August 30, 2013

ASOP No. 6 Revision (Second Exposure)
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036

Re: Comments on ASOP No. 6, *Measuring Retiree Group Benefit Obligations*

Members of the Actuarial Standards Board:

On behalf of the American Academy of Actuaries'[1] Joint Committee on Retiree Health, I thank you for the opportunity to comment on the proposed revision to Actuarial Standard of Practice (ASOP) No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Costs or Contributions.* We commented at considerable length a year ago on the first exposure draft (ED) and are pleased that the second ED effectively addresses many of the concerns expressed. Our comments again are divided into three categories: an overview of general comments on the ED, responses to the ASB's specific request for comments, and a section-by-section discussion of concerns about substance and wording in the ED. Our comments also address coordination with other ASOPs.

General Comments

We appreciate the efforts to update this important ASOP for retiree group benefits (RGB) practice. Our letter highlights concerns and identifies areas for improvement; however, many of our reservations about the initial ED have been addressed. There are fundamental differences between pension and retiree health, and our comments focus on the need for ASOPs to recognize those differences. We continue to have concerns that ASOP No. 4 language regarding pensions is used more than is needed within ASOP No. 6 and that the problem of implicit subsidies (and age specific costs for groups in pooled health plans) is not sufficiently addressed. Many concerns we had about terminology have been met, but some remain.

We support the ASB's intention to coordinate guidance between RGB and pension standards and are pleased that the new exposure drafts for both ASOP Nos. 4 and 6 have moved toward improving that coordination. We note that four of the six requests for comments in the ED parallel those in ASOP No. 4, and a fifth asks for a comparison with ASOP No. 4. We make additional suggestions in this comment letter, and we are preparing a separate letter with other Academy committees specifically to address areas for improved coordination.

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

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Standards put forward requirements for the practicing actuary, usually through the use of the word "should." In this ED, there are approximately 200 instances in which a variation of the word "should" is used; however, we would suggest that many may not be required. In some cases, "should consider" would be more appropriate. There are opportunities to lessen the burden suggested in the ED by the roughly 200 requirements for the actuary due to variations of the word "should". Some suggestions for this are included in the Section comments below. We constructed a spreadsheet of the instances we found, which we can make available, to aid in scrutiny of the requirements embedded in the ED.

Responses to Request for Comments

The ASB requested comments on six specific aspects of the proposed changes to ASOP No. 6. Our comments are as follows:

1. *Does the use of bold font to identify defined terms improve the readability and clarity of the standard?* The use of bold font to identify defined terms does improve the readability and clarity of the standard.

2. *Is the revised guidance regarding pooled health plans clear, sufficient, and appropriate? If not, how should it be changed?* The revised guidance regarding pooled health plans could be clearer and currently may be neither sufficient nor appropriate. We comment further on this later, but we observe that a significant amount of guidance currently in the pooled health paragraphs (Section 3.7.8) has wider application and would fit more appropriately in the preceding section on age-specific costs (Section 3.7.7). The concern with leaving such valuable guidance only in Section 3.7.8 is that an actuary for whom pooled health plans may not be as relevant could miss such guidance. We suggest the standard might provide more clarity by moving this language to Section 3.7.7, which also would provide more flexibility within Section 3.7.8. We also are concerned about guidance that states the actuary should "make a reasonable assumption regarding the distribution table…" when such a table is not available. The "should" language is too strong, while the remainder of the subsection is not offering real guidance, particularly for an actuary dealing with a small plan.

3. *Are the revised disclosure requirements regarding funded status clear, sufficient, and appropriate? If not, how should they be changed?* Disclosure regarding funded status remains a concern, and the ED offers little guidance for RGB assignments. Often the program sponsor has indicated no intention to prefund RGBs. This is a primary distinction between pension practice, for which the law requires prefunding a plan, and RGB practice, for which no comparable compulsion exists. Acknowledging the difference, and editing the language so that it accommodates the RGB actuary, would be a significant step in effective coordination of the retirement standards.

4. *Do you feel that a qualitative assessment is reasonably practical for the actuary relative to a quantitative assessment, and reflects an appropriate level of disclosure in light of the effort required to make the assessment?* This question did not point to examples within the ED. We found only one requiring a qualitative assessment—Section 3.18.2 with associated disclosure in

Section 4.1(p). Section 3.18, however, is a prime example of ASOP No. 4 language and concept being applied to RGB benefits, even though such guidance may not be relevant to RGB. Statements in Section 3.18 that may be relevant use language that is too complicated. In most RGB cases, the qualitative Section 4.1(p) disclosure would seem to be simple—the implication of the sponsor funding policy on future RGB prefunding contributions is that no such contributions are expected and the funded status equals the liability that might be considered accrued. As to whether this is practical, making this assessment is as practical on a qualitative basis as a quantitative basis. But a disclosure using the language of Section 3.18 is less likely to be understood than a simpler statement that the plan sponsor is not prefunding and has not communicated an intention to do so.

5. *Is the coordination of guidance on market-consistent present value measurements in the second exposure draft of ASOP No. 6 and the working version of ASOP No. 27 appropriate*? We believe the coordination of guidance in this area is <u>not</u> appropriate. ASOP No. 27 guidance on the assumptions based on market data discussed in ASOP No. 27 Section 3.6.1 provided good examples for the assumptions necessary for developing a market consistent present value for pension obligations, particularly in (d) by "examining" annuity prices. For RGB practice, however, we question the application of the concept of a market-consistent present value, since we believe there is no market for RGB benefits. Definition 2.20 suggests that the terminology "market-consistent present value" refers to the "price at which benefits that are expected to be paid in the future would trade in an open market between a knowledgeable buyer and seller." The nature of these obligations—the lack of vesting of these benefits, the ability of many organizations to change the coverage commitment and obligation, and the changing nature of health care delivery in the US—is that they are virtually nonexistent, which makes the concept of a buyer questionable. It may be preferable to reconsider the definition in Section 2.20 and review its usage in ASOP No. 6.

6. *ASOP No. 4 proposes a somewhat less restrictive definition of a reasonable actuarial cost method than... this exposure draft. The Pension Committee intends that the language in the two standards will ultimately be consistent. Which language do you believe is more appropriate? For example, is it inappropriate to use the Aggregate Cost Method for a frozen plan with active employees?* The definition of reasonable "actuarial cost method" in ASOP No. 6 (Section 3.17(a)) is simpler and therefore preferred over the definition of "actuarial cost method" in Section 3.13(a) of ASOP No. 4. An even simpler statement would be, "An actuarial cost method that produces a normal cost for benefits when no employees are accruing benefits under the plan is not reasonable." One option for a statement structured as a "should" sentence is, "The actuary should recognize that, when no participants are accruing benefits under the plan, a reasonable cost method will not produce a normal cost for benefits."

As to the question related to aggregate cost method for a frozen plan, using the pension concepts of frozen plan and benefit accrual for funding a retiree health plan is difficult, and, in practice, rare. Beneficiary status is usually dependent on attaining certain age and service levels; at a point in time, some active employees may have reached those levels. Assuming "frozen" means no accruals to those levels, there would be no further normal cost under the usual definition. Nonetheless, an amortization of unfunded frozen benefits over the remaining working lives by an

aggregate cost method might meet the technical definition of normal cost. In most RGB programs, however, that would mean allocating normal cost after the benefits were earned fully and, thus, without accruals. Since there are active participants, the language in ASOP No. 4 (ED) would not be applicable, even though no one is accruing benefits. The language in ASOP No. 6 (ED) would be applicable, as would the two we suggested above. While such a scenario of funding to frozen RGB accruals over a short period of remaining working life is feasible and might be appropriate, no committee member has had experience with such a scenario.

In sum, the two definitions (in ASOP Nos. 4 and 6) may not need to be exactly the same, since the "accrual" nature of the respective benefits differ. The two ASOPs' definitions could be consistent without having exactly the same language. And, as was noted in our letter last year, trying to adapt concepts reasonable for pensions to RGBs may take considerable effort, which should not be underestimated.

Section by Section comments

In the title for the standard that is shown above Section 1, the terms "periodic cost" and "prefunding contribution" have not been used.

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose

Benefit payment projection should be displayed more prominently as a purpose. The standard should recognize that projection of future program benefit payments (i.e., cash flows) is often of great interest to plan sponsors and that actuarial projections of cash flows alone have substantial value. Since the title of this standard is on measuring obligations and determining costs or contributions, that may be why this is not mentioned in Section 1.1 but is mentioned in Section 1.2(f). One suggestion is to modify the last sentence of Section 1.1 as follows: "This standard provides guidance for coordinating and integrating the elements of an actuarial valuation of a retiree group benefits program, including the projection of retiree group benefit cash flows." We also believe that ASOP Nos. 6 and 4 would be enhanced by recognizing benefit payment projections as the initial item listed under Section 1.2.

1.2 Scope

ASOP No. 4 in Section 1.1 says that the term "plan" refers to a defined benefit (DB) pension plan, thus excluding defined contribution (DC) arrangements. No such exclusion is seen in ASOP No. 6, but there also is no acknowledgement of arrangements such as defined dollar programs or programs containing health retirement accounts, in which the sponsor would carry a RGB obligation and this standard would apply. These are still DB plans, similar to cash balance plans or fixed dollar pensions. This will be more common with the Affordable Care Act (ACA), so the standard may need to clarify whether it is in scope. Without explicitly excluding it, the standard would apply.

On the other hand, if DC arrangements in RGB are excluded for ASOP No. 6, there is a need to define DC arrangements that are not in scope. A difference with pensions is that a DC pension plan has segregated assets and the plan sponsor is not subject to any future risks. For RGB, the accounts may not be funded—simply notional—but the sponsor is subject to various risks, so a

valuation is still needed. There are many helpful principles to guide the actuary in the ED of ASOP No. 6, but the wording may be too restrictive. Perhaps ASOP No. 6 could include a separate paragraph with overall guidance.

Another class of benefits that would be covered by this standard is executive health and/or fringe benefits for retired executives. How does the ASB intend this ASOP to apply to executive group benefits?

1.4 Effective Date
We note the mention of roll-forwards, whereas there is no similar mention in ASOP No. 4. Later we suggest how roll-forwards could be addressed in Section 3.4 with closer coordination to ASOP No. 4.

Section 2. Definitions
While the word "cost" was dropped in the 2013 ED and replaced by "periodic cost," the word "cost" remains in other places and is used in a variety of ways (e.g., claims experience, rates, expenditures, etc.). Because of the varying and inexact usage of the word, and to coordinate with other retirement standards in which cost is used as periodic cost, we recommend a revision of ASOP No. 6 to clarify the intentions of the guidance. Specifically, we suggest a minimal use of "cost" other than as periodic cost.

We also recommend that "implicit subsidy" be defined. In particular, it would be helpful to clarify whether implicit subsidies arise a) only because of increasing age or b) because actives and pre-65 retirees share a premium.

Section 2.5 defines "actuarial valuation" as the measurement of obligations. "Obligations" is not defined, however, so it is not clear whether a study that simply projects benefit payments is an actuarial valuation. The organization of Section 1.2, which mentions measurement of obligations as one of six items and confines cash flows to an example of the sixth item, implies that cash flow projections are not the result of an actuarial valuation.

In Section 2.13, we note that the word "periodic" appears twice in the phrase "net periodic postretirement benefit periodic cost." If the intent was to reference Financial Accounting Standards Board (FASB), the correct term is "net periodic postretirement benefit cost." Other accounting standards may use different terms. Rather than limit the reference in the ASOP to the FASB reference, we suggest that a more widely applicable phrase may simply be "periodic cost."

2.14 Covered Population
The use of "participating dependents" is redundant and confusing since dependents are later defined as covered. Also, participant seems to be reserved for non-dependents, as we read this definition and that in Section 2.39. This is a concern since the word "participant" is used in other places as though it includes dependents (Section 3.5.1(d)). "Participating dependents" is used later is Section 3.6.4, in which "participant" is used as though it does not include dependents.

2.16 Dependents
It is not clear if yet-to-be-identified dependents are included. It is a common practice, when dependent eligibility is determined only at the time the working participant retires, to assume some percentage of active employees will have an eligible dependent at retirement. But because such participants cannot yet be identified individually, it is not clear whether they are considered ”individuals,” as that word is used in defining “dependents” and ”participants.” The definition could be modified to include potential future dependents and read “People who are covered or may become covered under a retiree group benefits program by virtue of their relationship to retired or active participants.”

2.19 Immediate Gain Actuarial Cost Method and Section 2.37 Spread Gain Actuarial Cost Method. We question the need to define these terms, given their limited relevance in the body of the standard and to RGB practice. Other than a disclosure in Section 4.1(s), the only reference is to the second of these two items once in Section 3.17. The distraction caused by defining terms of limited relevance offsets any benefit.

2.20 Market Consistent Present Values
We offer further comment in Section 3, but we will point out that no market for RGB programs has developed. If the term persists in the ASOP, we suggest removing the words “that are expected” in this definition. They are too restrictive. The sentence would then read, “…consistent with the price at which benefits to be paid in the future would trade…” Expected benefits might be appropriate for death benefits, but health benefit projections are not really expected amounts.

The phrase, "health plan" appears in Section 2.23 Medicare Integration. We suggest that this phrase be replaced by **retiree group benefits program or benefit plan.** If “health plan” is never defined, and it doesn’t need to be, its use in the standard should be avoided.

2.27 Participant Contributions
We suggest a definition as follows: "Payments made by a participant to offset the costs of coverage of a **retiree group benefits program.**" It also might be clarified whether a dependent, as defined, can make a participant contribution, as defined, and what that means in situations in which a contribution is required from a dependent but not a retiree.

2.30 Pooled Health Plan
The phrase “in which the claim cost portion of its” is redundant given the last half of the sentence. The word “rates” after “premium” is not needed, per the Section 2.32 definition of “premium.” The initial sentence could then begin, “A health benefit plan with premiums based at least…” This is one instance in which the term “health benefit plan” seems justified. In general, however, “health plan” should either be defined or avoided, in which case “pooled plan” would suffice.

The word “group” is not used often in the standards as a noun (the main instance being Section 3.7.8 on pooled health plans), and is defined nowhere. On the other hand, “covered population”

is defined. We suggest the word “population” be considered as a replacement here and other places in the standard when “group” is used as a stand-alone noun.

We suggest that the words “cost” and "rate" be deleted from the phrase "health care cost trend rate assumption" and “health care trend assumption” be used instead. The word "rate" is not consistently paired in the ED’s references to trend, and the word “cost” is unneeded. The phrase “health care cost trend rate” does appear again in Section 3.12.1(a) and Section 4.1(j); “heath care trend” would suffice in both instances.

2.32 Premium
We note that this definition of premium as a price incorporates the idea of premium as a rate. Later use of the term “premium rate” is redundant. The elimination of the word “rate” in those instances and others would allow it to be used in place of “cost” in quite a few areas in this standard.

2.40 Trend
The definition of “trend” should not reference *expected* benefit payments. Trend can refer to a past change in payment levels, as can be seen in Section 3.7.12, in which the trend adjustment is based on changes in earlier periods. The definition we suggest is the one in the current ASOP No. 6—“A measure of the rate of change, over time, of per capita health care rates." The definition also should be consistent with the reference to trend in Section 3.12.1(a), which does not mention benefit payments currently. There may be some reluctance to define “trend” as solely a health-related word, but that is how it is used in the standard. The ASB might want to consider whether an exclusion of aging should be included in this definition, since it is later found in Section 3.12.1(a) and is a point worth mentioning twice.

We also note this definition of “trend” as a rate of change. Later use of the term “trend rate” is redundant. The elimination of the word “rate” in those instances and others would allow it to be used in place of “cost” in quite a few areas in this standard.

Section 3. Analysis of Issues and Recommended Practices
We remain concerned that too much of the ED deals with unimportant areas of practice, but we appreciate that some significant changes have been made since the first ED.

3.2 General Procedures.
A number of the procedures in this section are rarely part of RGB practice. While these may have been included as part of the coordination with ASOP No. 4, we question whether that coordination is worth dimishing the substance of the standard. We do note that some of the procedures are better expressed in this standard than in ASOP No. 4.

3.3 Purpose of Measurement
The absence in the examples of mention of benefit payments is striking. As noted in our comment above on Section 1, ASOP Nos6 and 4 would be enhanced by recognizing the initial importance in retirement valuations of cash flow and benefit payment projections.

3.3.3 Risk or Uncertainty
This sentence includes an actuary "should" statement, prefaced by a clause indicating that action is to be consistent with ASOP No. 41 on Actuarial Communications. But the referenced section in ASOP No. 41 states, "3.4.1 Uncertainty or Risk—the actuary should consider what cautions regarding possible uncertainty or risk in any results should be included in the actuarial report." Since ASOP No. 6 Section 4.1 indicates that any communication must comply with the requirements of other ASOPs including ASOP No. 41, why do we need to include in ASOP No. 6 Section 3.3 Purpose of Measurement a statement that the actuary should consider "the risk or uncertainty inherent in the measurement assumptions and methods"? We suggest this Section 3.3.3. be deleted or clarified (if another purpose is intended). Also, why is the ordering of the words "risk or uncertainty" not used consistently between the two standards (and ASOP No. 4, in which the exact wording as in ASOP No. 6 appears)?

3.4.1 Information as of a Different Date
This section under measurement date considerations states that if asset and participant information used for a measurement is as of a date that differs from the measurement date, the actuary should make appropriate adjustments to the data or should adjust the obligations to the measurement date. In either case, the actuary should determine that any adjustments are reasonable in the actuary's professional judgment. We believe that if the actuary is making appropriate adjustments as required by this section, it is redundant to require the actuary to determine that these adjustments are reasonable.

Section 3.4 might be a more appropriate section for inclusion of the commentary on roll-forwards, which is now at the very end of Section 3. ASOP No. 4 has a third subsection under Section 3.4. ASOP No. 6 does not have a corresponding subsection but maybe it should. In ASOP No. 4 the subsection is titled "Adjustment of Prior Measurement" and it seems to refer to roll-forwards, although never using that term. Consideration should be given to moving the present Section 3.24 on roll forwards into a new subsection under Section 3.4, with appropriate and corresponding changes to make ASOP Nos. 4 and 6 the same when possible and different only when necessary.

3.5.1(d)(2) Participant Postretirement Contribution Reasonableness
This is a place to introduce the concept of Implicit Subsidy, which we have noted needs definition.

3.5.1(d)(4) Contributions as defined by Limits on Plan Sponsor Costs
This subsectionis poorly worded. The limit commonly known as a cap is on the per capita amount, as plans limit claims payouts, not the periodic cost or prefunding contribution, which may be limited by the cap indirectly. This misconception is seen again in Section 3.5.2(b). Also, in many cases, the limit is on the amount to be paid by the plan sponsor, not on plan payout itself, which may be unaffected. The word "subsidy" could be introduced here to indicate it is the sponsor subsidy that is capped, which is likely to create a rising cost shift to the participants. This affects the participant contributions, which is the heading for this subsection. To better tie in with that heading, Section 3.5.1(d)(4) might begin with, "Participant contributions may be affected by limits designated for amounts to be paid by plan sponsors, in a period such as a year.

Such a limit on the sponsor's subsidy of the plan is commonly known as a "cap" when placed on the average per capita payment. Another type of limit is on the aggregate sponsor subsidy in any current or future period. Limits on subsidies such as these are likely to create a cost shift to participant contributions. The actuary should consider whether the limits…."

3.5.1(f) Health Care Delivery System Attributes
"The actuary should consider that various health care delivery system attributes can affect costs differently. For example, certain delivery systems may lock-in costs for an extended period of time because of their provider contracts." This section acknowledges the complexity in health care delivery arrangements and places the burden of considering this complexity on the actuary, including developing an understanding of negotiated price lock-ins for providers as part of developing a health care cost basis. While we agree this information may be useful to consider, access to this information may be limited at best, so this consideration may place an unrealistic burden on the actuary in many cases. In addition, an "extended period" for such lock-ins is still a relatively short period in the context of a RGB valuation, for which the actuary is more focused on long-term trends. We recommend further clarification with respect to the standards guidance for the actuary in this section.

3.5.1(g) Benefit Options
The introduction of new benefit options does not always result in additional contributions or cost; it may result in reductions (e.g. HDHP offering along with more traditional plans). Also, the actuary may want to consider the effect of benefit options on participants' behavior and adverse selection.

3.5.1(h) Anticipated Future Changes
This section, which states that "for most measurement purposes, the actuary should consider only changes that have been communicated" could be strengthened to state that "for most measurement purposes, the actuary should recognize…." Also, in this section, the final sentence related to disclosure of anticipated future changes being included, seems redundant, given the language in Section 4.1(d).

3.5.2(b) Patterns of Plan Changes
See our Section 3.5.1(d)(4) comments.

3.5.2(c) Governmental Programs
"The actuary should consider the historically enacted legislative and administrative policy changes in Medicare and other governmental programs…" We would expect practitioners to reflect current law and policy, including appropriate trend assumptions for costs in cases in which there is integration with governmental programs. With the use of "historically enacted," this section, however, seems to suggest that the actuary anticipate more legislative or administrative policy changes based on history. We would recommend this section be deleted or clarified.

3.5.3. Reviewing the Modeled RGB Program

The second and last sentence concludes with a statement that the actuary should consider if a deviation from known program provisions and administrative practices is temporary or permanent. We believe it would be inappropriate for the responsibility to consider whether this deviation is temporary or permanent to be with the actuary. We suggest that this section be rephrased to indicate that the actuary should discuss his or her finding of this deviation with the plan sponsor to seek guidance from the plan sponsor regarding whether this deviation is temporary or permanent.

3.6 Modeling the Covered Population

The "access only" situation should be mentioned in the standard. This is when the actuary has been told that a benefit plan exists but that, for all or some portion of the covered population, the program only provides for access to the plan, not a subsidy of the plan costs. In theory, the participant contributions are to cover all of the plan expenditures. This might be in the preceding section for "plan provision" or in this "covered population" section, but there is need for guidance for the actuary. Can the actuary simply disclose what has been said about such an access-only provision and not value that portion of the population? Or, is there an actuarial responsibility to examine whether the sponsor's financing of the plan is, in actual operation, offset by adequate participant contributions and, if not, proceed to measure the obligation implicit in the shortfall?

Section 3.6.1 *Census Data* introduces the word "acceptance," which reappears in Section 3.12.3 (a) and Section 3.20. The words "lapse" and "re-enrollment" also are introduced. Section 3.12.3 (a) discusses "participation" and "coverage" assumptions. There, and in other parts of the ED, "participation rates" are mentioned and seem to be referring to the same thing as "acceptance," which does not seem to be the appropriate word for enrolling or participating in a plan that requires a contribution.

3.6.4 Dependents and Surviving Dependents of Participants

This now requires that dependents and surviving dependents who are participants be modeled separately, since they may have eligibility and benefit provisions that are different from the retirees. Secondly, dependents who are children of retirees may be modeled "appropriately" if the actuary considers the obligation to be significant (i.e. actuarial judgment and lesser degree of precision may be acceptable with respect to this population). This section may benefit from some clarification and we offer the following suggestions:

- Instead of "participating dependents," we recommend using the phrase "dependents and surviving dependents who are participants."
- The first paragraph is a clear reference to spouses and surviving spouses. The first sentence of the second paragraph also refers essentially to spouses and surviving spouses and is redundant. We therefore suggest it be deleted.
- Instead of "dependent children," use the phrase "dependents who are children of retirees."

3.6.6 Use of Grouping

This requires the actuary to disclose combining of health plans (undefined, as we noted earlier) and grouping of populations, referencing Section 4.1(i), which also states that the actuary should

disclose any combining of benefit plans for measurement purposes. Practitioners sometimes may encounter situations in which judgment may be applied in grouping plans (e.g., due to small legacy groups with relatively similar benefits). Therefore, we suggest that the last sentence be amended to state "The actuary should consider disclosing, if significant, such combinations of plans and of grouping populations." We also note that our recommendation for this slightly less stringent requirement is supported by the sentence of the fourth paragraph in Section 3.6.7 which states "The actuary should also document any significant actuarial judgments applied during the modeling process." This sentence cautions the actuary to disclose significant judgments that may be interpreted to encompass any grouping or combinations of health plan populations.

3.6.7 Hypothetical Data
This section has been improved. Does this section justify the percentage assumption for dependents of actives that we noted in conjunction with Section 2.16? If so, that might be used as an example here. Does this now relate to Section 3.7.8 and making reasonable assumptions about the population distribution table for a pooled plan? If so, that might be mentioned.

3.7 Modeling Initial Per Capita Health Care Costs
We appreciate many of the changes that have been made since the earlier ED. We note that uses of the word "cost" remain a concern. While the defined word "cost" has been replaced by "periodic cost" in this ED, which has reduced some potential confusion, too many variations in meaning remain. Earlier in this letter, we noted some extraneous uses of the word "rate" and suggested elimination of those would allow "rate" to be used in place of "cost" in some instances in the standard. Section 3.7 is one instance in which we think clarity can be gained using "rate," such as in per capita health care rates. Minimizing the use of the word "cost" would seem to be an important part of coordination with ASOP No. 4, in which "cost" is the stand alone term for periodic cost.
Section 3.7.1(a) *Paid Claims* requires the actuary to analyze the data for likely differences between the level of paid claims and incurred claims. We would recommend modifying this section to state "should consider analyzing" rather than "should analyze." In some situations the impact may be insignificant and/or the scope/timing of the work or the availability of data is not sufficient to provide for this analysis.

3.7.4 Credibility
There is no threshold definition here, other than "fully credible," but we note that low enrollment counts still can be credible if enough historical periods are available. Please note also that the current revision of ASOP No. 25 may mean reference to that standard should expand beyond the current mentions in this ED.

3.7.6 Impact of Medicare and Other Offsets
The use of the undefined term "health plan" could be replaced by "program" or "benefit plan." The last sentence of the first paragraph does not pertain to Medicare, which might be better recognized if it were in a paragraph of its own. The last paragraph, requiring that "The actuary should be aware of any significant changes to Medicare…," is a concern for a few reasons. For one, consideration is better guidance than awareness. For another, the significance to the actuarial measurement task is not whether the Medicare change was significant, but rather

whether the effect of any change is significant to the measurement. Also, if adjustment is needed, it is not necessarily to the historic data; the adjustment needed is more likely to an assumption. Finally, the concluding "to fit the purpose…" is somewhat gratuitous; why add it here when it applies throughout the standard? Other options we suggest include, "The actuary should consider changes to Medicare and other governmental programs that may have affected historical data being used in the
measurement and, if the impact is significant, make appropriate adjustments" or "The actuary should consider making adjustments for material changes to Medicare and other governmental programs that have affected - or will affect - claims offsets."

3.7.7 Age Specific Costs
We strongly agree with the emphasis on age variation and its effect on rates, including the implicit subsidies that may be embedded. The ED may misplace some of this emphasis, however, by putting it in Section 3.7.8 and treating it as "additional analysis." It belongs in Section 3.7.7. We suggest that the following items in Section 3.7.8 are applicable to any group being valued and should be included in Section 3.7.7:

- A plan in which the experience of actives and retirees is blended;
- Implicit [hidden is used] subsidy, which is certainly more wide-spread than pooled health plans. In fact, an example is found in Appendix 1 at the bottom of Page 44 that has nothing to do with a pooled health plan. As we note in our comments about implicit subsidy in Section 2, clarification is needed as to whether subsidies are due to increasing age only or because actives and pre-65 retirees share a premium.
- The use of the demographics (total age distribution) of the group under consideration in determining the age-specific costs;
- The use of the plan's total expected claims or premium in determining the age-specific costs;
- The use of manual rates as the basis for age-specific costs.

Once those changes are made, Section 3.7.8 would make the point that the actuary should use the demographics, total expected claims, premium and/or manual rates of the entire pooled health plan, not just the group being valued.

3.7.8 Pooled Health Plans (including Community Rated Plans)
Some members of the committee believe cross subsidies within pooled plans may be due to factors such as area, industry, retirement or disability experience, and anti-selection due to differences in the portion of retiree's premium paid by the employer. We did not, however, have consensus on the need to specify these in the standard. This section also indicates that the actuary should use age-specific costs, which we hope would be conveyed adequately in Section 3.7.7. Modifying Section 3.7.8 regarding using age-specific costs, as appropriate, could provide some flexibility if data with which to develop true age-specific costs is not available.

Since there is no mention of self-insured plans in the ASOP, we suggest the "premium equivalent" term be replaced by premium. However, we also question why there is no mention of self-insured plans, which often are the RGB plans served by actuaries.

The last sentences of the second paragraph state "If information is not available from the pooled health plan, then the actuary should make a reasonable assumption regarding the distribution table for the pooled health plan to determine the age-specific cost. Alternatively, the actuary may base the age-specific cost on manual rates or other resources relevant to the plan of benefits covering the members of the group being valued." We suggest replacing "should" in the first sentence with "may" and "distribution table for" with "age distribution of." The section suggests that the actuary approximate age-specific rates by either (i) constructing a hypothetical age distribution without any knowledge of the overall risk pool or (ii) using manual rates. Without understanding the risk pooling factors used to develop the employer's actual premium, however, generating age-related rates using a hypothetical age distribution or manual rates could produce arbitrary claims costs for the valuation. This is a concern for small-sized employers within the pooled health plan with little to no credibility. We request that the ASOP No. 6 subcommittee provide more guidance on developing age-specific rates when the pooled health plan risk pooling basis, including the age distribution, is not available.

3.7.10 (b) Enrollment Practices
If "adverse selection" is what is being referred to as "the effect," then that term should be used. If not, the meaning should be clarified.

3.7.12 Adjustment for Trend
We recommend the use of the word "should" rather than "may" in the second sentence. This is a recommendation we made last year that was not incorporated, with the reviewers noting that "in some situations it may be appropriate to consider only the experience of the health plan." We agree, but those situations are rare. Our concern is that an actuary inexperienced in adjusting claims data may use internal trends or past surveys to bring past experience to the initial year. For instance, if there are two years of claims data, with the current year being (in retrospect) the outlier, a problem can arise if the adjustment of the older year is based on the internal trend between the years. The effect would be to adjust the normal year into an outlier so that now all experience appears at the outlier rate incorrectly. By saying the adjustments "should reflect experience from outside…" the standard would compel the actuary to reflect on (not just consider) the change in regional or national rate levels. This does not mean the adjustment has to be based on outside experience, but indicates adjustments will have been examined against experience outside the plan. The exceptional situations cited by the ASB reviewers last year would seem to be those in which the internal data for each year has full credibility (i.e., a very large group). But in those cases, why even adjust for a second year? We strongly recommend use of the word "should," and suggest that the ASB could instead include an example of a possible exception.

Section 3.7.15 *Administrative Expenses* refers to the modeling of administrative expenses. A plan sponsor also may be responsible for other expenses such as PPO access fees, stop-loss premiums, capitation rates, etc. It may be useful if this section also made reference to other non-administrative expenses.

We agree with Sections 3.8, 3.9, and 3.10 as they are written. With minor changes, these sections also could be appropriate for ASOP No.4.

3.11 Other Information from the Principal
It is unclear why this element has a separate section. We are unsure of what an accounting election is and how it fits into the actuarial measurement. There is a “should” statement here, but it is not clear what might be lost if the actuary does not obtain this information. The actuary’s duty needs to have more detail, or this should be deleted in ASOP Nos. 4 and 6.

3.12 Projection Assumptions
In the last line on Page 22 of the ED, Section 3.12.1 has an incomplete reference to the Accounting Standards Codification (ASC) for –DB plans. The sentence refers to “ASC 715-“ but the “30” is missing. It is possible that more is missing from this sentence, so we recommend reviewing it and filling in the incomplete information.

3.12.1(a) ***Health Care Trend Rate***
Given the definitions in Section 2, the words “cost” and “rate” are unnecessary in the heading; it can be health care trend. The second and third paragraphs of this section distinguish between initial and long-term trend and gives guidance for when they vary. The first sentence of the third paragraph, however, is good guidance whether they vary or not. It fits better at the beginning of the second paragraph before mention of long-term trend. Other concepts in the two paragraphs could then be aligned—first comes selection of the ultimate trend and then consideration of the transition from initial to ultimate, not the reverse order as it currently states. In the current second sentence, second paragraph, the clause “should determine the appropriate length of a select period” should be replaced with less burdensome language. We suggest, “should choose an appropriate length for a select period,” which avoids implying there is one, and only one, appropriate select period. We also believe the current last sentence of the third paragraph repeats material covered earlier, so it should be deleted, too. Asking an actuary to show that selection of the “transition pattern and select period” reasonably reflects “anticipated experience,” goes beyond what should be expected from a trend assumption that may exceed 50 years, each year of which could be considered to have different anticipated experience.

An important consideration for the ASB is whether the economic section would be better served in ASOP No. 27. There should be more coordination of language and concept between this section of ASOP No. 6 and that of ASOP No. 27. By that, we do not mean that the style of ASOP No. 27 should be imposed on the health care economic assumptions of ASOP No. 6, but rather that a style compatible with the economic assumptions of pension and RGB should be developed. In the current working draft of ASOP No. 27, a template seems to have been followed for both the investment return assumption and compensation increase assumption that could be used for the health care trend assumption. A wider definition of “productivity growth,” beyond compensation, would benefit ASOP No. 27. The current definition contrasts with what is in the ASOP No. 6 ED—“projected growth of per capita GDP.”

The other assumptions in Section 3.12.1 do not clearly fit with ASOP No. 27 and the use of outside data. Mention of “relevant … economic factors” in the third paragraph, second sentence, may not clarify whether the projections are those of the actuary, of those responsible for the

RGB program, or of recognized national agencies or think tanks. Each of the factors— GDP growth, inflation, HCE percentage—might be projected differently.

The ASB could provide additional guidance on the selection of health care cost trend rates by inclusion of pertinent economic guideposts in an appendix. While Section 3.12.1 does reference some factors appropriate for consideration for long-term trend, guidance to aid in the selection of an appropriate transition and select period is not provided. Appendix 4 of ASOP No. 27, which lists external sources to which an actuary may turn when developing economic assumptions, is an example of such supplementary guidance. Economic and data references to which an actuary may refer when selecting components of the health care trend assumption may be helpful to the practitioner and could be included in an additional appendix in ASOP No. 6 if this section is not linked to ASOP No. 27.

The last paragraph in Section 3.12.1.(a) includes an admonition that the actuary consider annual or lifetime maximums on benefits, which would seem to belong with the section of the standard dealing with modeling of provisions. Such an admonition is not appropriate in a section that has been treating health care trend in a generic sense without reference to all the complications, such as those that make gross trend different than net trend. We advise that this sentence, or the concept involved, be moved to Section 3.5.1 (c).

In Section 3.12.1(b), we note that the phrase "long-term care insurance" is used. Section 2.9 references "long-term care" but not "long-term care insurance." We suggest deleting the word "insurance."

3.12.1(c) Participant Contribution Changes
The last sentence of the first paragraph may be viewed as limiting and construed as only applicable to situations in which a cap on benefits has not yet been placed. We suggest adding the following sentence: "In cases in which a plan has a cap on benefits already in place, the actuary should consider modeling participant contributions based on the provisions of the Retiree Group Benefits Program and on communications to participants which describe application of the cap."

3.12.1(d) Adverse Selection
As in our previous letter, we note that adverse selection is not a “process.” That word can be deleted, particularly since “adverse selection” is a defined term.

We also note that Section 3.7.10 (b) on enrollment practices uses the word “effect” and seems to be referring to adverse selection. We suggest using the term “adverse selection,” which could clarify the meaning.

The last paragraph of this section cautions the actuary that, if adverse selection is deemed to have a significant effect, the actuary should document how the adverse selection was reflected.
We therefore suggest adding the reference to "adverse selection" in the parenthetical phrase of Section 4.1(k).

We suggest deleting the text in Section 3.12.2(d) and replacing it with the following: "The actuary should note that measured results will vary based on a mortality assumption that may include provision for expected mortality improvement in accordance with Section 3.5.3 of ASOP No. 35. Trend rates to measure increases in per capita health care costs will also influence the results of a measurement. While trend rates will interact with assumed mortality rates, the actuary should select each of these assumptions in accordance with Section 3.12.5."

In Section 3.12.3 (b) *Dependent Coverage*, we suggest adding the word "materially" in the last sentence following the word "differs".

Deleting much of the first sentence in the second paragraph of Section 3.12.4 *Effect of Retiree Group Benefits Program Design Changes on Assumptions* would offer clearer guidance and delete a questionable "should assume" statement. The paragraph could then start with "Even though many plans have reserved the right…," connecting to what is now the second sentence. The phrase "for most measurement purposes" is also highly ambiguous. If the ASB believes it is important to give guidance as to whether actuarial assumptions should regard programs as continuing indefinitely, "may assume" or "should consider" is the more responsible actuarial stance than "should assume." Another reason to eliminate "should" is that if the actuary assumes the program will continue indefinitely, the actuary may have the responsibility to note the implications of pay-as-you-go funding or limited prefunding. Disclosure as to the actuary's assumption about future plan changes, however, would be appropriate regardless of the assumption.

3.14 Measuring the Value of Accrued or Vested Benefits
Although the ASB review comments in Appendix 2 indicate a belief that the standard is clear about the possibility that RGB are not vested or accrued, we continue to think that the concepts of accrual and vesting in group benefit plans are not comparable to the well-defined concepts in the pension plan area. Before actuaries "*measure the value of any accrued or vested benefits*," actuaries should consider carefully what "accrued" and "vested" means, often in consultation with plan sponsor and their legal counsel. Therefore, we suggest the standard preface the entire section with more guidance than simply "Depending on the scope of the assignment." We also suggest some wording changes that better reflect the nature of the RGB.

In pension plans, the plan strictly defines the terms "accrued" and "vesting" or "vested" in cases in which a participant has earned benefit payments in the future on completion of a defined length of service regardless of whether they continue in employment with that employer in the future. Eligibility provisions for receiving benefits at retirement are defined separately from satisfying accrual and vesting requirements. Group benefit plans, in contrast, rarely provide for any kind of entitlement to future benefits prior to satisfying the retirement eligibility provisions of the plan while still employed by the sponsor. The question of being entitled to receive group benefits upon retirement is a matter of the eligibility provisions, not any pre-retirement satisfaction of vesting or benefit accrual.

The entirety of Section 3.14 could be deleted. If this Section 3.14 is retained, we suggest that the ASB:

- Move sub-paragraph (e) to the beginning of the section. For example the section can begin with "Depending on the scope of the assignment, the actuary should consider whether, or the extent to which, any retiree group benefits are accrued or vested. In making such determination, and subsequently measuring the value of any accrued or vested benefits as of a measurement date, the actuary should consider the following…"

- In subparagraph (a), add "employment contracts" after "plan provisions."

- Consider adding a paragraph between subparagraph (a) and (b) that says, "the meaning of accrued or vested as defined by plan sponsors and their legal counsel, and how they may differ from the meanings used by the actuarial community…"

- Consider deleting "for accrued and vested benefits" after "the extent to which participants have satisfied relevant eligibility requirements," since eligibility requirement is usually not defined for accrued and vested benefits.

- Consider deleting subparagraph (f), since plan provisions rarely address accrued benefits for RGB.

- In subparagraph (g) item 4, consider changing it to "changes in retiree group benefits eligibility or investment policy."

3.15 Market-Consistent Present Value
Regarding market-consistent present value we have the following comments:

- The definition of market-consistent present value in Section 2.20 uses the terms "actuarial present value" and "benefits that are expected to be paid in the future." In the actuarial community, "benefits expected to be paid" usually implies using best-estimate assumptions to generate benefit payments, and "actuarial present value" usually does not include risk loading or discount due to uncertainty in the benefit payments. Market pricing, however, frequently takes into account uncertainty in the benefit payments in addition to best-estimate assumptions and requires a risk loading or discount for such uncertainty. Thus, the concepts underlying these two terms are not compatible with market pricing. We suggest both terms be changed so that actuaries, following this definition, would not ignore the risk loading, or discount, the market may impose to compensate for such uncertainty in the benefit payments.

- Since uncertainty in the benefit payments (e.g., the uncertainty in the initial claims costs and medical trend) and the degree to which this is taken into account affects the calculation of market-consistent present value, we suggest that ASOP No. 6 mention them as considerations when calculating market-consistent present value. Additionally, we suggest that ASB provide general guidance on how such uncertainties from economic and demographic assumptions (in ASOP Nos. 27 and 35) should be taken into account in the market-consistent present value. For instance, medical trend or retiree medical plan

participation rate frequently are best-estimate assumptions. How should it be taken into account in the market-consistent present value? If they are to remain as best-estimates, what disclosures are needed by the actuary?

- In RGB there is frequently no data as to how the market participants price benefits. For example, how do market participants discount or load for the uncertainty in medical trend? When such an important assumption is not market-based, is the market-consistent present value concept meaningful for RGB?

- A possible alternative for the definition of "market-consistent present value" (Section 2.20) is to replace "benefits that are expected to be paid in the future" by "a set of contingent cash flows," and remove "actuarial" from "actuarial present value." The market-consistent present value concept does not need to refer to benefit payments in the definition. Separating out projected benefits from the definition of "market-consistent present value" allows the actuary to consider what characteristics and uncertainties of the cash flows are under consideration and how cash flows are tied back to the benefit plans. Valuing the cash flows may require techniques such as stochastic projections and Monte-Carlo simulations that are beyond "actuarial present value."

- In Section 3.15(b), the term "benefits earned" is not defined elsewhere. Given that RGB may not accrue or vest like pension benefits, we suggest changing "earned" to "attributable" or some other more generalized notion.

3.17 Actuarial Cost Method
See Response to general question 6.

3.18 Allocation Procedure
The requirements in Sections 3.18.1 and 3.18.2 seem to presuppose that the objective of prefunding contributions is to accumulate assets sufficient to pay future benefits. For RGB, however, this may not be the plan sponsor's objective in prefunding. If the plan sponsor does not intend to accumulate assets sufficient to pay future benefits, it would not be necessary for the actuary to make such assessments. We suggest that Sections 3.18.1 and 3.18.2 are preceded by "If the objective of prefunding is to accumulate assets sufficient to pay all future benefits, then the actuary should consider the following."

Alternatively, the definition of prefunding contributions can include a statement that the objective of prefunding is to accumulate assets sufficient to pay future benefits so that the actuary can determine whether the plan sponsor's action of setting aside funds for retiree group benefits constitutes prefunding contributions.

3.20 Volatility
Potential sources of volatility listed in the ED include plan experience compared to economic or demographic assumptions or changes in those assumptions, but this section is silent on the initial claim assumption as a source of volatility. This assumption, however, is key to the results. It is based on the actuary's judgment (not simply accepted from an insurer or administrator), and is

often subject to volatility as claim experience varies from the assumption. The volatility stemming from changes in the initial claim assumption should be emphasized by inclusion in the examples. We are aware that Section 3.21 provides guidance on the importance of evaluating expected versus actual claim experience, but that should not be a reason to avoid mention in Section 3.20.

The last paragraph in Section 3.20 mentions "selecting a range of variation in these [economic and demographic] assumption…" (Note this is the same text as ASOP 4 3.16.) A mention of a disclosure of this selected range and the rationale would be appropriate. Maybe it is implicit in Section 4.1(i), but in this case, some additional mention of disclosure might be warranted, especially as this range may limit the range of volatility shown.

3.21. Reasonableness of Results
This section appears appropriate and could have a parallel section in ASOP No. 4. In the absence of this section in ASOP No. 4 raises the question of why the RGB actuary needs to look at modeled cash flows, last measurements, etc., but not the pension actuary.

3.22 Evaluation of Assumptions and Methods
Section 3.22.3 discusses the inability to evaluate a prescribed assumption or method set by another party. With respect to development of age-adjusted claims costs for pooled plans under Section 3.7.8, can the actuary performing a valuation for a sponsor participating in the pooled plan use this exception, because evaluating the aging factors for the entire pool would require "performing a substantial amount of additional work beyond the scope of the assignment"?

Section 3.23 Reliance on a Collaborating Actuary
This section states "the actuary (or actuaries) issuing the actuarial opinion must take professional responsibility for the overall appropriateness of the analysis, assumptions, and results." This seems to imply that all signing actuaries are responsible for the entire report, including areas in which the actuary may have limited expertise (and relies on the health care actuary for the per capita rates and trend assumption). If the intended meaning is that one principal signing actuary will be responsible for the entire report, clarifying language will be helpful. It is, of course, desirable that the qualified OPEB actuary should have a good working knowledge of both pension and health care concepts, but the current standard and ED do not appear to require this level of qualification. We also note that while having the signing actuary responsible for assumptions and results is appropriate, including all "analysis" in that responsibility may be too ambiguous and unworkable, since it would include analysis never communicated in the actuarial opinion. We suggest it be only "appropriateness of assumptions and results."

Section 3.24 Use of Roll-Forward Techniques
We are somewhat concerned about this section, since roll-forwards should not be encouraged in actuarial standards and are not mentioned in ASOP No. 4 (or ASOP No. 27). The qualifying words in the first paragraph, last sentence, "is not expected to differ significantly" will be difficult to identify. While language in the first sentence checks off "appropriate for the purpose" and Section 3.24.3 indicates that appropriateness matters, the list that follows is inadequate. For example, a roll-forward may be reasonable for developing the sponsor's periodic costs for

accounting but may not be appropriate for certifying the prefunding contribution requirement. As to the placement of this section as the last item before Section 4, we suggest placing an abbreviated treatment of roll-forwards in Section 3.4 on measurement date considerations. In the parallel section in ASOP No. 4, there is commentary on adjustment of prior measurement, which seems to encompass roll-forwards, although never using the term.

Section 4. Communications and Disclosures

In Section 4.1(g), the requirement states "if hypothetical data is used, a description of the data..." This also should include a comment by the actuary about the source of the data and if the use of such data is expected to have a significant impact on valuation results. An example may be the best way to illustrate this—for example, if the date of hire is missing for a fairly small percent of the population. That can be estimated from the known data without having a material effect on the valuation results. On the other hand (and this is an area in which we could see this disclosure being applicable), suppose there is a valuation for a pooled plan but the plan does not provide data on the demographics of the population making up the pool. Under Section 3.7.8 we would be making an assumption about the demographics of the pool, which would involve using hypothetical data, would be highly subjective, and would be quite material from a valuation perspective. In such cases, it would be appropriate—and important—for the actuary to disclose the limitations caused by using hypothetical data.

In Section 4.1(i), rather than the current ED language of "a brief description of the information and analysis used in selecting…," we suggest "a brief description of the basis for each significant assumption, including, as appropriate, information and analysis used in selecting that assumption." We also note differences with the same section in ASOP No. 4.

In Section 4.1(j) and (k), although this list is not intended to be exhaustive, we suggest the addition of "plan selection/migration" to the parenthetical.

In Section 4.1(o) and (p), we discussed the implications of this on cases in which the plan sponsor is not attempting to accumulate enough assets to make benefit payments when due, which is often the case in OPEB funding. As we understand the references to Section 3.18, the requirements in (o) and (p) would apply only in cases in which the sponsor is attempting to prefund all future benefits. The sponsor's pre-funding approach needs to be described such that the user will understand the intent of the sponsor's pre-funding policy (and any limitations associated with it).

For Section 4.1(q), see earlier comments under Section 3.14 about "accrued" and "vested".

Appendix 1

Many of the comments above would affect content in this appendix. Generally, ASOPs avoid including educational material, which is often made available through practice notes. If the ASB should decide that material in the appendix of the ED would be more appropriate outside of an ASOP, our committee would welcome the opportunity to provide that information through related practice notes.

Here are some specific comments on the current appendix.

- In the paragraph immediately before the section titled "Current Practices," a reference is made to ASOP No. 4 as "an umbrella standard to tie together the applicable standards for pension plans and address overall considerations for the actuary when measuring pension obligations." The committee suggests adding the following: "This ASOP No. 6 *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Prefunding Contributions* was revised to address overall considerations for the actuary practicing in the Retiree Group Benefits area. ASOP No. 6 will govern in the event of a conflict with any of the ASOPs listed in Section 3.1 of this ASOP."

- In the section titled "Measurements Using Premium Rates," we suggest commentary be provided in the event an actuary cannot obtain the age-gender distribution from the insurance carrier that determined the premium for a group.

- We suggest deleting item (6) in the section titled "Interaction Between Trend and Plan Provisions." We repeat our concern about a similar statement in Section 3.12, and we suggest that references to modeling lifetime and other dollar maximums should not be linked to references to trend. Such references would be more appropriate in Section 3.5.1 (c).

- In the section titled, "Participant Contributions," it is noted that "If the model assumes contributions increase at the same trend as assumed for age-specific claims costs, the projected contributions will not have a constant relationship to projected claims, due to the aging of the population."

  We suggest adding the following: "When valuing a capped benefit, the actuary can evaluate how the participant (retiree) contributions are developed and how closely the sponsor adheres to the stated capped level of benefits."

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We appreciate the opportunity to provide these comments to the ASB, and we would be more than happy to discuss any of our comments and concerns with you. Thank you in advance for your consideration, and if you do have any questions, please contact David Goldfarb, the Academy's pension policy analyst, at 202.223.8196 or Goldfarb@actuary.org.

Sincerely,

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American Academy of Actuaries