior meeting survey regarding new drug trends and potential impact of new regulations.

Rise of Weight Loss Drugs

Obesity is a chronic disease that affects a wide range of people with 31% of adults considered overweight (BMI 25-29.99) and 42% of adults considered obese (BMI 30+). People who are overweight often have comorbidities such as diabetes, cancer and cardiovascular disease.

It's estimated that half of the US population will qualify for weight loss drugs. That is more than 1 billion people worldwide. The impact of weight loss reaches farther than reductions in health costs (which one source estimates at \$26 billion per year). A Walmart executive implied revenue is impacted when customers buy less food. Airlines report saving money due to lower fuel costs from lower weight passengers.

Weight loss drugs have been evolving since 1995 with newer drugs reporting greater weight loss efficacy (10%-25% weight loss with a high safety profile). The newest to hit the market are GLP-1 drugs with a significant purchase price of \$1,000 to \$1,400 per month. These were initially used for diabetes but demonstrated significant success in weight loss. They are being rebranded at different dosages (and higher costs) for weight loss. New studies are potentially making a case to use GLP-1s for related illnesses such as cardiovascular disease and strokes. There are several new drugs in the pipeline and the expected market for these drugs is forecasted at \$77 billion for pharma by 2030. Projected PMPM spend of these drugs is \$4.71 to \$32.22 PMPM over the next three years, depending on the number of people seeking treatment. This will vary by client, region and population demographics. Cost relief will not be for another decade.

There is significant social media noise creating high demand for these drugs. There are approximately four female utilizers for every one male. Female users span all income brackets but male users tend to be in higher income brackets. For those new to therapy, utilization declines throughout the first year of treatment, with 1/3 persistent after 12 months. This is due to GI side effects and lack of adherence. Unfortunately, there is an average weight gain of 2/3

once the drug is discontinued. It is recommended that GLP-1s require prior authorization including step-therapy and doctor documentation of actual diabetes.

Biosimilars

A biosimilar is a biological medicine that is highly similar to an approved biological medicine (known as the 'reference biologic'), with comparable efficacy and safety. There are significant differences between biosimilars and generic drugs as demonstrated in the table below.

Biosimilar

Made from biologic (natural) source
 Large, complex
 Similar to original drug
 Have existed for 14 years
 Requires Phase III clinical trials

Generic

Made from (same) chemicals
 Small, less complex
 Exact copy of original drug
 Have existed for 39 years

Between 2015 and 2022, the FDA approved 40 injectible or specialty biosimilars drugs. There are several biosimilars in the pipeline although lawsuits are delaying launches. There are 5 interchangeable biosimilars which makes providers more comfortable. Interchangeable also means the pharmacist may substitute for the reference drug without contacting the prescriber (depending on state law). Biosimilar usage will depend on cost (to plan sponsor and member), availability of copay cards (not all have them), provider acceptance, benefits (such as less pain at the injection site due to being citrate free) and supply.

Humira biosimilars are some of the most popular as this is a high spend drug for many plans (treats autoimmune disorders including inflammatory conditions). Depending on the biosimilar, there is a 5% to 92% discount off the cost of Humira.

The net cost of a drug is the ingredient cost less the rebate. Drugs with high wholesale acquisition costs (WAC) tend to have high rebates. Low WAC may have no or low rebates. The net cost of a Reference Drug and a Biosimilar could be the same depending on the rebates. Then cost benefit comes down to timing of rebates and/or member cost sharing if coinsurance is a factor.

AMP Caps

Some drug products have seen consistently high list price increases over several years. In an attempt to curb these costs under Medicaid, an inflationary rebate is used to control cost increases above and beyond inflation. Under the current law, rebates are capped at the average manufacturer price (AMP). AMPs is the average price paid to manufacturers by wholesalers who are purchasing drugs for resale. This methodology allows the net cost of a drug to go as low as \$0.01. Under the American Rescue Plan Act (ARPA), rebates are no longer capped at the AMP effective 1/1/2024. This allows the net cost of a drug to drop below zero which would mean a manufacturer would be paying Medicaid to dispense the impacted drugs. Manufacturers responded by cutting the cost of insulin (and other drugs) which reduces the inflation rebate and results in positive net drug costs. This change is not unique to a manufacturer nor a therapeutic class.

Medicaid pricing (and rebate) methodology differs considerably from the commercial market. However, manufacturers reduced the drug price across all lines of business. Commercial plan

costs are based on average wholesale price (AWP) with discounts. Factoring in lower AWP's but also lower rebates may have no impact on the net cost of the drug. There is the potential for cost shifting from the member to the plan sponsor if the plan has coinsurance. This is mechanically similar to a Point of Service (POS) rebate strategy which reduces the net cost and corresponding member coinsurance. However, the plan sponsor shares the POS rebate with the member versus collecting the entire rebate later.

Insulin has been the biggest category impacted so far but other drugs with generic competition are impacted as well. Additional categories are anticipated on drugs that have been in the market for some time.

This will have an impact on the 10 drugs referenced in the Inflation Reduction Act for price negotiation. Some of those drugs have already had their list prices reduced and are not expected to have successful further negotiations.

Many PBMs responded by changing their formularies and rebate guarantees. The current expectation is that plan sponsors will not see a significant change in overall drug costs.

Session 506

I Walk the Line

Speakers:

- Alicia Traviss, FCA, FSA, EA, MAAA – Athena Actuarial Consulting
- Chris Snell, FCA-R, FSA, EA – Colgate-Palmolive
- Justin Hornburg, FCA, FSA, MAAA
- Patricia Rotello, FCA-R

Session Host: Michelle Boyles, FSA, EA, MAAA – Bolton Partners, Inc.

Overview

Consulting is a fine line to walk between understanding how to solve client problems and matching the solutions you have to offer. Sometimes the client isn't receptive to a solution that makes sense to you. Sometimes you are being asked to offer solutions or products that don't make sense to the client. During this interactive session, the audience is presented with case studies and asked to discuss the scenario and ways to deal with the tough conversations.

Background

You want to sell services to your client, but there can be impediments. Clients will only do what they want when they need it, so consulting is a task of balancing your boss with your clients.

You need to sell, but you don't want to feel "salesy". Some options could be: taking your client to lunch, slipping the sales pitch in at the end of a regular valuation results meeting, or setting up a separate meeting specifically for the proposed service. Even if you're not going to "win the sale", it's still important to present/articulate the "why" and the "why not". You need to make sure your clients know what's out there, even if it's not a good fit for them and then tell them why it isn't a good fit. The goal is to be a trusted advisor, not a used car salesman.

As consultants, we have to recognize that different client contacts (even at the same client) may have different priorities. With different stakeholders it is hard to get them to the "have to have" or at least the "nice to have" mindset, where they would be interested in the proposed service. Some considerations for overcoming obstacles include: know when your clients are setting budgets, be aware of what your clients can handle in terms of staffing, and don't forget your clients' personal views – if the wrong person is "in the seat", how do you handle that?

Case Studies

One common scenario is where your company sets cross-selling goals where you are tasked with introducing an unknown colleague to your clients. The first step is to get to know the colleague, which can be accomplished in various ways including internal discussions or a lunch and learn to review the sales pitch to better understand the product. Once you are comfortable with the colleague you can approach your client contact who would then be able to introduce you to the appropriate contact within their organization. If you don't think that it's a good fit for your client, you will need to have difficult internal discussions, but you shouldn't risk the client relationship. It can also build goodwill with your client contact if you're honest about the pitch, including why you're bringing it to them.

The next scenario is approaching your clients to charge out of scope fees for an upgrade to the valuation system. Some strategies for selling include purely selling your client on the benefits of the new system – make them see the value to be willing to pay the fees. If it's an internal process improvement, consider splitting the charge between the client and the company or spreading the cost equitably across clients. You could also spread the cost over the period of the contract to recoup the cost without a big upfront charge to the client. To help set the stage for potential future cost increases, consider adding a stewardship component to your regular meetings: say this is what we've done for you in the last year, to help highlight the value you bring to the relationship.

A current trend among retirement plans is to offer a terminated vested lump sum window, but what if your client just isn't interested, despite the potential financial benefits? You need to find a way to develop or show empathy to find the root issues for your client so that you can solve those issues. Sometimes the issue is timing and you can offer to provide additional resources. However, the client can realistically only offload so much – employees will still need support/have questions, so the project will be a huge time drain for the client. No doesn't necessarily mean no, often it's just "not now". A lot depends on the strength and nature of your relationships – with your regular client contact, with HR at the client, and with finance at the client. You need to take care to satisfy all parties without damaging your relationships.

The next case study considers how to proceed when your employer is pressuring you to sell a new software that you know has issues and bugs; sales will be a "large part" of your review, so the stakes are high. A popular answer was to simply quit. But other, more measured, steps include: going back to your employer to discuss fixes and concerns, selling as a beta version at a discount, pursuing a long-term sale to launch in six months when the bugs are fixed, and reviewing what the actual risks to your client are to help frame the sales process.

The final two scenarios cover the taxation of long-term disability benefits and adding a high deductible health plan. Both scenarios involve selling to a client who does not see the benefit in changing or does not believe in the product at all. For both, the first step is to lean into empathy to understand the different points of view and reluctance to change the benefits. Either change could be sold as part of an overall benefit structure review and benchmarking project so that you can better sell the small change and benefit the client with the overall review to improve the competitiveness of their benefit offerings.

Session 507

How pension plan designs affect your workforce

Speakers:

- Daniel J. Siblik: ASA, FCA, EA, MAAA – Segal
- Kevin Spanier: ASA, EA, MAAA, FCA – Buck, A Gallagher Company
- Dan Doonan: Executive Director - National Institute on Retirement Security
- Ed Oliphant: Chief Financial Officer – WeGo Public Transit

Moderator: Todd Kanaster: ASA, FCA, MAAA - S&P Global Ratings

Session Host: Matt Staback: FSA, EA, MAAA, FCA, CERA – Buck, A Gallagher Company

Background

Plan design can change participant behaviors and can be affected by several parameters, but “why” is the big question. The two most common ways for participants to leave a plan is through termination and retirement. Participants may want to leave prior to retirement if they are not satisfied with the opportunity for advancement in their careers, current pay, benefits, work to life balance, or being unhappy overall. When participants retire, why do some decide to retire early while others retire later than expected? Often, it results from finances, health, economic shocks delaying or expediting retirement, workplace environment, or a combination of these. In Mercer’s 2022 Insider Employees’ Minds study, financial concerns have risen while health and personal fulfillment have decreased from 2021 to 2022. Employee’s mindset can change from year to year making it difficult to pinpoint the key factors in participant’s behavior. A large percentage of Americans are living “paycheck-to-paycheck” according to the Press Release on January 30, 2023 from LendingClub Corporation. The ability to save for retirement through an employer sponsored defined benefit or contribution plan can alleviate the burden on employees and certain design considerations can influence workforce behavior.

Plan Designs Affect your Workforce

Offering early retirement windows can encourage participants to retire earlier than they might have otherwise. Severance windows can be designed a number of ways including additional vesting service, additional benefit service, lump sum payment, and pay enhancements. Early retirement windows allow participants to potentially have a higher benefit or can even provide participants the ability to commence prior to normal eligibility. Estimating the usage of the window can sometimes be tricky as it can be viewed as a “choose it or lose it” with the window only being offered for a limited time. Ultimately, it comes down to the design of the window, how often plans offer severance windows, and participant’s behavior to determine the actual effect on retirement patterns.

Cost of living adjustments (COLAs) can persuade participants when they choose to retire and can possibly delay retirements depending on if the plans provide COLAs or not. Plans with automatic COLA provisions or consistent ad hoc COLAs reassure participants their benefit will provide some increase in their benefit over time in the attempt to keep up with inflation. However, plans not giving any COLA can delay retirements as participants may be afraid that

they have not saved enough money, knowing their benefit will stay flat over time and ultimately wear away. A participant whose benefit increased at Social Security CPI or a flat 3.0% COLA from 2009 – 2023 would receive a 36% to 42% higher benefit in 2023 than a plan who does not provide a COLA. COLAs do, however, come with a price that usually isn't cheap, resulting in plans weighing the cost versus the benefit of a COLA. Plans considering COLAs can design them annually or ad hoc with a flat percentage increase or through CPI under numerous data tables, varying from city to regional to national. Plans should consider whether participants pay into Social Security or not. Data from 'NCPERS 2023 Public Retirement Systems Study: Trends in Fiscal, Operational, and Business Practices' shows an average 1.8% COLA was given to participants who are Social Security eligible compared to an average of 2.5% to participants who are not Social Security eligible. Another design consideration to increase participants' retirement income is an additional annual annuity payment. A 13th annual annuity payment increases annual income by 8.3% and can be seen as an ad hoc COLA increase. Then again, it is only a one-time increase and may not keep up with inflation, but it is often easier to cost out than COLAs and provides more benefit to participants than no COLA at all.

Deferred Retirement Option Plans (DROPs) can help plans hold onto older employees by allowing active members to continue working while they start "receiving" pension payments. When a member elects to enter a DROP, the annuity payments during the DROP period will go into a DROP account. At the end of the specified DROP period, a member will receive the DROP account in the form of a lump sum payment in addition to the ongoing annuity payment for the period after they leave the DROP. The member will no longer accrue any additional benefit increase while in the DROP period. DROPs provide employers with transition planning and cost savings of trying to train or hire a replacement. They can also be seen as a positive benefit for members and if designed appropriately, can be minimal cost or cost neutral to the plan. However, DROPs have liquidity risk, a reputation of allowing participants to "double dip" by receiving a paycheck and retirement payments at the same time, can increase investment risk depending on the rate of return, and if not designed properly, can become a significant portion of the assets. Plan sponsors should consider who will be eligible for a DROP, how long can members stay in a DROP, the interest crediting rate, COLA provisions, how employee contributions are handled, state and local laws, 415 limits, and what the plan's goals are. Some states require DROP programs to be cost neutral and there are certain DROP characteristics that add additional cost. It is important DROPs are designed appropriately and the assumptions are reasonable as underestimating the utilization of a DROP can make it seem cost neutral when it really may not be. DROPs can be a useful design feature to retain older members especially when other design features may encourage departure from a plan. A sponsor in Missouri recently implemented a DROP into a plan that capped service at 30 years and had a rich unreduced normal retirement provision. The DROP provided the opportunity for members who hit the 30-year service cap to work additional years while collecting their pension benefit versus retiring and obtaining employment elsewhere. The plan was able to minimize cost by having a partial delay in COLAs where benefits going into the DROP account did not receive any COLAs, but once someone commences their benefit, COLA is provided. Some plans have even eliminated COLAs completely during the DROP period to further reduce costs.

State of Alaska

Recently, a study was performed on employees of the State of Alaska examining their behavior in the defined benefit (DB) and defined contribution (DC) plans. Before the study, it was

believed participants behave similarly between the two plans. When looking at the numbers, DC participants are quitting at a much higher rate than participants in the DB plan and the majority are leaving the DC plan through terminations rather than retirements. Retention on female teachers specifically based on ultimate termination rates starting at age 30 expects 38 teachers out of a 100 in the DB plan to still be active as of age 55 compared to only 11 teachers in the DC plan. For males, 40 are expected to still be active in the DB plan at age 55 compared to 7 in the DC plan. When comparing to other state plans, Alaska has the lowest cumulative years taught during a 30-year period when examining select and ultimate rates. The difficulty for the State of Alaska retaining members results from participants viewing Alaska as a temporary vacation home where most only plan to stay for a few years while also being the only state with no defined benefit plan provided to new hires. Unfortunately, all states seem to struggle with retention of newly hired participants, but the problem is amplified in Alaska due to external factors such as geography and weather.

WeGo Public Transit

WeGo provides transit for the Nashville-Davidson metro area who employs approximately 800 participants including bus operators, mechanics, and administrative support staff. The plan has several benefits including pension, post-retirement medical and non-contributory 401(k) in attempt to attract and retain employees. In a recent study, experience indicates higher than expected turnover for those with less than 10 years of service and especially in the first two years of employment. Recently, WeGo has taken steps to attract and increase retention of participants particularly in the first two years of employment by increasing starting driver pay by 25%, reducing top pay step progression from 48 to 36 months, and sign-on bonuses paid in installments over the first year. Once participants are vested, data shows that members start to value their pension plan more as well as the rich post-retirement medical plan which has a \$325 deductible and max out of pocket of \$1,500/\$2,500. The combination of the generous post-retirement medical plan and history of COLAs seem to be key drivers of retaining older members.

Session 601

Working with the PBGC

Speakers:

- Israel Goldowitz – The Wagner Law Group
- Katherine B. Kohn – Thompson Hine LLP

Moderator: Scott A. Hittner, FCA, MAAA, FSA, EA – October Three LLC

Session Host: Tiera Wiegand, FCA, FSA, EA – WTW

While maintaining an ongoing pension program requires working with the Pension Benefit Guaranty Corporation (PBGC) to pay annual premiums, financially healthy plans and plan sponsors may not have much involvement beyond that. Currently, the PBGC covers just shy of 24,000 plans, with no projected solvency concerns over the next 40 years. Though the single employer program has a surplus of over \$36B, current policies continue to be uniformly enforced.

Risk Monitoring

The PBGC requires reporting for eleven different types of events that may signal an increased risk of terminating while underfunded (plan events) or a change in the employer's financial ability to maintain the plan (corporate events). In addition, corporate transactions are monitored by the PBGC due to the risk they can pose to the plan's financial health and/or PBGC. Under this Early Warning Program, actuaries will typically need to assist the plan sponsor in providing actuarial analyses to the PBGC to illustrate the effect of the event over the next five years. The PBGC also monitors for derisking activity but has limited enforcement options available.

Current economic conditions continue to prompt plan sponsors to further derisk and/or terminate their pension plans.

Standard Termination

There are three types of plan terminations – standard, involuntary and distress – the type affects the process of working with the PBGC.

A standard termination occurs when the plan sponsor voluntarily decides to terminate the plan and there are sufficient assets to pay out the promised benefits. While most plan terminations are for plans with under 300 participants, larger plans are beginning to terminate as well (for example, the JC Penney termination had ~39,000 participants). All plans with over 1,050 participants are subject to PBGC audit, as well as a random sample of plans that don't meet that criterion. Recent PBGC audits haven't resulted in large differences in payment to participants as benefit calculations are generally correct.

One of the most common issues identified during the PBGC audit is premature lump sums, when lump sums are paid before annuities are secured, which may result in insufficient assets to terminate the plan (and therefore a violation of the ERISA §4044 rules). Smaller plans often have challenges finding annuities if the headcount is too small as insurers don't want to or don't offer the appropriate annuity contracts at that scale. The PBGC has a list available of insurers

that have provided annuities in the past, but does not endorse any provider. In addition, plan sponsors taking de-risking action (both annuity buy-outs and lump sum programs) before a plan termination need to take care that the programs close prior to the termination process and assets remain sufficient for final distribution to avoid ERISA Title IV violations. The recent SECURE 2.0 legislation will result in more publicly available information around plan termination, which could result in increased lawsuits.

Standard terminations can also occur in bankruptcy cases, depending on the circumstances. If the plan appears to have sufficient assets, the PBGC may agree to allow a standard termination to occur rather than an involuntary termination. Alternatively, if the plan requires a top-up contribution for a standard termination to occur, the bankruptcy court would need to approve the contribution. The unsecured creditor committee (UCC) may agree to allow some funds to be used for this purpose since it ultimately minimizes the remaining bankruptcy claims pool, as occurred with the American Airlines plan termination.

Distress Termination

When a plan does not have sufficient assets, a distress termination can be initiated by the plan sponsor if they can demonstrate that their poor financial condition is not temporary and all other options have been exhausted. These options may include layoffs, selling off real estate, etc. Like the funding waiver application process, there are several tests available. In practice, most plan sponsors are unable to show that the cost of the pension plan is unreasonably burdensome due to headcount reductions, and instead rely upon plan termination as a necessity for business continuation. This process requires extensive information to be shared with the PBGC. The plan sponsor may negotiate with the PBGC to convert their termination to an involuntary termination to simplify the information request. In addition to the termination, the process of resolving claims to address unpaid contributions, unfunded benefits, termination premiums, and fiduciary breach claims will extend for many years.

Involuntary Termination

Similar to distress terminations, involuntary terminations occur when the plan sponsor is in poor financial health, but these terminations are initiated by the PBGC instead of the plan sponsor. The PBGC has statutory authority to terminate plans as well as a range of enforcement discretion. If the plan can't pay current benefits due, an involuntary mandatory termination will occur. However, if a company is in liquidation mode but has a reliable, recurring income stream (such as rental income) that allows it to continue to make the minimum required contributions, the PBGC may choose to "bet the business plan" and allow the plan to continue, rather than forcing an involuntary termination. During the claims process, the PBGC can consult with the IRS to waive parts of the excise tax associated with unpaid contributions, though there is not a formal process to handle this.

Session 607

Revised ASOP No. 4 Requirements (in Addition to LDRM)

Speakers:

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Background

The Actuarial Standards Board (ASB) voted to adopt updates to Actuarial Standard of Practice (ASOP) No. 4 in December 2021. The revisions to ASOP No. 4 became effective for actuarial reports issued on or after February 15, 2023, for measurement dates on or after February 15, 2023. The purpose of ASOP No. 4 is to provide guidance to actuaries regarding measuring pension obligations and determining pension plan costs and contributions. ASOP No. 4 was last revised about a decade ago, and the updates adopted in December 2021 include a number of significant changes to the prior version.

Amongst the changes to ASOP No. 4, perhaps the most noteworthy update includes the addition of a Low-Default-Risk Obligation Measure (LDRM). The LDRM update requires the calculation and disclosure of a liability measured using a discount rate derived from low-default-risk fixed income securities. Additionally, the updates include the calculation and disclosure of a Reasonable Actuarially Determined Contribution (RADDC). Additional clarifications were added to provide guidance regarding actuarial cost methods, amortization periods, smoothing methods, and contribution allocation procedures. ASOP No. 4 now outlines the disclosure of additional items not previously required to be provided.

Low-Default-Risk Obligation Measure (LDRM)

The addition of the LDRM has garnered significant attention from the actuarial community. This “theoretical measurement” is intended to provide supplementary, useful information to intended recipients to provide them an additional measure to assess the funded status and benefit security of the pension plan. The LDRM is required to be calculated and disclosed once a year. It is not intended to be the “right” liability measure. It is a snapshot measurement using current yields and, as such, may be quite volatile from year-to-year. In certain situations, such as when plan assets are heavily invested in fixed income, the LDRM may actually be lower than valuation liability measures.

The LDRM requirement is to disclose the plan’s liability using a discount rate derived from low-default-risk fixed income securities whose cash flows are reasonably consistent with the pattern of benefits expected to be paid. Examples of securities that actuaries may use to determine the discount rate used in the calculation of the LDRM include U.S. Treasury yields, settlement rates, high-quality corporate or tax-exempt bond yields, non-stabilized funding rates for single employer plans, and multiemployer current liability rates. Other than the discount rate, the actuary may use the same assumptions used in the valuation. However, at the actuary’s discretion, other assumptions consistent with the measurement may be reflected, such as in situations where lump sum assumptions vary by changes in the discount rate. The actuary should use an “immediate gain actuarial cost method” where

gains and losses are included as part of the unfunded liability rather than the normal cost (e.g., unit credit, projected unit credit, entry age normal).

Professional judgment should be used when providing commentary on the LDRM. The commentary should help the intended user understand the significance of the LDRM with respect to the funded status, plan contributions and security of participant benefits.

Plan Funding and the Actuarially Determined Contribution (ADC)

ASOP No. 4 now provides more details around a number of items related to how the plan is funded and may impact how Actuarially Determined Contributions (ADC) are determined.

Amortization methods should take into account a number of different factors, both individually and collectively, including open vs. closed periods, sources of bases (e.g., gain/loss, assumption changes, or plan changes), payment patterns, surplus vs. deficit, duration, average future working lifetime, and funded status. Actuaries will need to apply a multi-prong test, assessing the amortization method's ability to amortize the Unfunded Actuarial Accrued Liabilities (UAAL) and bases in a reasonable time period.

Output smoothing methods are designed to reduce volatility in contributions over time. Techniques may include, but are not limited to, phasing in assumption change impacts on contribution levels over time, blending prior valuations with subsequent valuations, or placing corridors around changes in contribution amounts from year to year. Actuaries should select output smoothing methods which produce a "reasonable relationship" between the smoothed contribution and the ADC.

Contribution and cost procedures should take into account a number of factors, including benefit security, intergenerational equity, ADC predictability, characteristics of benefit payments, funding goals, etc. If there are certain frequent events (e.g., ad-hoc COLAs), it would be prudent to take those into consideration. There may be funding requirements, such as state or local mandates, that will dictate in part how contributions and costs are allocated. There are several new requirements regarding contribution procedures where the actuary must assess and provide a qualitative estimate.

ASOP No. 4 now requires the disclosure of a Reasonable Actuarially Determined Contribution (RADC) in situations where the contribution requirement is not prescribed by (Federal) law. In determining the RADC, the actuary should use professional judgment to assess whether or not non-prescribed assumptions are reasonable. Contribution lags, which may be prevalent in situations such as plans with a biennial or triennial valuation, should be considered to ensure that the smoothed contributions stay within a reasonable range.

Gain/Loss analyses should be completed between measurement dates to assess the reasonableness of assumptions. There are very limited situations where a gain/loss analysis would not be beneficial (e.g., certain very small plans). The actuary should separate out at least investment gains/losses from other gains/losses in the analysis. A question was raised in the session around analyzing gains and losses during a transition of work; the consensus within the group was that a gain/loss analysis should be completed upon taking over work for the first time.

Documentation and Disclosures

The actuary should document compliance with the ASOP requirements and in such a way that another actuary could assess the reasonableness of the actuary's work. A discussion ensued in the session

around how much should be disclosed; points were raised around “should” vs. “should consider” wording as defined in ASOP No. 1, as well as the consideration of “unintended” audiences (e.g., taxpayers or bond manager). It was also noted that if another actuary cannot understand what is being done in a valuation, additional disclosures may be prudent, even if not explicitly required.

While not all the disclosure requirements are new, several additional required disclosures were added or enhanced under ASOP No. 4 pertaining to the following: assumptions, methods, biases, contribution allocations/funding policies, the amortization of unfunded liabilities, and the gain/loss analysis. While it may be brief, pertinent conditions that were taken into account should be disclosed. The actuary should use judgment when disclosing the details of the gain/loss analysis and should consider if assumption adjustments or additional experience studies should be performed.

In the Q&A a number of topics were discussed, including misuse of the term “Actuarially Determined Contribution” by the public, clients’ understanding of the LDRM, and discount rate rounding.