

May 16, 2014

Ms. Erika Schulty
Society of Actuaries
475 N. Martingale Rd., Ste. 600
Schaumburg, IL 60173

Re: RP-2014 and MP-2014 Comments

Dear Ms. Schulty:

The Committee on Investment of Employee Benefit Assets (CIEBA) appreciates this opportunity to comment on the Society of Actuaries' (SOA) recently released exposure drafts on the RP-2014 mortality tables and mortality improvement scale MP-2014.

CIEBA represents more than 100 of the country's largest corporate pension funds. Its members manage almost \$2 trillion of defined benefit and defined contribution plan assets on behalf of 17 million plan participants and beneficiaries. As the largest organization of corporate pension investment officers, CIEBA represents the interests of employee benefit plan sponsors before legislators, Congress, regulators and the media. Since 1985, CIEBA has provided a nationally recognized forum and voice for corporate pension plan sponsors on investment and fiduciary issues.

Overview of CIEBA comments regarding RP-2014 and MP-2014

As voluntary sponsors of large defined benefit and medical plans, CIEBA members have a strong commitment to the long-term health and viability of the defined benefit system. CIEBA members also understand the importance of reasonable measurement standards that are used by numerous stakeholders including participants, regulators, and investors.

We greatly appreciate the valuable, often difficult work the SOA performs in producing mortality tables and improvement scales that generally serve as a guidepost for valuing liabilities of corporate pension and retiree medical plans. Given that demographics and mortality rates evolve slowly over time, we also welcome this latest proposed update to the tables and projection scale, and support the SOA's plans to update tables and projection scales more frequently in the future, particularly with respect to triennial updates of the projection scales.

At the same time, we are concerned about several factors that may be driving large proposed increases to liability values in the new tables and scales, and the implications of these changes. Our comments below generally focus on certain content of the underlying data and assumptions used, and the resulting magnitude of change between current and prior proposals, which has significant implications for plan sponsors if these proposals are implemented in their current form.

Data Supporting Mortality table RP-2014

Mortality table RP-2014 is thoughtful in its approach to providing more current standards for projecting pension liabilities. However, we would like to highlight the fact that, in the final data set, 66% of healthy retiree dollar-weighted exposure was represented by only five plans, leading to potential concentration risk of industries, medical plan coverage types, and geography. Further, blue collar concentrations for employees and healthy retiree groups, particularly for females, are considerably higher than in the previous study.

Additionally, we are concerned about the number of records excluded from original submissions, raising the possibility that the resulting data set might not be as robust and/or broadly representative as possible. Specifically:

- 11% of individual life-years were excluded due to not having a common ID across all years of study, a different approach than that taken in the 2000 table. It may be that the participant died during the study period and the record of their beneficiary used, which would increase mortality rates.
- Numerous records were excluded due to data being designated outliers (i.e., inconsistent with expectations) that were not subsequently verified by the actuaries. This group included nearly half of employee records submitted plus public plan records representing over three-quarters of healthy retirees.
- The decision was made to combine female healthy retiree and beneficiary data into a single table. However, female beneficiary data makes up approximately 40% of the value of the combined group. This decision could lead to lower perceived mortality rates as the data is not tracking the significant number of participants that pre-deceased their female beneficiaries. Coupled with the low number of female employee records retained (less than 2300), this could be a driver of the particularly high level of potential percentage changes in female-related annuity values.

Collectively, these facts may contribute to the significant magnitude of change from the prior RP-2000 table. Given the data collection challenges, in situations such as these, we would be in favor of comparing these results to those of broader data sets such as information collected by the PBGC.

Data Supporting Projection Scale MP-2014

As the exposure draft for the MP-2014 projection scale states, predicting future mortality improvement is inherently subjective and therefore involves uncertainty.

We ask you to consider the long-term assumption embedded in the MP-2014 projection scale of 1%. Specifically:

- While this rate is near the 1.1% rate cited by the exposure draft for the age-sex-adjusted death rate over the last century, to conclude that a similar rate will persist it must be reasonable to conclude that the drivers and conditions present over the last century will persist at a similar rate in the future. As the SOA states, during the past century “various sub-periods have exhibited quite dramatic variations in mortality improvement.” Indeed, the exposure draft cites a study showing the more recent period of 1982 to 2009 shows a slower rate of improvement of 0.9%.

- We recognize that longevity improvements are innately difficult to predict, and historical analysis requires significant amounts of consistent, long-term data. As these data are not always available, we appreciate that no method for constructing the required data set is perfect. We are concerned, however, that there is a fundamental mismatch between determining the base mortality tables on more narrow corporate participant data, and then applying mortality improvement scales based on broader Social Security trends. We believe that this dictates the need for some caution in the resulting conclusions, as tying the two unique sources of data together may not be an optimal predictor of future outcomes.

We are also concerned that the proposed improvement scale MP-2014 is both generational and two-dimensional. While period effects are more easily understandable, cohort effects seem less so. Without a detailed understanding of what is driving the differences in levels of mortality improvement rates among generations, it is difficult to reliably forecast their persistence.

We also agree with the SOA's assessment that future mortality increases will be impacted, both positively and negatively, by many complex factors. Perhaps projections can best be made by understanding the causes of historical shifts in longevity and estimating whether those trends, and pacing, are apt to continue. On the positive side, the past century has seen remarkable medical breakthroughs (antibiotics, surgeries, statins, cancer treatments, and dialysis to name a few). While medical breakthroughs undoubtedly will continue, the question is whether the pace of new discoveries can match those of the last century. On the negative side, obesity, diabetes, resistance to antibiotics, and incidence of Alzheimer's/dementia are on the rise. In fact, it is now estimated that 50% of patients over the age of 65 have three or more chronic conditions, and more than 50% of the overall U.S. population is expected to have a chronic disease by the year 2020. Competing trends such as these have led to differing opinions on how fast mortality may change in the future.

As the exposure draft rightly points out, future mortality improvement will also depend on "the rate of future increase in health spending and the efficiency of that spending relative to mortality improvement." Further, "a fundamental consideration ... is the ability and willingness of our society to pay for the development of new treatments and technologies ..." In fact, the establishment of the Medicare and Medicaid programs quite likely contributed to a rise in longevity over the last century; whether new programs can replicate this boost has yet to be determined. Healthcare spending will likely be a continuing challenge for U.S. citizens in the future, as healthcare cost increases remain significantly above general levels of inflation as well as overall economic growth. Demographics in the U.S. are not helping the situation, as the old-age dependency ratio is projected by the United Nations to rise from less than 20% in 2010 to 35% by 2040. All of these factors leave the question on the future pace of mortality improvements subject to serious debate.

Conclusions and Recommendations

We again thank the SOA for its significant effort to date and for the opportunity to comment on these exposure drafts.

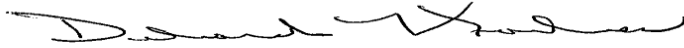
Mark-to-market changes in the valuation of plan liabilities will quickly affect company balance sheets and income statements. Additionally, we understand that ultimately these tables and scale may be used by the government in funding rules. The outcome of these current SOA proposals are sizable changes to the estimated annuity values when moving from the most commonly used RP-2000/AA-scale method, the magnitude of which has major implications for plan sponsors who voluntarily offer these benefits to employees.

Although we understand that the SOA's role is not to decide how and when these mortality tables are reflected in pension funding determinations or lump sum calculations, we feel that the SOA should be concerned with how their work product is used. We believe that legitimate concerns exist that the proposed tables/scales may be overestimating future rates of mortality improvement. Since decision-makers are likely to accept this table and the mortality improvement rates as the best way to assess future mortality, we stress the need to address the uncertainties inherent in the analysis, other possible outcomes and alternative methodologies that are less dependent on these future projections. We have provided some additional details on possible approaches in our comments below.

First, we strongly endorse the SOA's stated intention to perform more frequent updates to the mortality tables and improvement scale in the future. Due to the inherently subjective nature of projecting future mortality improvements, practical consideration should be given to using either improvement for a static period or more moderate generational scales, with updates on a more frequent basis, as a reasonable alternative approach. In this way, mortality improvements could continue to be captured while mitigating the risk of over-shooting lifespan projections. This approach would also implicitly recognize the difficulties of data collection and resulting potential imprecision, allowing for reasonably periodic corrections. We would finally suggest incorporating language in the final document reflecting the fundamental challenges in the process to produce these tables and scales, recognizing that corporate plan actuaries and auditors may appropriately modify them for individual plan use.

Ultimately, the current proposed changes to the mortality tables and improvement scale will result in a significant change to near-term plan sponsor calculations of pension and retiree medical liabilities. We respectfully request that you give consideration to how the SOA can best help the decision-makers selecting the mortality tables and scales that will apply to employee benefit plans to deal with the uncertainty that surrounds this type of analysis. This will allow them to make informed judgments to address these concerns. For example, a full understanding of the range of possible future mortality improvements might lead to a decision to more gradually implement this new table and the rates of improvement to mitigate the effects of any uncertainty about current assumptions and projections. This may avoid potentially significant, abrupt negative impact to plan sponsors over the near term which may not materialize over the long term.

We appreciate the SOA's work to date and the opportunity to comment on the RP-2014 and MP-2014 exposure drafts. CIEBA would be pleased to provide any further information or respond to any questions that the Society's staff may have.



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