NATIONAL REPORT FOR THE UNITED STATES
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This national report for the United States of America has three major sections:

- Background Economic Information
- Outline of National Social Insurance Benefits
- Current Consulting Issues

BACKGROUND ECONOMIC INFORMATION

EXCHANGE RATE

During the 2½ years ending January 1992, the exchange rate for the UK £1 has fluctuated primarily in the range of US $1.60 to US $1.80. It was somewhat below that in July 1989 and slightly above that range, hitting approximately $2.00 at the very beginning of 1991. Recently it has climbed slowly to a current level of about $1.80.

INFLATION RATE

Inflation in the United States is most commonly measured by changes in the Consumer Price Index for all Urban Consumers. During the last ten years, this index has increased annually at a fairly low level of about 3% - 4%. The only significant exceptions to this were 1986 with a 1% increase and 1990 with a 6% increase.

INTEREST RATES

Interest rates have fallen fairly steadily during the last two years, with fairly significant decreases during 1991. As of January 1992, most short-term interest rates were at their lowest levels during the last 20 to 30 years. Some ten-year rates have fallen to their lowest levels in almost 20 years and 30-year rates are at their lowest levels in the last five years, with further decreases likely. The Federal Reserve Bank's discount rate was reduced to 3½% in December, 1991, a 27-year low, to help propel the U.S. economy out of its recession.

AVERAGE WAGE

The most commonly used average wage is the one used in the national retirement program (Old-Age, Survivors, and Disability Insurance), to be described below. This average wage is used for indexing various portions of the calculation of benefits. It is average annual wage of all persons in covered employment in the first quarter of the year. The estimated average wage for 1992 is $22,875, a 4.4% increase over the estimated average for 1991 of $21,913.

NATIONAL SOCIAL INSURANCE BENEFITS

The Old-Age, Survivors, and Disability Insurance Program under the Social Security Act of 1935 provides retirement and related benefits as indicated by the name of the program. Medicare, which was established 30 years later, provides coverage for hospital and medical costs for persons age 65 and over and for certain disabled persons. In addition to these two federal programs, there are state programs covering unemployment, work-related injuries and illnesses, and, in some cases, temporary disability. Several needs-based programs are also available for certain medical and other living costs.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

Coverage

Almost all workers in the country are covered under the OASDI program or under the separate railroad retirement program. The only major exceptions are for certain employees of the federal, state, and local governments. Effective July 1, 1991, all employees of state and local governments had to be covered by OASDI unless they had a comparable or better retirement program.

Eligibility

Eligibility for benefits requires essentially ten years of relatively modest earnings in covered employment. The minimum annual earnings to receive credit for a full year of coverage has been increasing since 1978 and is $2,280 in 1992. Disability benefits also requires coverage during five of the ten years just prior to disability.

Benefit Commencement

Full retirement benefits under the program are payable at the normal retirement age (NRA), which has been 65 since the program's inception. This age will gradually start increasing for people born in 1938 until it reaches 67 for those born in 1960. Reduced benefits are available as early as age 62, with a 20% reduction now and 30% when the NRA becomes 67. Increased benefits are payable to those who retire after age 65, with increases up to age 70. The annual increase for delayed retirement was 3%, became 3½% in 1990, and will gradually go up to 8% during the next two decades.

Eligibility for disability benefits requires a total and permanent disability that has been in effect for at least five months. This means inability to engage in any gainful occupation as a result of a medical illness or injury that can be expected to continue for at least twelve months or to result in death.

Additional Benefits

Additional benefits are payable to eligible spouses and children of those receiving retirement or disability benefits. A benefit of 50% of the worker's primary insurance amount (PIA) is payable to a spouse over age 65 or a spouse who is caring for a child under age 16 (or certain disabled children). Each eligible child, meeting certain criteria, is also entitled to a benefit. A spouse over age 62 is entitled to a reduced benefit. Maximum family benefits apply and are generally 150% of the worker's PIA for disability and about 175% for retirement. An individual can only receive benefits based on one person's earnings record.

Survivor Benefits

Benefits are payable after the death of an eligible worker or retiree. The PIA is payable to a widow age 65 or older, and 71.5% of the PIA is payable to a widow age 60 (or under age 60 if disabled). Seventy-five percent of the PIA is payable to the child, but with the 175% maximum family benefit applicable.

Benefit Calculation

The PIA is based on the highest 35 years' earnings, with fewer years required for disability and death before age 62. Earnings in each year are limited to the maximum taxable wage base in that year, but are indexed to bring that level closer to current compensation levels. The maximum wages considered from the 1950's through most

of the 1970's were relatively low compared to current maximum wage levels, even reflecting inflation. This means that the indexing does not quite bring prior years' covered earnings up to current maximum wage levels. In addition, indexing only brings earnings up to the second year before the "eligibility" year, which is generally age 62. This essentially means that only partial indexing applies for earnings prior to 1983, with the average for years prior to 1973 only being indexed up to about 50% of the current maximum wage level.

The benefit formula is skewed so as to give relatively larger benefits to lower-paid workers than to higher-paid ones. A worker retiring at age 65 in 1992, with 35 years of coverage, will receive a benefit of about 24% of his final year's earnings, if he is exactly at the maximum taxable wage level for 1991 of $53,400. A worker retiring in 1992 at an "average income" level, which is about 40% of the maximum wage base, would receive a benefit of about 44% of final year's earnings. A low-income worker might receive up to 60% of earnings.

Annual cost of living adjustments are effective in January, based on the increase in the Consumer Price Index. In the last few years these have been in the 4% - 5% range, with the most recent one being 3.7% effective January 1992. These increases are applied to all years after initial eligibility (generally age 62) in calculating benefits.

Earnings Test

Benefits payable prior to age 70 are subject to an earnings test. For those age 65 to 69, benefits are reduced $1 for each $3 of earnings above $10,200. For those under age 65, benefits are reduced $1 for each $2 of earnings above $7,440. The exempt amounts are indexed; the ones shown are for 1992. For disability beneficiaries, the only earnings test is one that might affect determination of continued disability. In

addition, up to half the benefits are subject to federal income tax for individuals earning more than $32,000.

Financing

The OASDI program is financed through a combination of payroll taxes on employees and employers, interest earnings on accumulated assets, and a transfer of income taxes payable on the benefits. There are two separate trust funds, OASI for retirement and survivor benefits and DI for disability benefits. The trusts are invested in U.S. Government obligations and benefit payments and expenses come out of the trust. The current payroll tax is 6.2% **each** on employer and employee, on earnings up to the maximum taxable wage base. The tax is 12.4% for self employed, who obtain some federal income tax deductions however. A change in the law to include deferred compensation, including pre-tax salary reduction savings plans, increased the 1990 taxable wage base by an additional $900 above what it otherwise would have been. The maximum taxable wage base was $53,400 in 1991 and is $55,500 in 1992.

The current funding structure is more than adequate for 10 to 20 years and will produce a very large trust fund at that time, which will then decrease over the next 20 or 30 years. The 75-year projection shows that the current tax structure is not adequate.

HOSPITAL INSURANCE & SUPPLEMENTARY MEDICAL INSURANCE (MEDICARE)

Hospital Insurance (Medicare Part A)

Eligibility

Individuals age 65 and over who are eligible for monthly old-age benefits are eligible for hospital insurance. Certain disability beneficiaries are also eligible. Others age 65 and over can enroll if they pay a monthly premium of $192.

Benefits

The hospital insurance program covers institutional services such as:

- *Hospital Services*: Almost all in-patient costs excluding a $652 deductible per stay and co-insurance of $163 a day for the 61st through 90th days. An additional 60 days is available with a $326 per day co-payment. Room and board, nursing, drugs, supplies, diagnostic, and therapeutic services are all covered.

- *Nursing Home Care*: After three consecutive days in the hospital, care in a skilled nursing facility is covered for up to 100 days with a charge of $81.50 for each day over 20. Custodial care is not covered.

- *Home Health Services*: Unlimited home health visits prescribed by a doctor are covered. This includes intermittent nursing care, therapy, home health aide, certain medical supplies, and equipment (excluding drugs). Custodial care, homemakers, and meals are excluded.

- *Hospice Care*: Care in an institution for terminal illnesses for an individual with a life expectancy of six months or less is covered. This in lieu of most other hospital insurance benefits.

Supplementary Medical Insurance (Medicare Part B)

Eligibility

All resident citizens (and certain aliens) age 65 or over are eligible. Enrollment is generally automatic for those who become eligible for hospital insurance coverage, but coverage can be declined. (A premium payment is required.)

Services Covered

- *Doctor's Services*: This includes surgery, office visits, osteopaths, dental surgery, optometrists, and limited coverage of podiatrists and chiropractors.

- *Medical and Other Health Services*: Non-self-administered drugs, laboratory tests, X-rays, emergency room, artificial devices, medical equipment, ambulance services, certain physical, occupational and speech therapy, home health services not covered under Part A, home dialysis supplies and equipment, etc., are covered.

Benefits

The plan pays 80% of reasonable costs or charges for covered services after an annual $100 deductible. There are some significant limits both on what providers can charge patients and on what patients are required to pay providers. Physicians who accept assignment must accept the Medicare-approved charges as payment in full.

This means the patient is responsible only for the deductible and co-insurance and not for any excess of the bill over what Medicare says is reasonable.

For other physicians, "balance billing" will be severely limited by 1993. The physician will only be able to **collect** at most 9% more than the Medicare-approved charge. A major change in the basis on which physicians are being reimbursed is being phased in over the five-year period starting in 1992. The Resource Based Relative Value System (RBRVS) will reduce the amount that many high-paid specialists (e.g., surgeons and radiologists) will receive and increase the amount that some lower-paid physicians such as internists and family physicians receive, based on the time spent with the patient and some other factors. Reimbursement for "procedures" is reduced and reimbursement for evaluation and management is increased.

Financing

The Medicare program is financed by a separate tax of 1.45% **each** on employers and employees (2.9% on self employed). Effective 1991, the maximum earnings subject to this tax was increased from the maximum applicable under the OASDI program ($53,400 in 1991) to $125,000. The maximum taxable earnings for the hospital insurance program for 1992 is $130,200.

The current funding structure is adequate under short-range (14-year) projections and is inadequate under the long-range (75-year) projections. The fund becomes progressively more inadequate in each of the three 25-year subperiods. In order to be in actuarial balance just for the first 25 years, a 33% increase in income or 25% reduction in outgo, or some combination, is needed.

Part B is financed separately, with participants contributing about 25% of the cost of that program, $31.80 a month in 1992, and the other 75% coming from the General Fund of the U.S. Treasury.

Medicare Catastrophic Coverage

The catastrophic coverage benefits and additional taxes, some of which were effective January 1989, were repealed as of January 1, 1990. The repeal was primarily a result of political pressure from retirees objecting to the additional taxes required by that program. This severe reaction from retirees is expected to influence the National Health Insurance debates in the 1990s.

CURRENT CONSULTING ISSUES

The most controversial consulting issue mentioned in the National Report two years ago, nondiscrimination and qualification standards for health and welfare plans under Section 89 of the Internal Revenue Code, was repealed.

The major employee benefit consulting issues in the United States currently, are:

- Medical Cost Containment
- Retiree Medical Benefits
- Retirement Plan Changes as a Result of the Tax Reform Act of 1986
- Corporate Restructuring

Medical Cost Containment

The most significant issue in benefit consulting currently is dealing with several years of medical cost increases for employers in excess of 20% a year. The U.S. now spends 11.8% of its Gross Domestic Product on health expenditures compared to an average of 7.6% for the other major countries. That share in the United States has also been growing twice as fast as the average of the other major countries. Plan sponsors have been looking at many ways of controlling these costs, including:

- Cost shifting in the form of higher employee contributions, increased deductibles and employee co-payments, and more restrictive coordination with other plans.

- Greater managed care initiatives, including limitations on choice of provider and access to specialists.

- Major case management and use of most efficient resources.

These changes have fueled the growth of cafeteria or flexible benefit plans which can make cost shifting and other changes more palatable to employees and result in better employee communication, education, and understanding.

Due to the successful use of the issue in a recent special Senatorial election in Pennsylvania, health care reform has also become one of the major issues of the 1992 Presidential and Congressional elections. Proposed reforms and discussion of them has been growing geometrically. A related major issue is the lack of insurance, and in many cases access to health care, for 37 million people, almost 15% of the population.

Retiree Medical Benefits

On December 21, 1990 the Financial Accounting Standards Board (FASB) issued Statement No. 106 on *Employers' Accounting for Postretirement Benefits Other Than Pensions*. The standard requires a change from pay-as-you-go accounting to accrual accounting for postretirement medical and life insurance benefits, effective for fiscal years beginning after December 15, 1992. The most significant impact is for postretirement medical benefits. Some companies have already taken very large charges to earnings as a result of early implementation of the Statement. Most corporations have not yet disclosed the effect of Statement No. 106, but some that have done so have indicated significant liabilities. For example, the Big Three automotive companies have disclosed liabilities totalling $35 billion.

Almost all companies with such postretirement benefits are looking at the cost of those benefits, the impact on profit and loss and on the balance sheet when the Statement becomes effective, and how they might change their plans to soften that impact. Many companies with such plans have made major changes in the benefits that will be provided to future retirees. A number of companies have also significantly reduced benefits to current retirees. Design, implementation, and communication of modified plans will keep growing during 1992.

One major actuarial issue in the valuation of such plans is that the most significant actuarial assumption, future increases in medical costs as a result of trend, is one that is both extremely difficult to predict and has an enormous impact on results. The valuation of these plans also brings together a wider range of assumptions and effects than most consulting actuaries have traditionally used.

Retirement Plan Changes as a Result of the Tax Reform Act of 1986 (TRA'86)

Final regulations were issued in all areas of TRA'86 affecting qualified retirement plans. The period of "good faith compliance" ends December 31, 1991 for many plans and the final regulations must be implemented effective for plan years beginning in 1992. The law and associated regulations have required changes affecting the following:

- Nondiscrimination in coverage and benefit delivery

- Acceleration of tax on benefits and well funded plans and improved funding of poorly funded plans.

As the regulations implementing changes under TRA'86 are issued, some pension plans that did not seem to comply based on the law and early interpretations now can comply as a result of the way the law has been implemented. The 1990 National Report discussed plans that provide a benefit equal to a percentage of pay minus a percentage of benefits under the Social Security Act (offset integration with Social Security benefits). These plans seemed to be prohibited under the terms of the law, but for many plan sponsors they comply easily under the regulations.

The regulations have also spawned new types of design in both defined benefit and defined contribution plans using new service-weighted and age-weighted formulas. For example, both service-weighted and age-weighted defined contribution plans have been explored and implemented during 1991. The regulations permit defined contribution plans that offer benefit delivery much closer to that of a traditional defined benefit plan. We are also seeing similar variations in "cash balance" plans, defined benefit plans that look like defined contribution or individual account plans, because they have fixed interest rate credited on accounts. There are many

consulting opportunities in developing plan designs that comply with the new regulations and meet the plan sponsor's objectives.

Corporate Restructuring

Economic pressures have forced many U.S. corporations to downsize their workforce. To help accomplish this, employers have turned increasingly to Early Retirement Incentive Programs (ERIP). A survey of 60 of the largest employers in the country found that 40% of these offered an ERIP during the period 1987 - 1990. Activity in this area is increasing due to the effects of the recession. Several of the very largest employers have announced plans to reduce their workforce significantly in the next two to three years.

The consulting actuary plays an important role in the design and pricing of an ERIP. ERIP benefits are a combination of: lump sum cash payments, pension improvements, and extended retiree medical benefits. Each of these appeals to different segments of the employee population. The specific headcount reduction goals can be targeted through plan design. Accurate estimates of "acceptance rates" among affected employees is critical to the ERIP planning and pricing process.

In designing an ERIP, employers will want to know the likely number of acceptances and the associated cost. Although the general accounting principle is that an ERIP is immediately recognized for accounting purposes, judicious plan design can result in some pension ERIPs being amortized. Employers that have adopted FASB Statement No. 106 (retiree medical) may also have to recognize a one-time cost as a result of an ERIP. The 1990s should be a period of intense activity and innovation in this area.

MAJOR CHANGES

As a result of a number of different forces, including the continuing recession in the United States, the pension actuarial consulting business in particular, and benefits consulting in general, are coming under more and more pressure. This is manifested in several related ways:

- A decrease in the perceived worth of actuarial consulting services with those services being considered a "commodity."

- Significant reductions in fees for actuarial services by all of the major consulting firms.

- Less allegiance by clients to their actuaries and a greater willingness to change actuaries.

- A business need for actuaries to be much more than technicians, but to become trusted business partners of our clients and strategic thinkers who can add value to their business.

One bright spot on the horizon is increased opportunities for benefits administration work as a result of out-sourcing by clients of some of these functions. In total, however, the consulting actuarial profession in the U.S. is facing its greatest challenges in the history of the business. Continued growth for decades has finally stopped and business has actually started to decline.