ACTUARIAL STANDARDS BOARD

• SECOND EXPOSURE DRAFT •

Proposed Revision of
Actuarial Standard of
Practice No. 6

Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Prefunding Contributions

Comment Deadline:
August 30, 2013

Developed by the
Retiree Group Benefits Subcommittee of the
Actuarial Standards Board

Approved for Exposure by the
Actuarial Standards Board
March 2013

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SECOND EXPOSURE DRAFT—March 2013

March 2013

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Prefunding Contributions

FROM: Actuarial Standards Board (ASB)

SUBJ: Proposed Revision of Actuarial Standard of Practice (ASOP) No. 6

This document is a second exposure draft of a revision of ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Prefunding Contributions*.

Please review this exposure draft and give the ASB the benefit of your comments and suggestions. Each written response and each response sent by e-mail to the address below will be acknowledged, and all responses will receive appropriate consideration by the drafting committee in preparing the final document for approval by the ASB.

The ASB accepts comments by either electronic or conventional mail. The preferred form is e-mail, as it eases the task of grouping comments by section. However, please feel free to use either form. If you wish to use e-mail, please send a message to **comments@actuary.org**. You may include your comments either in the body of the message or as an attachment prepared in any commonly used word processing format. Please do not password-protect any attachments. Include the phrase “ASB COMMENTS” in the subject line of your message. Please note: Any message not containing this exact phrase in the subject line will be deleted by our system’s spam filter.

If you wish to use conventional mail, please send comments to the following address:

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

The ASB posts all signed comments received to its website to facilitate transparency and dialogue. Anonymous comments will not be considered by the ASB nor posted to the website. The comments will not be edited, amended, or truncated in any way. Comments will be posted in the order that they are received. Comments will be removed when final action on a proposed standard is taken. The ASB website is a public website and all comments will be available to the general public. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

Deadline for receipt of responses in the ASB office: **August 30, 2013**

Background

The ASB provides coordinated guidance for measuring pension and retiree group benefit obligations through the series of ASOPs listed below.

1. ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*;

2. ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Costs or Contributions*;

3. ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations*;

4. ASOP No. 35, *Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations*; and

5. ASOP No. 44, *Selection and Use of Asset Valuation Methods for Pension Valuations*.

Although the titles of ASOP Nos. 27, 35, and 44 reference Pension Valuations, they are also applicable to Retiree Group Benefits Valuations. Additional guidance is also provided in other standards, including ASOP No. 5, *Incurred Health and Disability Claims* and ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages.*

In April 2012, the ASB issued an exposure draft of ASOP No. 6:
http://www.actuarialstandardsboard.org/pdf/exposure/asop6_exposure%20draft_april_2012.pdf

Eighteen comment letters were received and reviewed:
http://www.actuarialstandardsboard.org/comments/asop06rev_comments.asp

The comment letters reflected diverse viewpoints and the Retiree Group Benefits Subcommittee found them to be helpful. The ASB thanks all those who took the time to comment.

The ASB also issued an exposure draft of ASOP No. 4 and a second exposure draft of ASOP No. 27 in January 2012. Seventeen comment letters were received on the exposure draft of ASOP No. 4 and fifteen comment letters were received on the second exposure draft of ASOP No. 27. Several commentators linked comments on ASOP No. 4 and ASOP No. 27. The Pension Committee found these comment letters to be helpful. Many of these comments are also applicable to this revision of ASOP No. 6. The ASB thanks all those who took the time to comment. The Pension Committee and the Retiree Group Benefits Subcommittee are continuing their work on several standards. The issues affecting actuaries working in the retiree group benefits area include:

- Coordinating changes to ASOP Nos. 4 and 6 so that consistent guidance is provided in areas that are common to both pension and retiree group benefits.

- Addressing economic value issues regarding both actuarial methods and actuarial assumptions, thus requiring revisions to both ASOP Nos. 6 and 27, and possibly to ASOP No. 35 as well.

- Coordinating changes to ASOP No. 35 that may be required due to changes in ASOP No. 27 so the two standards provide consistent guidance.

In January 2013, the ASB issued a second exposure draft of a revision of ASOP No. 4. The guidance in ASOP Nos. 4, 6, and 27 are intended to be coordinated. In order to help interested parties comment on the second exposure drafts of ASOP Nos. 4 and 6, the ASB felt it would be helpful to see how guidance in ASOP No. 27 has evolved through the recent exposure and comment process. The Pension Committee's current working draft of ASOP No. 27 has been posted on the ASB website at the following: http://www.actuarialstandardsboard.org/pdf/ASOP_No%2027_Working_Draft_December_2012.pdf.

The working draft of ASOP No. 27 is not being exposed for comment but does reflect guidance that the Pension Committee believes works in concert with the guidance in the second exposure drafts of ASOP Nos. 4 and 6.

Changes to ASOP No. 35 that align with a revised ASOP No. 27 are also likely to be exposed for comment after final revisions to ASOP No. 27 have been issued.

Key Changes in the Second Exposure Draft of ASOP No. 6

Some of the changes in the second exposure draft of ASOP No. 6 introduce new concepts while others are refinements to language in the first exposure draft. Readers are encouraged to review the transmittal memo to the first exposure draft of ASOP No. 6 for a discussion of all the changes introduced.

Definitions
This second exposure draft uses a **bold font** in the text of the ASOP to indicate a defined term.

Retiree Group Benefits Program
In the first exposure draft, commentators were asked whether the distinction among retiree group benefits plan, benefit plan, and optional benefits was helpful and whether it could be further clarified. In addition to the use of a bold font to indicate a defined term, the phrase "retiree group benefits plan" was revised to be "retiree group benefits program" in order to make a clearer distinction.

Pooled Health Plans
A number of commentators on the first exposure draft indicated that for small groups participating in large community rated plans the actual pool premium would be more indicative of the group's costs than costs based on the pool's age/gender claims costs and that the current ASOP was generally interpreted to permit the use of a blended premium for a true community-rated plan. Other commentators expressed some confusion with the treatment of groups that

participate in pooled health plans. They felt that it was difficult to determine when it was acceptable to use the blended premium (premiums based on active and retiree experience) and when it wasn't. The second exposure draft specifically states that the "actuary should use age-specific costs in the development of the initial per capita costs…." It goes on to say, in the section on pooled health plans, that the "actuary should reflect the full age-specific cost, including the implicit subsidy, regardless of the size of the group being valued." In other words, even community-rated plans require age rating. The only exception is if there are no age-related subsidies such as may be possible for individual Medicare Advantage plans.

In addition, as requested by commentators, this second exposure draft provides additional guidance on the derivation of age-specific costs for groups that participate in pooled health plans.

Periodic Cost and Prefunding Contribution
Several commentators expressed the opinion that the words "cost" and "contributions" were used in several different ways, which could create confusion. In addition to the use of a bold font to indicate a defined term, the defined term "cost" was replaced by "periodic cost" and the defined term "contribution" was replaced by "prefunding contribution" in order to reduce the possibility of confusion.

Funded Status
The second exposure draft keeps "funded status" as a defined term. In response to the comment letters received, guidance related to the term "fully funded" has been removed from the second exposure draft and has been incorporated in the guidance related to funded status. The proposed disclosures regarding funded status have been modified and are detailed in section 4.1(t).

Contribution Allocation Procedure Assessments and Disclosures
The disclosure language in this second exposure draft has been revised.

Types of Actuarial Present Values of Retiree Group Benefits Obligations
The Committee removed nearly all of the present value type language from the first exposure draft. The concept of a market-consistent present value remains in the second exposure draft as a defined term and with some guidance in section 3.15. The market-consistent present value language now references broad economic and demographic assumptions inherent in observable market pricing of retiree group benefits cash flows. The proposed language in section 4.1(r) requires the actuary who does determine a market-consistent present value to describe how benefit payment default risk or the financial health of the plan sponsor was reflected in any market-consistent present value of accrued or vested benefits.

Amortization
The Committee added a disclosure requirement in section 4.1(n). If the unfunded actuarial accrued liability is expected to increase at any time during the amortization period or if the unfunded actuarial accrued liability is not expected to be fully amortized, the actuary should so disclose.

Relationship between Assets and Obligations
Language in the second exposure draft has been modified in section 3.16 to make the guidance more clear on how the relationship between assets and obligations should be considered.

Coordination with ASOP No. 4
The ASB recognizes the need for better coordination between ASOP No. 4 and ASOP No. 6. The second exposure draft includes language to improve this coordination.

Request for Comments on ASOP No. 6

The ASB is issuing a revised version of ASOP No. 6 as a second exposure draft to provide members of actuarial organizations governed by the ASOPs and other interested persons an opportunity to comment.

The Retiree Group Benefits Subcommittee would appreciate comments on the proposed changes and would like to draw the readers' attention to the following areas in particular:

1. Does the use of bold font to identify defined terms improve the readability and clarity of the standard? If not, what suggestions do you have to improve the recognition of defined terms in the standard?

2. Is the revised guidance regarding pooled health plans clear, sufficient, and appropriate? If not, how should it be changed?

3. Are the revised disclosure requirements regarding funded status clear, sufficient, and appropriate? If not, how should they be changed?

4. Some disclosures now require a qualitative assessment rather than a quantitative assessment. 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?

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?

6. Section 3.13(a) of the second exposure draft of ASOP No. 4 has a somewhat less restrictive definition of a reasonable actuarial cost method than that used in section 3.17(a) of 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 ASB reviewed this draft and voted in March 2013 to approve this exposure.

Subcommittee on Retiree Group Benefits

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The ASB establishes and improves standards of actuarial practice. These ASOPs identify what the actuary should consider, document, and disclose when performing an actuarial assignment. The ASB's goal is to set standards for appropriate practice for the U.S.

<u>**SECOND EXPOSURE DRAFT—March 2013**</u>

ACTUARIAL STANDARD OF PRACTICE NO. 6

MEASURING RETIREE GROUP BENEFITS OBLIGATIONS AND DETERMINING RETIREE GROUP BENEFITS PROGRAM COSTS OR CONTRIBUTIONS

STANDARD OF PRACTICE

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

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries when performing professional services with respect to measuring obligations under a **retiree group benefits program** and determining **periodic costs** or **prefunding contributions** for such **retiree group benefits programs**. This standard provides guidance on assumptions that are specific to **retiree group benefits programs**. In addition, it addresses broader measurement issues, **cost allocation procedures**, and **contribution allocation procedures**. This standard provides guidance for coordinating and integrating all of the elements of an **actuarial valuation** of a **retiree group benefits program**.

1.2 Scope—This standard applies to actuaries when performing professional services with respect to the following tasks, in connection with a **retiree group benefits program**:

a. measurement of obligations. Examples include determinations of **funded status**, assessments of solvency upon **retiree group benefits program** termination, market measurements and measurements for use in pricing benefit provisions;

b. assignment of the value of **retiree group benefits program** obligations to time periods. Examples include **prefunding contributions**, accounting **periodic costs**, and **periodic cost** or **prefunding contribution** estimates for potential **retiree group benefits program** changes;

c. development of a **cost allocation procedure** used to determine **periodic costs** for a **retiree group benefits program**;

d. development of a **contribution allocation procedure** used to determine **prefunding contributions** for a **retiree group benefits program**;

e. determination as to the types and levels of benefits supportable by specified **periodic cost** or **prefunding contribution** levels; and

f. projection of **retiree group benefits** obligations, **retiree group benefits program periodic costs** or **prefunding contributions**, and other related measurements. Examples include cash flow projections and projections of a **retiree group benefits program's funded status**.

Throughout this standard, any reference to selecting actuarial assumptions, **actuarial cost methods**, asset valuation methods, and **amortization methods** also includes giving advice on selecting actuarial assumptions, **actuarial cost methods**, asset valuation methods, and **amortization methods**. In addition, any reference to developing or modifying a **cost allocation procedure** or **contribution allocation procedure** includes giving advice on developing or modifying a **cost allocation procedure** or **contribution allocation procedure**.

This standard highlights health and death benefits because they are the most common forms of **retiree group benefits**. This standard applies to situations involving other types of **retiree group benefits**, but does not apply to measurements of pension obligations or social insurance programs.

This standard does not require the actuary to evaluate the ability of the **plan sponsor** or other contributing entity to make **prefunding contributions** to the plan when due.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority), or for any other reason the actuary deems appropriate, the actuary should refer to section 4.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard will be effective for any actuarial work product with a **measurement date** on or after twelve months after adoption by the Actuarial Standards Board (ASB); however, if roll-forward techniques are used in the measurement, the standard is not effective until three years after the last full measurement before adoption by the ASB. Earlier adoption of this standard is encouraged.

Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice.

2.1 Actuarial Accrued Liability—The portion of the **actuarial present value of projected benefits** (and **expenses**, if applicable), as determined under a particular **actuarial cost method**, that is not provided for by future **normal costs**. Under certain **actuarial cost methods**, the **actuarial accrued liability** is dependent upon the actuarial value of assets.

2.2 Actuarial Cost Method—A procedure for allocating the **actuarial present value of projected benefits** (and **expenses**, if applicable) to time periods, usually in the form of a

normal cost and an **actuarial accrued liability**. For purposes of this standard, a pay-as-you-go method is not considered to be an **actuarial cost method**.

2.3 Actuarial Present Value—The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of actuarial assumptions with regard to future events, observations of market or other valuation data, or a combination of assumptions and observations.

2.4 Actuarial Present Value of Projected Benefits—The **actuarial present value** of benefits that are expected to be paid in the future, taking into account the effect of such items as future service, advancement in age, and expected future per capita health care costs (sometimes referred to as the present value of future benefits).

2.5 Actuarial Valuation—The measurement of relevant **retiree group benefits** obligations and, when applicable, the determination of **periodic costs** or **prefunding contributions**.

2.6 Adverse Selection—Actions taken by one party using risk characteristics or other information known to or suspected by that party that cause a financial disadvantage to the **retiree group benefits program** (sometimes referred to as antiselection).

2.7 Amortization Method—A method under a **contribution allocation procedure** or **cost allocation procedure** for determining the amount, timing, and pattern of recognition of the unfunded **actuarial accrued liability**.

2.8 Benefit Options—Choices that a **benefit plan member** may make under a **benefit plan** including basic coverages (for example, choice of medical plans) and additional coverages (for example, contributory dental coverage).

2.9 Benefit Plan—An arrangement providing medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) to **participants** of the **retiree group benefits program**, whether on a reimbursement, indemnity, or service benefit basis.

2.10 Benefit Plan Member—An individual covered by a **benefit plan**.

2.11 Contingent Participant—An individual who is not currently a **participant** but who may reasonably be expected to become a **participant** through his or her future action.

2.12 Contribution Allocation Procedure—A procedure that uses an **actuarial cost method** to determine the periodic **prefunding contribution** for prefunding a **retiree group benefits program**. It may produce a single value, such as **normal cost** plus an amortization payment of the unfunded **actuarial accrued liability**, or a range of values. This term does not relate to the process of determining the **participant contribution**.

2.13 Cost Allocation Procedure—A procedure that uses an **actuarial cost method** to determine the **periodic cost** for a **retiree group benefits program** (for example, the

procedure to determine the net periodic postretirement benefit **periodic cost** under accounting standards).

2.14 Covered Population—Active and retired **participants**, participating **dependents** and **surviving dependents** of **participants** who are eligible for benefit coverage under a **retiree group benefits program**. The **covered population** may also include **contingent participants**.

2.15 Dedicated Assets—Assets designated for the exclusive purpose of satisfying the **retiree group benefits program** obligations. Examples include the following:

a. life insurance policies held by the **plan sponsor** to cover some of the **plan sponsor**'s retired **participant** death benefits;

b. welfare benefit trusts (for example, voluntary employees' beneficiary associations (VEBAs));

c. Internal Revenue Code section 401(h) accounts in a qualified pension plan; and

d. Internal Revenue Code section 115 trusts sponsored by governmental entities for **retiree group benefits**.

2.16 Dependents—Individuals who are covered under a **retiree group benefits program** by virtue of their relationship to an active or retired **participant**.

2.17 Expenses—Administrative or investment expenses borne or expected to be borne by the **benefit plan** or **retiree group benefits program**.

2.18 Funded Status—Any comparison of a particular measure of plan assets to a particular measure of plan liabilities.

2.19 Immediate Gain Actuarial Cost Method—An **actuarial cost method** under which actuarial gains and losses are included as part of the unfunded **actuarial accrued liability** of the **retiree group benefits program**, rather than as part of the **normal cost** of the **retiree group benefits program**.

2.20 Market-Consistent Present Value—An **actuarial present value** that is consistent with the price at which benefits that are expected to be paid in the future would trade in an open market between a knowledgeable seller and a knowledgeable buyer. The existence of a deep and liquid market for **retiree group benefits program** cash flows or for entire **retiree group benefits programs** is not a prerequisite for this present value measurement.

2.21 Measurement Date—The date as of which the values of the **retiree group benefits** obligation and, if applicable, the assets are determined (sometimes referred to as the valuation date).

2.22 Measurement Period—The period subsequent to the **measurement date** during which the chosen assumptions or other model components will apply. The period often ends at the time the last **participant** is expected to receive the final benefit.

2.23 Medicare Integration—The approach to determining the portion of a Medicare-eligible claim that is paid by the health plan, after adjustment for Medicare reimbursements for the same claim. Types of **Medicare integration** include the following:

a. Full Coordination of Benefits (Full COB)—The health plan pays the difference between total eligible charges and the Medicare reimbursement amount, or the amount it would have paid in the absence of Medicare, if less.

b. Exclusion—The health plan applies its normal reimbursement formula to the amount remaining after Medicare reimbursements have been deducted from total eligible charges.

c. Carve-Out—The health plan applies its normal reimbursement formula to the total eligible charges, and then subtracts the amount of Medicare reimbursement.

2.24 Normal Cost—The portion of the **actuarial present value of projected benefits** (and **expenses**, if applicable) that is allocated to a period, typically twelve months, under the **actuarial cost method**. Under certain **actuarial cost methods**, the **normal cost** is dependent upon the actuarial value of assets.

2.25 Normative Database—Data compiled from sources that are expected to be typical of the **retiree group benefits program**, rather than from plan-specific experience. Examples of **normative databases** include published mortality and disability tables, proprietary **premium** rate manuals, and experience on similar **retiree group benefits programs**.

2.26 Participant—An individual who (a) is currently receiving benefit coverage under a **retiree group benefits program** or (b) is reasonably expected to receive benefit coverage under a **retiree group benefits program** upon satisfying its eligibility and participation requirements.

2.27 Participant Contributions—Payments made by a **participant** to support a **retiree group benefits program**.

2.28 Periodic Cost—The amount assigned to a period using a **cost allocation procedure** for purposes other than funding. This may be a function of plan obligations, **normal cost**, **expenses**, and assets. In many situations, **cost** is determined for accounting purposes.

2.29 Plan Sponsor—An organization that establishes or maintains a **retiree group benefits program**. Examples of **plan sponsors** include employers and Taft-Hartley Boards of Trustees.

2.30 Pooled Health Plan—A health **benefit plan** in which the claim cost portion of its **premium** rates is based at least in part on the claims experience of groups other than the group being valued. The use of projection assumptions that are not based solely on the claims experience of the group being valued (for example, the health care cost **trend** rate assumption) would not by itself create a **pooled health plan.**

2.31 Prefunding Contribution—A potential payment to prefund the **retiree group benefits program**, other than by the **participant**, determined by the actuary. It may or may not be the amount actually paid by the **plan sponsor** or other contributing entity.

2.32 Premium—The price charged by a risk-bearing entity, such as an insurance or managed care company, to provide risk coverage.

2.33 Prescribed Assumption or Method Set by Another Party—A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards gives the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method set by a governmental entity for a **retiree group benefits program** that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is deemed to be a **prescribed assumption or method set by another party**.

2.34 Prescribed Assumption or Method Set by Law—A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be acceptable by applicable law (statutes, regulations, and other legally binding authority). For this purpose, an assumption or method set by a governmental entity for a **retiree group benefits program** that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is not deemed to be a **prescribed assumption or method set by law**.

2.35 Retiree Group Benefits—Medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) that are provided during retirement to a group of individuals, on account of an employment relationship.

2.36 Retiree Group Benefits Program—The program specifying **retiree group benefits**: including eligibility requirements, **participant contributions**, and the design of the benefits being provided.

2.37 Spread Gain Actuarial Cost Method—An **actuarial cost method** under which actuarial gains and losses are included as part of the current and future **normal costs** of the **retiree group benefits program**.

2.38 Stop-Loss Coverage—Insurance protection providing reimbursement of all or a portion of claims in excess of a stated amount. **Stop-loss coverage** may be either individual or aggregate (sometimes referred to as excess loss coverage).

2.39 Surviving Dependent—A **dependent** who qualifies as a **participant** under the **retiree group benefits program** following the death of the associated **participant**.

2.40 Trend—A measure of the rate of change, over time, of the per capita expected benefit payments.

Section 3. Analysis of Issues and Recommended Practices

3.1 Overview—Measuring **retiree group benefits** obligations and determining **retiree group benefits program periodic costs** or **prefunding contributions** are processes in which the actuary may be required to make judgments or recommendations on the choice of actuarial assumptions, **actuarial cost methods**, asset valuation methods, and **amortization methods**.

The actuary may have the responsibility and authority to select some or all actuarial assumptions, **actuarial cost methods**, asset valuation methods, and **amortization methods**. In other circumstances, the actuary may be asked to advise the individuals who have that responsibility and authority. In yet other circumstances, the actuary may perform actuarial calculations using **prescribed assumptions or methods set by another party** or **prescribed assumptions or methods set by law**.

Other actuarial standards of practice provide guidance on asset valuation methods (ASOP No. 44, *Selection and Use of Asset Valuation Methods for Pension Valuations*), and actuarial assumptions and procedures (for example, ASOP No. 5, *Incurred Health and Disability Claims*; ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*; ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations;* and ASOP No. 35, *Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations*) not specifically addressed in this standard.

ASOP No. 6 addresses broader measurement issues including **cost allocation procedures** and **contribution allocation procedures**, and provides guidance for coordinating and integrating all of these elements of an **actuarial valuation** of a **retiree group benefits program**. In the event of a conflict between the guidance provided in ASOP No. 6 and the guidance in any of the aforementioned ASOPs, ASOP No. 6 governs.

3.2 General Procedures—When measuring **retiree group benefits** obligations and determining **retiree group benefits program periodic costs** or **prefunding contributions**, the actuary should perform the following general procedures:

a. identify the purpose of the measurement (section 3.3);

b. identify the **measurement date** (section 3.4);

c. develop a model that reasonably represents the following:

   1. known provisions of the **retiree group benefits program** as they currently exist and as they are anticipated to change in the **measurement period**, as appropriate for the purpose (section 3.5);

   2. the current population covered by the benefits in question, as appropriate for the purpose (section 3.6); and

   3. current benefit costs (sections 3.7 and 3.8).

d. evaluate the quality and consistency of data used in construction of the model, and make appropriate adjustments (section 3.9);

e. identify any significant administrative inconsistencies and make appropriate adjustments in the model or disclose the unresolved inconsistency (section 3.10);

f. obtain other information from the principal (section 3.11);

g. select actuarial assumptions (section 3.12);

h. evaluate **retiree group benefits** assets (section 3.13);

i. consider how to measure accrued or vested benefits, if applicable (section 3.14);

j. consider how to measure **market-consistent present values**, if applicable (section 3.15);

k. reflect how **retiree group benefits program** or **plan sponsor** assets as of the **measurement date** are reported (section 3.16);

l. select an **actuarial cost method**, if applicable (section 3.17);

m. select a **cost allocation procedure** or **contribution allocation procedure**, if applicable (section 3.18);

n. assess the implication of the **contribution allocation procedure** or contributions set by contract or law, if applicable (section 3.18);

o. consider the use of approximations and estimates (section 3.19);

p. consider sources of significant volatility (section 3.20);

q. review and test the results of the calculations for reasonableness (section 3.21); and

r. evaluate **prescribed assumptions and methods set by another party**, if applicable (section. 3.22).

3.3 Purpose of Measurement—When measuring **retiree group benefits** obligations and determining **retiree group benefits program periodic costs** or **prefunding contributions**, the actuary should take into account the purpose of the measurement. Examples of measurement purposes are accounting costs, contribution requirements, benefit provision pricing, comparability assessments, **retiree group benefits program** settlement, **funded status** assessments, market value assessments and **plan sponsor** mergers and acquisitions.

3.3.1 Anticipated Needs of Intended Users—The actuary should consider the anticipated needs of different intended users. For example, some intended users may be interested in **prefunding contribution** requirements while others may be interested in evaluating benefit security. Some intended users may be interested in comparing **retiree group benefits** obligations among different **plan sponsors** while others may be interested in comparing a **plan sponsor's retiree group benefits** obligation to the **plan sponsor's** other financial obligations.

3.3.2 Projection or Point-in-Time—The actuary should consider whether assumptions or methods need to change for measurements projected into the future compared to point-in-time measurements.

3.3.3 Risk or Uncertainty—Consistent with section 3.4.1 of ASOP No. 41, *Actuarial Communications*, the actuary should consider the risk or uncertainty inherent in the measurement assumptions and methods and how the actuary's measurement treats such risk or uncertainty.

3.4 Measurement Date Considerations—When measuring **retiree group benefits** obligations and determining **retiree group benefits program periodic costs** or **prefunding contributions** as of a **measurement date**, the actuary should consider the following:

3.4.1 Information as of a Different Date—The actuary may estimate asset and **participant** information at the **measurement date** on the basis of information as of a different date. In these circumstances, the actuary should make appropriate adjustments to the data. Alternatively, the actuary may calculate the obligations as of a different date and then adjust the obligations to the **measurement date** (see section 3.24 for additional guidance). In either case, the actuary should determine that any such adjustments are reasonable in the actuary's professional judgment, given the purpose of the measurement.

3.4.2 Events after the Measurement Date—Events known to the actuary that occur subsequent to the **measurement date** and prior to the date of the actuarial communication need not be reflected in the measurement unless the purpose of the measurement requires the inclusion of such events.

3.5 Modeling Provisions of Retiree Group Benefits Programs—In modeling the known provisions of the **retiree group benefits program**, the actuary should give appropriate consideration to the written plan documents, historical practices, administrative practices, governmental programs, communications to participants, and, depending on the purpose of the measurement, **plan sponsor** decisions and expected future **benefit plan** designs, as described in sections 3.5.1 and 3.5.2 below.

3.5.1 Components of the Modeled Retiree Group Benefits Program—The actuary should incorporate the significant elements of the known provisions of the **retiree group benefits program** into the model. Factors that the actuary should consider include:

a. Covered Benefits—Covered benefits may include reimbursements for covered services, fixed-dollar payments for covered events (such as death benefits), and other monetary benefits (such as Medicare **premium**s or defined dollar benefits).

b. Eligibility Conditions—All relevant eligibility conditions should be considered. These include, but are not limited to, conditions related to age, service, date of hire, employment classification, and participation in other benefit programs, such as Medicare or a pension plan.

c. Plan Benefit Limitations, Exclusions, and Cost-Sharing Provisions—Benefit limitations and exclusions (such as a lifetime maximum benefit in a medical plan) may affect plan payments, and such effects will change over time. The actuary should also consider participant cost-sharing provisions (such as deductibles, copayments, coinsurance, and out-of-pocket limits).

d. Participant Contributions—Many **retiree group benefits programs** require contributions from **participants** as a condition for their continued eligibility for coverage. The actuary should reflect the **participant contributions** in the model, as discussed below. In addition, **participant contributions** may affect both participation rates and **adverse selection**, thus affecting per capita claim costs.

1. Participant Postretirement Contribution Formula—In modeling the **retiree group benefits program**, the actuary should reflect the actual level of **participant contributions**. There is a wide variation in how **participant contributions** are determined (examples include flat amounts, amounts based on credited service at retirement, amounts based on claims costs for retired **participants**, and amounts based on combined costs for all **participants**).

2. Participant Postretirement Contribution Reasonableness—The actuary should compare for reasonableness the stated basis for **participant contributions** to what has been implemented. See section 3.10, Administrative Inconsistencies, for further guidance.

3. Preretirement Active Employee Contributions—A **retiree group benefits program** may require active employees to make preretirement contributions in order to earn eligibility for **retiree group benefits**. The actuary should consider how this requirement may affect future benefit eligibility and **plan sponsor periodic costs** or **prefunding contributions**.

4. Contributions as Defined by Limits on Plan Sponsor Costs—Some **retiree group benefits programs** place an upper limit on the **plan sponsor periodic cost** or **prefunding contribution** by designating a maximum average per capita amount to be paid in a year. These limits are commonly known as "caps." Other plans limit total **plan sponsor periodic cost** or **prefunding contribution** in any current or future period. The actuary should consider whether the limits will have a significant impact on the obligation. The actuary should consider how the **plan sponsor** is expected to implement these limits, when these limits are expected to be reached, their impact on **participant contributions**, and, thus, future participation, and, if appropriate, incorporate these limits into the modeled **retiree group benefits program**.

e. Payments from Other Sources—The cost of coverage in some **retiree group benefits programs** is partially or completely funded with payments from third party sources such as retiree medical savings accounts, terminal leave balances, or non-employer funding sources. The actuary should consider payments from other sources when measuring a **retiree group benefits program**'s obligations.

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.

g. Benefit Options—The actuary should consider the effect of **benefit options**, which may require additional **participant contributions** and may also result in additional **plan sponsor periodic costs** or **prefunding contributions**.

h. Anticipated Future Changes—For most measurement purposes, the actuary should consider only changes that have been communicated to plan **participants**, changes that result from the continuation of a historical

pattern, or changes that are required by law to be implemented within a specified period. However, depending upon the purpose of the measurement, the actuary may take into account future changes that the **plan sponsor** has requested the actuary to evaluate. The actuary should disclose that such an approach has been used (see section 4.1(d)).

3.5.2 Historical Practices—When appropriate, the actuary should consider historical practices in developing the model. Historical practices include the following:

a. Claims Payment Practices—If the actuary becomes aware of a significant inconsistency between administrative practice and plan documents, stated **plan sponsor** policies, **participant** communications, or applicable law (statutes, regulations, and other legally binding authority), the actuary should follow the guidance in section 3.10.

b. Patterns of Plan Changes—The actuary should consider the **plan sponsor**’s historical practices or patterns of regular changes in the **retiree group benefits program** (such as benefits, cost-sharing, and **participant contribution** levels). Depending on the purpose of the measurement, the continuation of such past practices or patterns may warrant inclusion in the model. The actuary should consider whether a limit or cap on **plan sponsor periodic costs** or **prefunding contributions** would be effective in light of historical practices such as past increases in the limit.

c. Governmental Programs—The actuary should consider the historically enacted legislative and administrative policy changes in Medicare and other governmental programs to the extent that the **retiree group benefits program** integrates with them.

3.5.3 Reviewing the Modeled Retiree Group Benefits Program—The actuary should consider whether the model continues to reflect actual known provisions and practices of the **retiree group benefits program**. If the administration of the plan has significantly deviated from the **retiree group benefits program** as modeled, the actuary should consider whether this deviation is temporary or should be treated as a permanent change in the **retiree group benefits program**.

3.5.4 Measurement Results by Category—The actuary should consider whether the measurement results need to be examined by category (for example, medical vs. dental; union vs. nonunion; retiree vs. **dependent**; **retiree group benefits program** paid vs. **participant** paid; and payments before Medicare eligibility age vs. payments after Medicare eligibility age). This examination may be necessary as a result of the nature of the assignment or in order to assess the reasonableness of the measurement model.

3.6 Modeling the Covered Population—The projected size and demographic composition of the **covered population** has a significant impact on the measurement. The actuary should

consider the need to model variations in the **covered population** (for example, when benefit eligibility varies by type of coverage). Open group measurements should be used when appropriate for the purpose of the measurement. These issues are discussed below.

3.6.1 Census Data—The actuary should collect sufficient census data in order to make a reasonable estimate of the obligation. The actuary may use individual census data or grouped data, as appropriate for the measurement. Data for retirees or other former employees who decline and terminate coverage may be needed to establish acceptance, lapse, and re-enrollment rates.

3.6.2 Employees Currently Not Accruing Benefits—Depending on the purpose of the measurement, the actuary should consider whether some or all of the employees currently not accruing service toward **retiree group benefits** eligibility may accrue service in the future and whether some or all of the employees currently not making required preretirement **participant contributions** may contribute in the future, and make appropriate allowance for them in the modeled population.

3.6.3 Contingent Participants—The actuary should examine the census data and take appropriate measures to reflect individuals who are not current **participants**, but may reasonably be expected to become **participants** through their future actions. For example, the actuary may need to make a re-enrollment assumption in situations where retirees or other former employees have opted out of medical coverage at retirement or termination, but may later elect to resume or begin coverage.

3.6.4 Dependents and Surviving Dependents of Participants—The actuary should include in the modeled population participating **dependents** and **surviving dependents** who are eligible for coverage. In doing so, the actuary should take into account that the **retiree group benefits program**'s eligibility conditions and benefit levels for **dependents** and **surviving dependents** may differ from the plan's eligibility conditions and benefit levels for retired **participants**. Benefit coverage for the **dependent** of a retired **participant** may continue subject to that **dependent** contributing to the plan, may continue for a limited period (for example, until Medicare eligibility, one year after the death of the retired **participant**, or a limiting age), or may cease when the retired **participant** dies.

The actuary should generally model **dependents** (other than dependent children) separately from retired **participants** because of differences in the timing of Medicare eligibility and in mortality between the retired **participant** and the **dependent**. For dependent children (including disabled adult dependent children), the actuary should consider whether the obligation related to dependent children is significant and model them appropriately. For example, for **retiree group benefits programs** that have liberal early retirement eligibility conditions, dependent children coverage can significantly increase the overall number of **participants** and, therefore, have a significant effect on the size of the **covered population**.

3.6.5 Appropriateness of Pension Plan Data—**Plan sponsors** that do not maintain separate **retiree group benefits program** databases may furnish pension plan data to represent the **covered population** of the **retiree group benefits program**. In such cases, the actuary should make appropriate adjustments. Examples of the types of adjustments that may be required are discussed below.

a. Retirees Covered by the Retiree Group Benefits Program but Not Receiving Pension Benefits—Former employees may be **participants** in the **retiree group benefits program**, but may no longer be participants in the pension plan (such as employees who received lump-sum pension payments). **Dependents** and **surviving dependents** of retired **participants** may be eligible for the **retiree group benefits program**, but may not be in the pension plan census data.

b. Retirees Receiving Pension Benefits but Not Covered by the Retiree Group Benefits Program—Retirees may be participants in the pension plan, but may not be covered by the **retiree group benefits program** (such as employees who terminated with vested pension benefits now in payment status). Employees may be eligible for pension benefits upon retirement or disability, but may not satisfy the eligibility conditions of the **retiree group benefits program** or may have waived coverage for certain or all of the underlying **retiree group benefits**.

c. Provisions Affecting Certain Employees—The pension plan may be frozen for a certain group of employees or may exclude employees due to age or service eligibility requirements, which might not affect their eligibility for the **retiree group benefits program**.

3.6.6 Use of Grouping—The actuary may use grouping techniques for modeling the population when, in the actuary's judgment, grouping is not expected to significantly affect the measurement results. One such technique is to group **participants** based on common demographic characteristics (for example, age and service), where the obligation for each **participant** in the group is expected to be similar for commonly grouped individuals.

Another technique is to group health plans with similar expected costs and features. A **retiree group benefits program** with multiple health plan designs (for example, through various collective bargaining agreements) may not require separate measurement for each individual health plan. Under such circumstances, the actuary, after evaluating the eligibility conditions and range of benefits provided, may decide it is appropriate to combine health plans that have similar expected costs and group the **covered populations** of those health plans. The actuary should disclose such combining of health plans and grouping of populations (see section 4.1(i)).

3.6.7 Hypothetical Data—When appropriate, the actuary may prepare measurements based on assumed demographic characteristics of current or future plan **participants**.

3.7 Modeling Initial Per Capita Health Care Costs—The actuary should develop assumed per capita health care costs to be the basis of the initial annual benefit costs for estimating the future health care obligations. In the actuarial development of health care costs, health plan experience is generally considered the best predictor of future claims experience, preferable to sole reliance on normative claims databases or other measures. Therefore, preferred methods involve development of annual per capita health care costs from the claims experience of the health plan when that experience is sufficiently credible. In the absence of credible health plan experience data, the actuary may use other methods (such as methods that use **premium** rates and normative claims databases) to develop the per capita costs.

The process of setting the per capita health care costs generally involves (a) quantifying aggregate claims costs; (b) quantifying a measure of exposure to risk, usually the count of individuals who were eligible for the health plan during the period the claims were incurred; and (c) applying other information such as **normative databases** and **premium** rates as appropriate.

Multiple initial per capita health care costs may be appropriate due to the modeling of known health plan and **participant contribution** provisions (section 3.5), demographic factors influencing claims, and claims experience (for example, different rates by gender, healthy vs. disabled, retired **participants** vs. **dependents**).

The actuary should document the methods and procedures followed in developing the initial per capita health care costs, such that another actuary qualified in this practice area could assess the reasonableness of the initial per capita health care costs. The actuary should also document any significant actuarial judgments applied during the modeling process.

The sections that follow address aspects of setting the per capita health care costs that are particularly important when projecting benefit costs for a long period. The actuary should consider the following elements.

3.7.1 Net Aggregate Claims Data—In most cases, the actuary's objective is the development of a net incurred claims rate. The actuary should, however, consider the factors involved in distinguishing net claims from gross claims and incurred claims from paid claims, as discussed below.

a. Paid Claims—Aggregate claims data received by the actuary will usually be grouped by the dates of payment, not by the dates on which claims were incurred. The actuary should analyze the data for the likely difference between the level of paid claims for a period and the level of incurred claims for the same period. When the differences are significant,

the actuary should make an adjustment, either to the historical paid claims or to the initial claims assumption, to account for the likely future level of claims activity.

b. Gross Claim Components—Aggregate claims data received by the actuary may show only net payments or may include cost-sharing components (such as deductibles and copayments), reimbursements, costs not covered, or other elements of gross claims. The actuary may determine the initial claims rate assumption from the net payments or the gross amounts.

3.7.2 Exposure Data—In developing an initial per capita health care rate, the actuary should obtain exposure data for the same time periods and population as the claims experience data that will be used. Since exposure data are historical in nature, the exposure data typically will be different from the census data used in modeling the future **covered population**. If the differences are significant, the actuary should review the data sets for consistency (see section 3.9).

Segmenting the exposure data by age and gender or by retired **participant** vs. **dependent** may be appropriate. The actuary should either obtain information to segment the population or employ reasonable assumptions as appropriate.

3.7.3 Use of Multiple Claims Experience Periods—The actuary should consider the use of multiple claims experience periods and adjust the experience of the various periods to comparable bases as described in sections 3.7.9, 3.7.10, 3.7.11, and 3.7.12. When combining multiple experience periods, the actuary should consider the applicability of each period based upon elapsed time and changes required to adjust to comparable bases.

The actuary may consider smoothing the results to account for historical irregularities. The actuary may weight the experience periods as appropriate.

3.7.4 Credibility—When data are not available or fully credible the actuary should make use of relevant **normative databases** or active plan experience on the same group adjusted for age and expected differences in such items as utilization and plan design. The actuary may use these supplementary data and professional judgment to validate, adjust, or replace the plan experience data.

ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages,* provides guidance to the actuary when assigning credibility to sets of experience data.

3.7.5 Use of Premium Rates—Although an analysis of the actual claims experience is preferable when reasonably possible, the actuary may use **premium** rates as the basis for initial per capita costs, with appropriate analysis and adjustment for the **premium** rate basis. The actuary who uses **premium** rates for this purpose should adjust them for changes in benefit levels, **covered population**, or **retiree group**

benefits program administration. The actuary should also make the appropriate adjustments to determine the age-specific costs (see sections 3.7.7 and 3.7.8).

If **premium** rates, adjusted or unadjusted, are used as the basis for initial per capita costs in the measurement, the actuary should make an appropriate disclosure and consider the factors described in other paragraphs of section 3.7.

3.7.6 Impact of Medicare and Other Offsets—When Medicare is the primary payer and has a significant impact on the per capita health care costs, the actuary should develop separate costs for Medicare-eligible participants. Such costs should reflect the health plan's **Medicare integration** approach or how the health plan supplements Medicare. The actuary should consider using separate per capita health care costs for those health plan members who are not or will not become eligible for Medicare due to exemptions for certain governmental entities. The actuary should consider the proportions of retired **participants** and their **dependents** that may be eligible for Part A and not for Part B due to non-payment of the **premium**. The actuary should also adjust for other offsets, such as workers' compensation and auto insurance, if their impact is considered to be significant.

The actuary should consider whether there is a significant inconsistency between the **Medicare integration** approach being applied by the claims administrator and representations to the actuary of the terms of the health plan. See section 3.10 for further guidance.

Depending on the purpose of the measurement, the actuary should consider whether it is appropriate to reflect reimbursements or other payments from the Medicare system (for example, the retiree drug subsidies for **plan sponsors** and direct subsidies for Part D plans).

The actuary should be aware of any significant changes to Medicare and other governmental programs that may have affected historical data being used in the measurement and make adjustments to that data as necessary to fit the purposes of the measurement.

3.7.7 Age-Specific Costs—Various factors influence the magnitude of costs for the group being valued, often including the ages and other characteristics of the health plan members. In general, for health coverage, benefit costs vary by age.

Therefore, as appropriate, the actuary should use age-specific costs in the development of the initial per capita costs and in the projection of future health plan costs.

Any age ranges used should not be overly broad. The relationship between the costs at various ages is an actuarial assumption that may be based on **normative databases**.

3.7.8 Pooled Health Plans (including Community Rated Plans)—If the group being valued participates in a **pooled health plan**, additional analysis relating to age-specific costs may be needed. For example, if the **pooled health plan** comingles the experience of active and retired individuals, and the **pooled health plan**'s **premium** rate for non-Medicare retirees does not reflect their full age-specific cost, the **pooled health plan**'s active rates include an implicit subsidy for the non-Medicare retirees. The actuary should reflect the full age-specific cost, including the implicit subsidy, regardless of the size of the group being valued.

A **pooled health plan** may base its **premiums** for participating groups, in whole or in part, on the claims, demographics, or other risk factors of the total population of the **pooled health plan**. To the extent the **premiums** are based on the demographics of the total population of the **pooled health plan**, and not adjusted by the demographics of the group under consideration, the actuary performing a **retiree group benefits actuarial valuation** for a group should use age-specific costs based upon the **pooled health plan**'s total age distribution and the **pooled health plan**'s total expected claims costs or **premium** equivalent rather than based on the group's own age distribution and its own expected claims costs or **premium** equivalent. If, however, the **premiums** are explicitly based, in part, on the composition of the group under consideration, the actuary should take into account the distribution of the considered group's members by age, or by age and gender, to the extent appropriate. The actuary may base the age-specific costs for the group being valued on a distribution table for the total number of covered health plan members by age, or by age and gender, provided by the **pooled health plan**. If the 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 sources relevant to the plan of benefits covering the members of the group being valued.

In some very limited cases, the use of the **pooled health plan**'s **premium** rate may be appropriate without regard to adjustments for age as long as there are no age-related implicit subsidies. For example, this approach may be appropriate for individual Medicare Advantage plans because Medicare rules dictate that these individual **premium** rates not vary by age. However, the actuary should reflect aging for a Medicare Advantage plan that is an employer group waiver plan because its costs are based on its own experience.

3.7.9 Adjustment for Benefit Plan Design Changes—The actuary should adjust the claims costs to reflect significant differences, if any, between the **benefit plan** designs in effect for the experience period and those in effect during the initial year of the **measurement period**. Where significant, the impact of changes in other provisions of the **retiree group benefits program** (for example, **participant contributions**) should be reflected.

3.7.10 Adjustment for Administrative Practices—Changes in administrative practices affect how costs emerge. The actuary should make appropriate provisions in the model for changes in administrative matters such as the following:

a. Claims Adjudication—The actuary should consider how overall costs and utilization rates may be influenced by the method by which enrollees and providers submit claims (for example, provider electronic submission vs. enrollee paper submission of claims).

b. Enrollment Practices—The actuary should consider the effect enrollment practices (for example, the ability of **participants** to drop in and out of a health plan) have had on health care costs.

3.7.11 Adjustment for Large Individual Claims—The actuary should recognize the significance that large claims may have with respect to claims experience and consider whether adjustments are appropriate. When data are relevant and available, the actuary should review the frequency and size of large claims and consider whether the prevalence of large claims is expected to be significantly different in the future. Future periods may have a higher or lower incidence of such claims than past experience periods under examination. The actuary should consider whether adjustments should be made to reflect annual or lifetime maximums. The actuary should review both **stop-loss coverage** and other large claims, as described below:

a. Stop-Loss Coverage—The actuary should consider the financial impact of stop-loss insurance in all projections.

b. Other Large Claims—The actuary should also consider large claims that may be below the **stop-loss coverage** level.

3.7.12 Adjustment for Trend—When adjusting the claims experience during earlier periods to the initial year of the measurement, the actuary should reflect the effect of **trend** that has occurred between those earlier claim periods and the initial year of the measurement. These adjustments of the initial per capita health care rate may reflect experience from outside the health plan.

The actuary should consider using separate **trend** rates for major cost components (for example, medical, drugs, and health plan administration.

3.7.13 Adjustment When Plan Sponsor is Also a Provider—The **plan sponsor** may also be a provider under the plan, as in cases where the **plan sponsor** is a hospital, medical office, clinic, or other health care provider. In these situations, the **plan sponsor** pays itself, in effect, for services it provides its own members. Therefore, the actuary should analyze the charges incurred and reimbursements received by such **plan sponsor**, and make appropriate adjustments in the measurement model to properly reflect the underlying transactions.

3.7.14 Use of Other Modeling Techniques—Health care costs may be modeled and projected using techniques other than those mentioned above. When using an alternative approach, the actuary should disclose the method used and comment on its applicability (see section 4.1(l)). Examples of alternative approaches include models that project a distribution of expected claims with an associated probability distribution and models that assign different claims costs for the last year of life.

3.7.15 Administrative Expenses—In addition to the cost of claims, the **plan sponsor** is usually responsible for the cost of administering the **retiree group benefits program**. The actuary should consider administrative **expenses** when performing the measurement. The actuary may model administrative **expenses** in various ways. For example, administrative expenses may be included in claims costs or expressed on a per capita basis, as a percentage of claims, or as fixed amounts.

3.8 Modeling the Cost of Death Benefits—Death benefits may be provided directly by the **plan sponsor** upon the death of a retired **participant** or may be paid by an insurance company through a life insurance program. The life insurance program may be either participating or nonparticipating with respect to policy dividends. The actuary should appropriately reflect the financial arrangement through which the benefits are provided, including dividends, **participant contributions**, carrier administrative **expenses**, and risk charges.

When selecting assumptions and measurement methods regarding death benefits, the actuary should consider that the actual cost of life insurance varies by age, but the insurance rates paid by the **plan sponsor** may not. The actuary should reflect appropriate costs by age in the projection model.

3.9 Model Consistency and Data Quality—The actuary should review the modeled plan provisions of the **retiree group benefits program**, **covered population**, per capita health care costs, and death benefit costs as a whole to evaluate their consistency. The actuary should evaluate the relevancy of any data received and the significance of all data used for actuarial purposes. ASOP No. 23, *Data Quality*, provides guidance on selecting and reviewing data and making appropriate disclosures regarding the data. The actuary should also take the following steps when reviewing the data:

3.9.1 Coverage and Classification Data—The actuary should consider the importance of coverage distinctions (such as HMO vs. PPO) and classification distinctions (such as hourly vs. salaried, or benefits that vary among different groups of retired **participants)** that result in variations in the benefit availability among **participants**. The actuary should consider whether such differences are significant enough to require further refinement of the model. The actuary should document the coverage and classification distinctions incorporated in the model.

3.9.2 Consistency—If the actuary finds data elements that appear to be significantly inconsistent with known plan provisions of the **retiree group benefits program**, other data elements, or data used for prior measurements, the actuary should take appropriate steps to address such apparent inconsistencies as discussed below. To the extent that significant inconsistencies cannot be reconciled, the actuary should disclose them (see section 4.1(v)).

a. Retiree Group Benefits Program Operations—If the actuary becomes aware of a significant inconsistency between administrative practice and plan documents, stated **plan sponsor** policies, **participant** communications, or applicable law (statutes, regulations,and other legally binding authority), the actuary should follow the guidance in section 3.10.

b. Medicare-Related Data—The actuary should make and document appropriate adjustments if data concerning Medicare eligibility and age are determined to be inaccurately or inconsistently coded for either claims or **covered population**.

c. Demographic Distinctions—The actuary should consider demographic breakdowns (such as age, gender, geography, and hourly/salaried classifications), which may reveal results that are inconsistent with prior data or the actuary's prior expectations.

3.9.3 Sources of Data—The actuary should consider the various types and sources of data available for the **covered population**, for the coverage and classification of **participants**, and for benefit costs, as discussed below:

a. Census Data—In most cases, the actuary will be supplied with eligibility and demographic information about **participants** in the **retiree group benefits program**. A **participant** census used for underwriting or pension purposes may contain useful information about the **covered population**. The actuary should determine whether these sources represent **retiree group benefits program** participation with sufficient accuracy (see sections 3.6.5 and 3.7.2) and, if not, seek more accurate census information. The actuary should review coverage and classification information for **dependents** and **surviving dependents** because of the impact they may have on the results of the measurement.

b. Claims Payment Data—Various sources of data are available for establishing per capita costs, including normative claims databases and experience data specific to the **benefit plan**. The actuary should review plan experience relative to normative ranges of value, but also recognize the legitimacy of the **benefit plan** experience, to the extent it is credible, and the limitations of applying normative data to an unrelated situation. ASOP No. 25 provides guidance in the assignment of credibility values to data.

c. Data Quality at Each Level of Usage—Data that may be of appropriate quality for determination of certain assumptions within a model may not be of appropriate quality for determination of other assumptions. When data are combined or separated, the actuary should review the data for suitability for the purpose. For example, data from a **benefit plan** may be sufficient for setting an aggregate per capita health care cost, but not be of sufficient size to set per capita health care costs by location.

3.10 Administrative Inconsistencies—In general, the actuary may rely on the **plan sponsor**'s representations. However, in the course of performing the measurement, the actuary may become aware of a significant inconsistency between administrative practice and plan documents, stated **plan sponsor** policies, **participant** communications, or applicable law (statutes, regulations, and other legally binding authority). Examples of areas of possible inconsistencies include: **participant contribution** determinations that combine claims for active and retired **participants** resulting in "hidden" subsidies (see section 3.5.1(d)(2)); claims payment practices including ignoring lifetime limits (see section 3.5.2(a)); **Medicare integration** (see section 3.7.6); and **retiree group benefits program** operations (see section 3.9.2(a)). The actuary should do the following upon becoming aware of such an inconsistency:

a. discuss the inconsistency with the **plan sponsor**, the administrator, or any other appropriate parties;

b. adjust the model appropriately, consistent with the purposes of the measurement;

c. document the resulting steps taken by the actuary in developing the model; and

d. disclose any significant unresolved inconsistency (see section 4.1(v)).

3.11 Other Information from the Principal—The actuary should obtain other information from the principal necessary for the purpose of the measurement, such as accounting or funding elections.

3.12 Projection Assumptions—In selecting projection assumptions, the actuary should consider the following:

3.12.1 Economic Assumptions—The actuary should comply with the guidance contained in ASOP No. 27 when selecting the inflation assumption, discount rate, investment return assumption, and compensation increase assumption to be used in measuring **retiree group benefits** obligations. In applying ASOP No. 27, the actuary should take into account the purpose of the measurement, and the differences between the characteristics of **retiree group benefits** obligations and the characteristics of pension benefit obligations. For example, the discount rate selected for measuring pension benefit obligations for purposes of ASC 715-

Defined Benefit Plans – Pension may not be appropriate for measuring **retiree group benefits** obligations for the purposes of ASC 715-60, because the payment patterns may be different.

The actuary should determine what other economic assumptions are needed including the following when relevant to the calculation:

a. Health Care Cost Trend Rate—The health care cost **trend** rate reflects the change in per capita health costs over time due to factors such as inflation, medical inflation, utilization, technology improvements, definition of covered charges, leveraging caused by health plan design features not explicitly modeled, and health plan participation. The actuary should not reflect aging of the **covered population** when selecting the **trend** assumption for projecting future costs (see sections 3.7.7 and 3.7.8 for a discussion of "age-specific costs"). The actuary should consider separate **trend** rates for major cost components such as hospital, prescription drugs, other medical services, **Medicare integration**, and administrative **expenses**. Even if the actuary develops one aggregate **trend** rate, the actuary should consider these cost components when developing the rate.

   The actuary should consider the sustainability of current **trends** over an extended period, and the possible need for a long-term **trend** assumption that is different from the initial **trend** assumption. If these two **trend** assumptions are different, the actuary should determine the appropriate length of a select period for transitioning between the initial **trend** assumption and the long-term **trend** assumption.

   When developing an initial **trend** assumption, the actuary should consider known or expected changes in per capita health costs in the year(s) following the **measurement date**. When developing a long-term **trend** assumption and the select period for transitioning, the actuary should consider relevant long-term economic factors such as projected growth in per capita gross domestic product (GDP), projected long-term wage inflation, and projected health care expenditures as a percent of GDP. The actuary should select a transition pattern and select period that reasonably reflects anticipated experience.

   The actuary should consider whether adjustments should be made to reflect annual or lifetime maximums.

b. Other Cost Change Rates—The actuary should consider other costs that may change in the future, such as the cost of life insurance and long-term care insurance.

c. Participant Contribution Changes—Depending on the modeled **retiree group benefits program**, the measurement may require an assumption for

the rate of change in **participant contributions**. For some **retiree group benefits programs**, this may be a function of health care **trend** rate or other economic assumptions. For some other **retiree group benefits programs**, there may be no **participant contributions** currently but caps on other funding sources and assumed **trend** rates may make it likely that **participant contributions** will be required in future years. In those cases, and depending upon the purposes of the measurement, the actuary should determine when **participant contributions** are expected to be required during the **measurement period** and model subsequent increases accordingly.

d. Adverse Selection—When a **retiree group benefits program** requires **participant contributions**, those choosing to participate may have a higher average benefit cost than those not participating would have had. Also when a **retiree group benefits program** offers **benefit options**, the process of **adverse selection** may have an impact on plan costs.

The actuary should consider whether **adverse selection** will result from such items as decreasing participation and, if **adverse selection** is projected to have a significant impact on the measurement, then the actuary should appropriately reflect that **adverse selection** in the measurement, either implicitly or explicitly. The actuary should document how that **adverse selection** is reflected in the measurement.

3.12.2 Demographic Assumptions—With respect to any particular measurement, each demographic assumption the actuary selects should be consistent with the other demographic assumptions the actuary selects. For example, if the mortality assumption anticipates increasing life spans, the actuary should consider whether the retirement assumption should reflect the fact that individuals may choose to retire later because they are healthier or because they may not have sufficient accumulated savings to afford a lengthened retirement period.

The actuary should comply with ASOP No. 35 when selecting the retirement, termination, mortality, and disability assumptions to be used in measuring **retiree group benefits** obligations. In applying ASOP No. 35, the actuary should take into account the purpose and nature of the measurement and the differences between the characteristics of **retiree group benefits** obligations and the characteristics of pension benefit obligations. More refined demographic assumptions may be required to appropriately measure **retiree group benefits** obligations than are required to measure pension obligations. In determining whether demographic assumptions developed primarily for pension benefit measurements are appropriate for **retiree group benefits** measurements, the actuary should consider the following:

a. Assumptions Based on Related Pension Plan Valuation—The actuary should determine whether the assumptions used in a related pension plan

valuation are appropriate for **retiree group benefits programs** and, if not, modify the assumptions appropriately.

b. Disability—Assumptions regarding disability incidence, recovery, mortality, and eligibility for Social Security disability benefits should be consistent with the coverage provided to disabled **participants** under the **retiree group benefits program**. When the actuary considers disabled life coverage significant to the measurement, the actuary should select assumptions that appropriately reflect when benefits are payable to disabled **participants**, the definition of disability, and how the benefits are coordinated with other programs.

c. Retirement—The retirement assumption is critical in retiree health plan measurements because of the higher level of primary coverage a retiree receives prior to becoming eligible for Medicare. The actuary should select explicit age- or service-related retirement rates. A single average retirement age is generally not appropriate.

d. Mortality—When the per capita health care costs are expected to increase during the projection period, the results of the measurement may be sensitive to the mortality assumption. The actuary should take this sensitivity into account when selecting a mortality improvement assumption under ASOP No. 35.

3.12.3 Participation and Dependent Coverage Assumptions—In addition to covering eligible retired **participants**, many **retiree group benefits programs** also cover **dependents** of retired **participants**. Also, **retiree group benefits programs** may offer some or all **participants benefit options**, such as HMOs, PPOs, and POS plans. The magnitude of **the retiree group benefits program** obligation can vary significantly as a result of the participation assumption and also the **dependent** coverage assumption. The actuary should therefore consider historical participation rates and trends in coverage rates when selecting these assumptions.

a. Retiree Group Benefits Program Participation—For **retiree group benefits programs** that require some form of **participant contribution** to maintain coverage, some eligible individuals may not elect to be covered, particularly if they have other coverage available. Plan participation in this context is the result of acceptance, lapse, and re-enrollment elections. The actuary should take into account empirical data and future expectations regarding these elections when selecting participation assumptions. When developing the participation rates, the actuary should consider how changes in **retiree group benefits program** eligibility rules, **benefit options**, and **participant contribution** rates have influenced experience over time. Furthermore, plan participation may be different in the future due to **participants**' response to changes in **participant contribution** levels and **benefit options**. For **retiree group benefits programs** that

anticipate changes in these factors the actuary should consider the appropriateness of participation rates that vary over the projection period for both current and future retired **participants**. The actuary should also consider eligibility rules governing dropping coverage and subsequent re-enrollment when selecting participation rates.

b. Dependent Coverage—The actuary should consider who is eligible for coverage under the **retiree group benefits program** and make appropriate assumptions regarding the coverage of **dependents**. The actuary should consider the impact of the **retiree group benefits program**'s rules governing changes in coverage after retirement, such as remarriage, if significant. The actuary should review historical data on **dependent** coverage rates and should consider **participant contribution** rates for **dependent** coverage. If the gender mix of future retired **participants** and currently retired **participants** differs, the actuary should consider developing separate **dependent** coverage rates for males and females.

c. Dependent Ages—Whenever practical, the actuary should use actual data for the age of **dependents** of retired **participants**. If actual data is not available for all retired **participants**, the actuary should review the empirical data and consider developing an assumption to account for the difference in age between the **participant** and the **dependent** for the missing data. The **dependents** of an active employee today may not be the same **dependents** covered at retirement. Therefore, the actuary should generally select an assumed age difference between **participant** and **dependent** for purposes of projecting future **dependent** coverage.

3.12.4 <u>Effect of Retiree Group Benefits Program Design Changes on Assumptions</u>—When selecting assumptions, the actuary should consider the impact of relevant **retiree group benefits program** design changes during the **measurement period**. Whenever changes in provisions are being modeled, the actuary should consider whether or not assumptions that in combination are appropriate for measuring overall costs are also appropriate for valuing the element under study. For example, if a **plan sponsor** adds or advises the actuary of its intent to add HMO coverage options that may be selected by a portion of its group of retired **participants**, the actuary should consider how that affects the cost of current coverage, future cost **trends**, and participation. Both short-term and long-term implications of the change should be considered.

For most measurement purposes, the actuary should assume that the **retiree group benefits program** will continue indefinitely even though many **plan sponsors** have reserved the right to change unilaterally or terminate their **retiree group benefits programs**. The actuary should only include assumptions in the measurement model that attempt to quantify the probability that the current plan provisions will change significantly in the future when appropriate for the purpose

of the calculation. In that event the actuary should disclose that such an assumption has been used (see section 4.1(d)).

3.12.5 Assumptions Considered Individually and in Relation to Other Assumptions—The actuary should select reasonable actuarial assumptions. The actuary should consider the reasonableness of each actuarial assumption independently on the basis of its own merits and its consistency with the other assumptions selected by the actuary. When selecting assumptions, the actuary should consider the degree of uncertainty, the potential for fluctuation, and the consequences of such fluctuation.

3.12.6 Changes in Assumptions—Whenever a change in an assumption is considered, the actuary should review other assumptions to assess whether they remain consistent with the changed assumption. For example, if the actuary is anticipating more disabled **participants** due to recent experience, consideration should be given to the impact on **benefit plan** costs of the health risk of this group.

3.13 Retiree Group Benefits Program Assets—In measuring the unfunded obligation and allocating **periodic costs** to time periods, the actuary should take into account **dedicated assets** of the **retiree group benefits program**, if any. The actuary should consider any additional requirements or restrictions on what assets can be taken into account that are imposed by the purpose of the measurement, such as requirements imposed by accounting standards. Depending on the purpose of the measurement, such as for management planning purposes, taking non-dedicated assets into account may be appropriate.

The actuary should obtain sufficient details regarding insurance policies held as **dedicated assets** to determine an appropriate value, reflecting the nature of the contractual obligations upon early termination of the policies, as well as the costs of continued maintenance of the policies. If the cash surrender value of the policies is not readily determinable, the actuary should rely on his or her professional judgment to develop an appropriate value, depending on the purpose of the measurement.

3.14 Measuring the Value of Accrued or Vested Benefits—Depending on the scope of the assignment, the actuary may measure the value of any accrued or vested benefits as of a **measurement date.** The actuary should consider the following when making such measurements:

a. relevant plan provisions and applicable law (statutes, regulations, and other legally binding authority);

b. the status of the plan (for example, whether the plan is assumed to continue to exist or be terminated);

c. the contingencies upon which benefits become payable, which may differ for ongoing- and termination-basis measurements;

d. the extent to which **participants** have satisfied relevant eligibility requirements for accrued or vested benefits and the extent to which future service or advancement in age may satisfy those requirements;

e. whether or the extent to which any **retiree group benefits** are accrued or vested;

f. whether the plan provisions regarding accrued benefits provide an appropriate attribution pattern for the purpose of the measurement (for example, following the attribution pattern of the plan provisions may not be appropriate if the plan's benefit accruals are significantly backloaded); and

g. if the measurement reflects the impact of a special event (such as a plant shutdown or plan termination), factors such as the following:

   1. the effect of the special event on continued employment;

   2. the impact of the special event on employee behavior;

   3. **expenses** associated with a potential plan termination, including transaction costs to liquidate plan assets; and

   4. changes in investment policy.

3.15 Market-Consistent Present Values—If the actuary calculates a **market-consistent present value**, the actuary should do the following:

a. select assumptions based on the actuary's observation of the estimates inherent in financial market data (as applied to assumptions for which guidance is provided in this standard as well as assumptions for which relevant guidance is provided in ASOP Nos. 27 and 35), depending on the purpose of the measurement; and

b. measure benefits earned as of the **measurement date**.

The actuary may reflect payment default risk or the financial health of the **plan sponsor,** if appropriate for the purpose of the measurement.

3.16 Relationship Between Asset and Obligation Measurement—The actuary should reflect how **retiree group benefits program** or **plan sponsor** assets as of the **measurement date** are reported. For example, if the **retiree group benefits program** or **plan sponsor** assets have been reduced to reflect a lump sum paid, the lump sum should be excluded from the obligation.

3.17 Actuarial Cost Method—When assigning plan **periodic costs** or **prefunding contributions** to time periods in advance of the time benefit payments are due, the actuary should select an **actuarial cost method** that meets the following criteria:

a. The period over which **normal costs** are allocated for an employee should begin no earlier than the date of employment and should not extend beyond the last assumed retirement age. The period may be applied to each individual employee or to groups of employees on an aggregate basis.

A reasonable **actuarial cost method** will not produce a **normal cost** for benefits when no employees are accruing benefits under the plan.

b. The attribution of **normal costs** should bear a reasonable relationship to the employee's compensation or service. The attribution basis may be applied on an individual or group basis. For example, the **actuarial present value of projected benefits** for each employee may be allocated by that employee's own compensation or may be allocated by the aggregated compensation for a group of employees.

c. Administrative **expenses** should be considered when assigning **periodic costs** or **prefunding contributions** to time periods. For example, administrative **expenses** may be included in the per capita costs as discussed in section 3.7.15. Alternatively, the **expenses** for a period may be added to the **normal cost** for benefits or **expenses** may be reflected as an adjustment to the investment return assumption or the discount rate. As another example, **expenses** may be reflected as a percentage of **retiree group benefits** obligations or **normal cost**.

d. The sum of the **actuarial accrued liability** and the **actuarial present value** of future **normal costs** should equal the **actuarial present value of projected benefits** and **expenses**, to the extent **expenses** are included in the liability and **normal cost**. For purposes of this criterion, under a **spread gain actuarial cost method**, the sum of the actuarial value of assets and the unfunded **actuarial accrued liability**, if any, should be considered to be the **actuarial accrued liability**.

3.18 Allocation Procedure—A **cost allocation procedure** or **contribution allocation procedure** typically combines an **actuarial cost method**, an asset valuation method, and an **amortization method** to determine the plan's **periodic cost** or **prefunding contribution**. When selecting a **cost allocation procedure** or **contribution allocation procedure**, the actuary should consider factors such as the timing and duration of expected benefit payments and the nature and frequency of plan amendments. In addition, the actuary should consider relevant input received from the principal, such as a desire for stable or predictable **periodic costs** or **prefunding contributions**, or a desire to achieve a target funding level within a specified time frame.

3.18.1 Consistency Between Contribution Allocation Procedure and the Payment of Benefits—In some circumstances, a **contribution allocation procedure** may not necessarily produce adequate assets to make benefit payments when they are due even if the actuary uses a combination of assumptions selected in accordance with this standard and ASOP Nos. 27 and 35, an **actuarial cost method** selected in

accordance with section 3.16 of this standard, and an asset valuation method selected in accordance with ASOP No. 44.

Examples of such circumstances include the following:

a. a plan covering a sole proprietor with funding that continues past an expected retirement date with payment due in a lump sum;

b. using the aggregate funding method for a plan covering three employees, in which the principal is near retirement and the other employees are relatively young; and

c. a plan amendment with an amortization period so long that overall plan **prefunding contributions** would be scheduled to occur too late to make plan benefit payments when due.

When performing professional services with respect to **prefunding contributions** for a plan, the actuary should select a **contribution allocation procedure** that, in the actuary's professional judgment, is consistent with the plan being able to make benefit payments when due, assuming that all actuarial assumptions will be realized and that the **plan sponsor** or other contributing entity will make **prefunding contributions** when due.

In some circumstances, the actuary's role is to determine the **prefunding contribution**, or range of **prefunding contributions**, using a **contribution allocation procedure** prescribed by applicable law or selected by another party. If, in the actuary's professional judgment, such a **contribution allocation procedure** is significantly inconsistent with the plan being able to make benefit payments when due, assuming that all actuarial assumptions will be realized and that the **plan sponsor** or other contributing entity will make **prefunding contributions** when due, the actuary should disclose this in accordance with section 4.1(o).

3.18.2 Implications of Contribution Allocation Procedure—If **prefunding contributions** are based on a **contribution allocation procedure** or the actuary knows the **plan sponsor**'s (or other contributing entity's) funding policy, the actuary should qualitatively assess the implications of that procedure or policy on the plan's expected future **prefunding contributions** and **funded status**. If **prefunding contributions** are not based on a **contribution allocation procedure** or funding policy, for example set in law or by contract such as a collective bargaining agreement, the actuary should qualitatively assess the implications of those **prefunding contributions** on the plan's expected future **funded status**. In making either of these assessments, the actuary may presume that all actuarial assumptions will be realized and the **plan sponsor** (or other contributing entity) will make **prefunding contributions** anticipated

by the **contribution allocation procedure** or otherwise. The actuary's assessment required by this section should be disclosed as described in section 4.1(p).

3.19 Approximations and Estimates—The actuary should use professional judgment to establish a balance between the degree of refinement of methodology and materiality. The actuary may use approximations and estimates where circumstances warrant. The following are some examples of such circumstances:

a. situations in which the actuary reasonably expects the results to be substantially the same as the results of detailed calculations;

b. situations in which the actuary's assignment requires informal or rough estimates; and

c. situations in which the actuary reasonably expects the amounts being approximated or estimated to represent only a minor part of the overall **retiree group benefits** obligation, plan **periodic cost**, or plan **prefunding contribution**.

3.20 Volatility—If the scope of the actuary's assignment includes an analysis of the potential range of future **retiree group benefits** obligations, plan **periodic costs**, plan **prefunding contributions**, or **funded status**, the actuary should consider sources of volatility that, in the actuary's professional judgment, are significant. Examples of potential sources of volatility include the following:

a. plan experience differing from that anticipated by the economic or demographic assumptions, as well as the effect of new entrants;

b. changes in economic or demographic assumptions, such as medical **trend**, acceptance, or lapse rates;

c. the effect of discontinuities in applicable **periodic cost** or **prefunding contribution** regulations, such as welfare benefit fund limits or the end of amortization periods;

d. the delayed effect of smoothing techniques, such as the pending recognition of prior experience losses; and

e. patterns of rising or falling **periodic cost** expected when using a particular **actuarial cost method** for the **covered population**.

In analyzing potential variations in economic and demographic experience or assumptions, the actuary should exercise professional judgment in selecting a range of variation in these assumptions while maintaining internal consistency among these assumptions) and in selecting a methodology by which to analyze them, consistent with the scope of the assignment.

3.21 Reasonableness of Results—The actuary should review the measurement results for reasonableness. For example, the actuary could compare the overall measurement results to benchmarks such as measurement of similar **retiree group benefits programs**, or could review the results for sample **participants** for reasonableness.

3.21.1 Modeled Cash Flows Compared to Recent Experience—The actuary should compare the expected claims produced by the model for the first year from the **measurement date** to actual claims over a recent period of years. If the expected and actual claims are significantly different, the actuary should consider the likely causes of such differences (for example, cost **trends**, large claims, a change in the demographics of the group, or the volatility of experience in **benefit plans** with limited credible experience), and consider the impact of those differences on the reasonableness of the measurement results.

3.21.2 Results Compared to Last Measurement—The actuary should compare the overall results to the last measurement's results when available and applicable. If the results are significantly different from results the actuary expected based on the last measurement, the actuary should consider the likely causes of such differences. If another actuary performed the prior measurement, some allowance may be made for differences due to different actuarial techniques or modeling. The actuary should, if practical, review the prior actuary's documentation and, if necessary, seek further information.

3.22 Evaluation of Assumptions and Methods—An actuarial communication should identify the party responsible for each material assumption and method. Where the communication is silent about such responsibility, the actuary who issued the communication will be assumed to have taken responsibility for that assumption or method.

3.22.1 Prescribed Assumption or Method Set by Another Party—The actuary should evaluate whether a **prescribed assumption or method set by another party** is reasonable for the purpose of the measurement, except as provided in section 3.22.3. The actuary should be guided by Precept 8 of the Code of Professional Conduct, which states, "An Actuary who performs Actuarial Services shall take reasonable steps to ensure that such services are not used to mislead other parties." For purposes of this evaluation, reasonable assumptions or methods are not necessarily limited to those the actuary would have selected for the measurement.

3.22.2 Evaluating Prescribed Assumption or Method—When evaluating a **prescribed assumption or method set by another party**, the actuary should consider whether the prescribed assumption or method significantly conflicts with what, in the actuary's professional judgment, would be reasonable for the purpose of the measurement. If, in the actuary's professional judgment, there is a significant

conflict, the actuary should disclose this conflict in accordance with section 4.2(a).

3.22.3 Inability to Evaluate Prescribed Assumption or Method—If the actuary is unable to evaluate a **prescribed assumption or method set by another party** without performing a substantial amount of additional work beyond the scope of the assignment, the actuary should disclose this in accordance with section 4.2(b).

3.23 Reliance on a Collaborating Actuary—The various elements of a **retiree group benefits** measurement require expertise in the two different actuarial fields of health data analysis and long-term projections. In recognition of the complexities involved, two or more actuaries with complementary qualifications in the health and pension practice areas may collaborate on a project. While each actuary may concentrate on his or her area of expertise during the project, the actuary (or actuaries) issuing the actuarial opinion must take professional responsibility for the overall appropriateness of the analysis, assumptions, and results.

3.24 Use of Roll-Forward Techniques—The actuary may determine that it is appropriate for the purpose of the measurement to use prior measurement results and a roll-forward technique rather than conduct a new full measurement. The actuary should not use roll-forward techniques unless, in the actuary's professional judgment at the time of the roll-forward calculation, the resulting measurement is not expected to differ significantly from the results of a new full measurement.

3.24.1 Full and Partial Roll-Forward—Roll-forward techniques include full roll-forwards of claims data and census data, as well as partial roll-forward techniques. For example, the actuary may use partial roll-forward techniques that use health care claim costs developed for the prior measurement trended forward to the current **measurement date** coupled with updated census data.

3.24.2 Limitation—The actuary may use roll-forward techniques to reduce the frequency of full measurements. The actuary should not roll-forward prior measurement results if the **measurement date** of those results is three or more years earlier than the current **measurement date**. For example, a January 1, 2000 measurement could be used to develop roll-forward results as of January 1, 2001 and 2002, but should not be used for measurements or **periodic cost** allocations after December 31, 2002. **[The dates used in this example will be updated in the final document to reflect the actual effective date of the revisions.]**

3.24.3 Appropriateness—The actuary should not use full roll-forward techniques when the **covered population**, **retiree group benefits program** design, or other key model components have changed significantly since the last full measurement.

Section 4. Communications and Disclosures

4.1 Communication Requirements—Any actuarial communication prepared to communicate the results of work subject to this standard must comply with the requirements of ASOP Nos. 23, 27, 35, 41, and 44. In addition, such communication should contain the following disclosures, when relevant and material. An actuarial communication can comply with some or all of the specific requirements of this section by making reference to information contained in other actuarial communications available to the intended users (as defined in ASOP No. 41), such as an annual **actuarial valuation** report.

a. a statement of the intended purpose of the measurement and a statement to the effect that the measurement may not be applicable for other purposes;

b. the **measurement date**;

c. a description of adjustments made for events after the **measurement date** under section 3.4.2;

d. information about known significant **retiree group benefits program** provisions (such as types of **benefit plans** provided, benefit eligibility conditions, retired **participant** and **dependent** coverage options, and **participant contribution** requirements), a description of known changes in significant plan provisions included in the **actuarial valuation** from those used in the immediately preceding measurement prepared, a description of any known significant **retiree group benefits program** provisions not reflected in the model along with the rationale for not including such significant plan provisions, and any anticipated future changes (see sections 3.5.1(h) and 3.12.4);

e. the date(s) as of which the **participant** and financial information were compiled;

f. summary information about the **covered population**;

g. if hypothetical data are used, a description of the data;

h. a description of any funding or accounting elections made by the principal that are pertinent to the measurement;

i. a brief description of the information and analysis used in selecting each significant assumption that was not prescribed. Items to disclose could include any specific approaches used, sources of external advice, and how past experience and future expectations were considered. For example, for the initial per capita health care costs and Medicare-related assumptions, a brief description of the methodology used to develop these assumptions as well as any combining of **benefits plans** (section 3.6.6) for measurement purposes and a description of the

extent to which they are based on **premium** (or self-funded equivalent) rates and any adjustments to those rates (see section 3.7.5) should be included;

j. a description of the future health care cost **trend** rates used (see section 3.12.1(a));

k. a description of all other significant assumptions (including, but not limited to, participation and dependent coverage assumptions);

l. if using modeling or projection techniques other than those mentioned in section 3.7, a description of the method used and a discussion on its applicability;

m. a description of the **actuarial cost method** and the manner in which **normal costs** are allocated, in sufficient detail to permit another actuary qualified in the same practice area to assess the material characteristics of the method (for example, how the **actuarial cost method** is applied to multiple benefit formulas, compound benefit formulas, or benefit formula changes, where such plan provisions are significant);

n. descriptions of the **cost allocation procedure** or **contribution allocation procedure** including a description of **amortization methods** and amortization bases, and a description of any pay-as-you-go funding (i.e., the intended payment by the **plan sponsor** of some or all benefits when due).

   If the unfunded **actuarial accrued liability** is expected to increase at any time during the amortization period or if the unfunded **actuarial accrued liability** is not expected to be fully amortized, the actuary should so disclose. For purposes of this section, the actuary should assume that all actuarial assumptions will be realized and **prefunding contributions** will be made when due;

o. a statement indicating that the **contribution allocation procedure**, if any, is significantly inconsistent with the plan accumulating adequate assets to make benefit payments when due, if applicable in accordance with section 3.18;

p. a qualitative description of the implications of the **contribution allocation procedure**, sponsor funding policy, or contributions set by contract or law, as applicable, on future expected plan **prefunding contributions** and **funded status** in accordance with section 3.18.2.

   The actuary should disclose the actuary's understanding of the sponsor's funding policy for the purpose of the actuary's assessment in accordance with section 3.18.2;

q. a description of the types of benefits regarded as accrued or vested if the actuary measured the value of accrued or vested benefits, and, to the extent the attribution

pattern of accrued benefits differs from or is not described by the plan provisions, a description of the attribution pattern;

r. if applicable, a description of how benefit payment default risk or the financial health of the **plan sponsor** was reflected in any **market-consistent present value** of accrued or vested benefits;

s. **funded status** based on an **immediate gain actuarial cost method** if the actuary discloses a **funded status** based on a **spread gain actuarial cost method**. The **immediate gain actuarial cost method** used for this purpose should be disclosed in accordance with section 4.1(m);

t. if the funded status is disclosed, a description of the particular measures of plan assets and plan obligations that are included in the actuary's disclosure of the plan's **funded status**. The actuary should accompany this description with each of the following additional disclosures:

   1. whether the **funded status** measure is appropriate for assessing the sufficiency of plan assets to cover the estimated cost of settling the plan's benefit obligations;

   2. whether the **funded status** measure is appropriate for assessing the need for future **prefunding contributions**; and

   3. if applicable, a statement that the **funded status** measure would be different if the measure reflected the market value of assets rather than the actuarial value of assets.

u. a brief description of the roll-forward method, if any, used in the calculations (see section 3.24);

v. a description of any significant and unresolved inconsistencies in data or administration, such as those mentioned in sections 3.9 and 3.10;

w. a statement, appropriate for the intended users, indicating that future measurements (for example, of **retiree group benefit program** obligations, **periodic costs**, **prefunding contributions** or **funded status** as applicable) may differ significantly from the current measurement. For example, a statement such as the following could be applicable: "Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: retiree group benefits program experience differing from that anticipated by the assumptions; changes in assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and changes in retiree group benefits program provisions or applicable law. Retiree group benefits models necessarily rely on the use of approximations and estimates, and

are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements."

In addition, the actuarial communication should include one of the following:

1. if the scope of the actuary's assignment included an analysis of the range of such future measurements, disclosure of the results of such analysis together with a description of the factors considered in determining such range; or

2. a statement indicating that, due to the limited scope of the actuary's assignment, the actuary did not perform an analysis of the potential range of such future measurements.

x. a description of known changes in assumptions and methods from those used in the immediately preceding measurement prepared for a similar purpose. For assumption and method changes that are not the result of a **prescribed assumption or method set by another party** and or a **prescribed assumption or method set by law**, the actuary should include an explanation of the information and analysis that led to those changes.

y. a description of all changes in **cost allocation procedures** or **contribution allocation procedures** that are not a result of a **prescribed assumption or method set by law**, including the resetting of an actuarial asset value. The actuary should disclose the reason for the change, and the general effect of the change on relevant **periodic cost**, **prefunding contribution**, **funded status**, or other measures, by words or numerical data, as appropriate; and

z. if, in the actuary's professional judgment, the actuary's use of approximations or estimates could result in a significant difference relative to the results if a detailed calculation had been done, a statement to this effect.

4.2 Disclosure about Prescribed Assumptions or Methods—The actuary's communication should state the source of any prescribed assumptions or methods. In addition, with respect to **prescribed assumptions or methods set by another party**, the actuary's communication should identify the following, if applicable:

a. any **prescribed assumption or method set by another party** that significantly conflicts with what, in the actuary's professional judgment, would be reasonable for the purpose of the measurement (section 3.22.2); or

b. any **prescribed assumption or method set by another party** that the actuary is unable to evaluate for reasonableness for the purpose of the measurement (section 3.22.3).

4.3 Additional Disclosures—The actuary should also include the following, as applicable, in an actuarial communication:

a. the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

b. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Note: The following appendix is provided for informational purposes, but is not part of the standard of practice.

Appendix 1

Background, Current Practices, and Supplementary Information

Background

The original ASOP No. 6 was effective October 17, 1988. In addition, actuaries were provided guidance by Actuarial Compliance Guideline (ACG) No. 3, *For Statement of Financial Accounting Standards No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions (AGC No. 3)*, which was originally effective December 1, 1992. During the time these documents were being developed, the Financial Accounting Standards Board was raising the visibility of financial issues related to retiree group benefits with its development of Statement of Financial Accounting Standard (SFAS) No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*. (Note that effective in July 2009, FASB reorganized all U.S. GAAP into one codification. Accounting Standards Codification (ASC) 715-60 — Compensation—Retirement Benefits – Defined Benefit Plans— Other Postretirement replaces SFAS No. 106.) Prior to the issuance of the accounting guidance currently included in ASC 715-60, most plan sponsors provided and accounted for retiree group benefits on a pay-as-you-go basis. The move to accrual accounting necessitated greater actuarial involvement. ASOP No. 6 and ACG No. 3 were written with a high level of educational content because the measurement of retiree group benefits obligations was an emerging practice area that would be new to many actuaries.

The measurement of retiree group benefits obligations continued to develop as an actuarial field within the profession. In 1999, the ASB determined that practice in this field had developed sufficiently to permit revision of ASOP No. 6. It convened a special task force of knowledgeable practitioners in the retiree group benefits field to draft the revision of this standard. The Task Force on Retiree Group Benefits was charged with (1) updating ASOP No. 6 to provide guidance to actuaries regarding appropriate practices and to reduce the amount of educational material; (2) determining whether there was a continuing need for ACG No. 3; and (3) evaluating the applicability to retiree group benefits of ASOPs written since the original adoption of ASOP No. 6. A revised version of ASOP No. 6 was adopted by the ASB in December, 2001.

The process of measuring retiree group benefits obligations is similar to the process of measuring pension obligations. Since the prior ASOP No. 6 was adopted, the ASB has adopted or revised the following standards that provide more detailed guidance regarding specific elements of the process of measuring retiree group benefits obligations:

1. ASOP No. 5, *Incurred Health and Disability Claims;*

2. ASOP No. 23, *Data Quality*;

3. ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages;*

4. ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations*;

5. ASOP No. 35, *Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations*;

6. ASOP No. 41, *Actuarial Communications*; and

7. ASOP No. 44, *Selection and Use of Asset Valuation Methods for Pension Valuations*.

In addition, ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*, was revised to create an "umbrella" standard to tie together the applicable standards for pension plans and address overall considerations for the actuary when measuring pension obligations.

Current Practices

This standard and the related standards listed above in the Background section cover actuarial practices that are central to the work regularly performed by actuaries measuring retiree group benefits obligations. The actuarial tasks covered by the standards are performed for a number of purposes, examples of which are discussed below:

1. Periodic Cost, Plan Sponsor Prefunding Contribution, and Benefit Recommendations—Calculations may be performed for purposes of determining actuarial periodic cost, plan sponsor prefunding contribution, and benefit recommendations and related information. Examples are calculations related to the following:

   a. recommendations as to the assignment of periodic costs or prefunding contributions to time periods for retiree group benefits programs;

   b. recommendations as to the type and levels of benefits for specified periodic cost or plan sponsor prefunding contribution levels;

   c. plan sponsor prefunding contributions required under standards imposed by statute, regulations or other third party requirements;

   d. maximum prefunding contributions deductible for tax purposes;

   e. information required to evaluate alternative plan designs, assumptions, cost management programs and provider networks; and

   f. determination of progress towards a defined financial goal, such as funding of

projected benefits or limiting annual plan cash expense.

2. Evaluations of Current Funding Status—Calculations may be performed for purposes of comparing available assets to the actuarial present value of benefits (or a subset of those benefits) specified by the plan. Examples are calculations related to the following:

   a. actuarial present value of current or future benefit accruals (to the extent retiree group benefits are accrued);

   b. actuarial present value of benefits payable to currently retired participants or active participants eligible to retire; and

   c. information required with respect to plan mergers, acquisitions, spin-offs, and business discontinuances.

3. Projection of Cash Flow—Calculations may be done for the sole purpose of projecting the annual cash flow of retiree group benefits obligations. Examples are calculations related to the following:

   a. Time horizon to exhaust trust assets; and

   b. Projections of participant contributions or changes in participant contributions.

4. Evaluations of the Impact of Government or Third Party Funding—Calculations may be performed to estimate the effect on funding of government or third party funding. Some examples of such funding are:

   a. Retiree Drug Subsidy (RDS) program providing partial reimbursements to plan sponsors of drug benefits for Medicare-eligible retired participants;

   b. Federal direct subsidy of Part D plans; and

   c. Pharmaceutical manufacturer discounts on brand name drugs during coverage gap.

Supplementary Information

Modeling of Retirement Obligations

The models used to value retiree health care benefit obligations have become increasingly sophisticated. Models commonly use age-specific initial per capita health care rates within the retired population (for example in individual age brackets). Some of these models are based on net incurred claims, while other models are based on gross expenses incurred reduced by amounts paid outside the plan or not covered by the plan. Some models project a distribution of

expected claims with an associated probability distribution, while other models use separate age-specific per capita claim costs for the last year of life and for survivors.

Despite the development of these more sophisticated approaches, some actuaries continue to use highly simplified models. Examples include using pension census data as the basis for the measurement, using only two initial per capita health care costs (for Medicare eligible participants and for participants who are not yet eligible for Medicare), and developing initial per capita health care costs based solely on premiums or normative databases. Such simplified approaches may result in significantly understated or overstated retiree group benefits obligations for the following reasons:

1. Retiree group benefits eligibility requirements are often different from pension benefit eligibility requirements, so pension census data may not appropriately reflect retiree group benefits program participation;

2. Significant discrepancies between the plan sponsor's stated policy and actual plan operation may not be identified and "hidden" subsidies may not be valued;

3. Normative databases may be applied inappropriately, or may be outdated;

4. The effects of aging of the retired population on future per capita claim costs may not be appropriately taken into account;

5. A trend assumption that reaches the ultimate rate too quickly may not adequately reflect the structural upward pressures on medical costs;

6. Expected future participation rates may not reflect recent experience; or

7. The impact of expected future participant contribution increases on future participation and projected per capita claim costs of participants may not be appropriately reflected.

Possible Data Inconsistencies

As part of the development of the model, the eligibility and payment data received may conflict significantly with information received about known retiree group benefits program provisions or administration. Examples of inconsistencies include the following:

1. Average claims costs that are secondary to Medicare are very high in relation to average costs that are primary. This might reveal that the carve-out method of integration with Medicare may not have been used, despite the plan sponsor's indication of that method, or that the classification of the covered dependent is based on the retired participant's age.

2. Participant contributions before Medicare eligibility are so low as to make it unlikely that plan sponsor subsidies are as limited as the plan sponsor may indicate.

3. The ratio of dependents to retired participants in total or for a subgroup (for instance, those who are not eligible for Medicare) is inconsistent with expectations. This might

mean that it is unlikely surviving dependent coverage is as stated, that coding of dependent ages is inaccurate, or that surviving dependents were coded as "retired participants."

4. Reported provisions include benefit maximums, but the actuary's analysis of claims data indicates a likelihood that claims are being paid in excess of the maximum.

Measurements Using Premium Rates

As defined in this standard, a premium is the price charged by a risk-bearing entity, such as an insurance or managed care company, to provide risk coverage. The premium usually has a basis in the expected value of future costs, but the premium will also be affected by other considerations, such as marketing and profit goals, competition, and legal restrictions. Because of these other considerations, a premium for a coverage period is not the same as the expected cost for the coverage period.

The demographics of the group for which the premium was intended may be different from the demographics of the group being valued. When these two groups are different, the premiums are unlikely to reflect the expected health care costs for the group being valued, even if it is a subset of the total group for which the premium was determined. In particular, the expected value of future costs for a group of retired participants is unlikely to be the same as for a group consisting of active participants and the same retired participants. Examples of this are shown in the "Participant Contributions" section below.

The term "premium rate" is commonly used for both insured group plans and self-insured group plans. In the case of self-insured plans, the "premium rates" may also be referred to as "budget rates" or "phantom premiums." Future changes in insured premiums are frequently affected by the experience of the insured group. Further comments about common types of retiree group benefits program premiums follow:

1. Self-Insured Premiums—Some self-insured plans have expenditures that the plan sponsor refers to as "premium rates." These rates may reflect the experience of retired participants, active employees, or both. Also, the rates may reflect only expected claims experience, or may include other adjustments (such as administrative expenses and stop-loss claims and premiums). Furthermore, the rates may reflect the effect of the plan sponsor's contribution or managed care strategy. The rates also may not reflect supplemental funding contributions not considered in the ratemaking process.

2. Community-Rated Premiums—In some regulatory jurisdictions, community-rated premium rates are required by statute for some fully insured plans. There is variation in the structure of community-rated premium rates. For example, retired participants not eligible for Medicare may be included with active employees in a community-rated premium category, while retired participants eligible for Medicare may be included in a separate community-rated premium category. There are also different community-rating methodologies, some incorporating group-specific characteristics. Note that a community-rated premium including both retirees not eligible for Medicare and active employees probably understates the expected claim cost for the retirees alone.

3. Other Fully Insured Plans—In addition to community-rated plans, there are other types of fully insured plans and there can be some variation in how actual plan experience affects the premiums. The same comments mentioned above for self-insured premiums apply here.

Interaction Between Trend and Plan Provisions
Plan provisions and health care trend rates in combination impact the projected net per capita health care costs. Examples of the interaction of plan provisions and health care trend rates include the following:

1. Covered charges can be affected by limits on allowable provider fees and the plan's Medicare integration approach. Benefit plan provisions may help in identifying these limits, as well as what services are covered.

2. Health plan deductibles may or may not be set at a fixed-dollar amount. Health care trend will, over time, erode the relative value of a fixed-dollar deductible.

3. Coinsurance payments may be expressed as a percentage or fixed-dollar amount. Again, over time, trend will erode the relative value of a fixed-dollar coinsurance.

4. The Medicare program provides coverage for most U.S. retirees over age 65; however, the retiree group benefits program may cover a different mix of services than Medicare. Trend rates may differ between Medicare-covered services and the retiree group benefits.

5. Other payments or offsets may exist, such as subrogation recoveries or plans other than Medicare. These payments or offsets may change in the future.

6. Lifetime and other maximum dollar limits also affect claims costs, and the effect can change over time.

Participant Contributions
Participant contributions are very important to the financial understanding of how retiree group benefits programs work. Plan sponsors must advise participants and plan administrators as to the specific dollar amounts of currently required contributions. Plan sponsors usually have administrative policies for determining future contributions (formulas, subsidy limits, or overall contribution philosophy). Based on the required contributions, an individual will decide whether to participate, which may result in adverse selection.

Formulas, subsidy limits, and the contribution philosophy of the plan sponsor are subject to different interpretations about what data and techniques are to be used in deriving the current monthly contribution used in the measurements of retiree group benefits obligations. Here are two examples:

1. The plan sponsor's stated policy is that retired participants who are not yet Medicare eligible will contribute 50% of the cost of their health care benefits. However, the plan

sponsor determines a retiree contribution of $100 per month ($1,200 per year) based on average annual per capita health care claims of $2,400 for active employees and pre-Medicare retirees combined. When the actuary evaluates the claims experience of pre-Medicare retirees separately from that of the active employees, the actuary determines that the average annual claim per retired participant is $4,000. So the plan sponsor subsidy is really $2,800 or 70%, not the stated 50%.

2. A "defined dollar benefit" plan sponsor will pay $2,000 annually toward retiree health care coverage for retired participants who are not Medicare eligible. The plan sponsor determines an annual retiree contribution of $500 based on average per capita claims of $2,500 for active employees and pre-Medicare retired participants combined. However, when the actuary evaluates the claims experience for pre-Medicare retired participants, the average annual claims per retired participant is determined to be $4,500. The actual plan sponsor subsidy is $4,000 ($4,500 average claims per retired participant less $500 retiree contribution)—double the "defined dollar benefit" of $2,000.

Once the contribution is determined for the current year, future increases can then be incorporated into the model. The contribution increase assumption is often a function of the claims trend assumption. 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.

Some plans impose conditions such that contributions will begin a certain pattern at some triggering point in the future. This can happen in a number of ways, but the most common may be the use of "cost caps," where the sponsor has limited its subsidy to an annual amount per capita that has not yet been reached. Participant contributions may or may not be required currently, but after the cap is reached participant contributions are to absorb all the additional costs. After the caps have been reached, this design is akin to the defined dollar approach, but before that point, the plan sponsor's costs will increase. The assumptions about future health care trend rates (interacting with the cost caps) will increase projected costs to a time when the caps are reached, and thereafter participant contributions will increase.

Finally, participation rates may be lower when contributions are required. Assumptions about lower participation rates can vary by small amounts and yet result in large differences in present values. Furthermore, lower participation may result in adverse selection on the part of participants. The combination of lower participation and adverse selection assumptions may or may not be significant in a measurement model.

Health Care Reform Considerations

The Patient Protection and Affordable Care Act (PPACA) was passed in the U.S. in March 2010 and includes many provisions that actuaries will need to consider in selecting assumptions in future valuations. Because the legislation was so comprehensive, it may be years before the impact of the new provisions result in a stable set of assumptions.

Key provisions of the PPACA that may affect retiree group benefits assumptions are:

Market Reforms. Several different requirements are imposed by the PPACA with varying effective dates. Whether these requirements apply will depend on if a plan is a retiree-only plan. These effective dates also may depend on whether a plan is grandfathered. Because these market reforms do not apply to retiree only medical plans, whether plans being valued meet the definition of such a plan (basically, a separate legal plan, unique plan identification and covers fewer than two active employees) is key.

Some plans are grandfathered from certain aspects of these market reforms if they do not significantly change the plan design from the date of PPACA enactment. The most common reason a retiree plan may lose its grandfather status is if the employer subsidy for the plan is reduced. All plans with a cap on the subsidy provided by the plan sponsor or other entity will eventually fail grandfather status.

Examples of PPACA changes required for all plans (except for retiree-only plans) include the following: having no lifetime limits; having no pre-existing condition exclusions; and providing coverage of dependent children until age 26 (can have a greater impact on pre-65 retiree plans than on active employee plans).

Examples of additional market reforms required for non-grandfathered plans include the following: providing coverage of preventive health care with no cost sharing, satisfying non-discrimination requirements for all medical plans, and providing the same coverage for emergency services regardless of network status.

The above reforms may significantly impact the appropriate level of starting health care claims costs as well as cost trends.

Medicare Advantage. Government payments to Medicare Advantage plans are generally reduced from those payable under prior law. These plans also must meet the same minimum loss ratio requirements that apply to other plans (greater than 85 percent). In addition, payments will be tied to quality measures and beneficiary satisfaction ratings. These changes may affect health care claims costs, trend rates and plan participation.

Retiree Drug Subsidy. Prior law allowed the plan sponsor to receive retiree drug subsidies (RDS) from the government tax-free and not reduce its actual pharmacy costs by the amount of the retiree drug subsidy received in determining its tax-deductible benefit cost. PPACA requires the employer to reduce its actual tax deduction for pharmacy costs by the amount of the retiree drug subsidy received, effectively eliminating the tax advantage of the RDS program for many for-profit employers. FASB required this part of the legislation be reflected in financial statements for private employers as soon as the impact could be determined.

The elimination of the tax favored RDS has led many plan sponsors to reevaluate alternative pharmacy designs and funding to yield financially better results. Any changes the plan sponsor makes may impact the valuation assumptions and methods, including eliminating the tax asset adjustments made for current RDS payments, adjusting future trends and adjusting claim costs for anticipated design changes.

High Cost Plan Excise Tax. The PPACA imposes a non-deductible excise tax beginning in 2018 on plans that exceed specified dollar thresholds. For 2018, the threshold for single coverage is $10,200 (may be adjusted depending on cost trends from 2014). For individuals aged 55 to 64, an additional $1,650 is added to the threshold. Retirees with family coverage have thresholds of $27,500 and an additional $3,450. The thresholds are indexed to general inflation after 2018. Many health plans will eventually exceed these thresholds over typical projection periods and, therefore, the liabilities could include payment of the tax plus any gross-up of the tax that might be charged by the insurer.

Health Exchanges. Health exchanges will be available beginning in 2014. These new exchanges will make available health insurance coverage for individuals who are not eligible for Medicare. Some plan sponsors may terminate current coverage or utilize the new options in their retiree benefit offerings. This may require changes to costs or the anticipation of selection of different plan options. Considerations may be similar to those involved in the current treatment of private exchanges for Medicare beneficiaries.

Appendix 2

Comments on the First Exposure Draft and Responses

The first exposure draft of this revision of ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Plan Costs or Contributions*, was issued in April 2012 with a comment deadline of July 15, 2012. Eighteen comment letters were received, some of which were submitted on behalf of multiple commentators, such as by firms or committees. For purposes of this appendix, the term "commentator" may refer to more than one person associated with a particular comment letter.

The Retiree Group Benefits Subcommittee carefully considered all comments received and the subcommittee, Pension Committee, and ASB reviewed (and modified, where appropriate) the proposed changes.

In addition, comments were received on the first exposure draft of the revision of ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions.* In areas where parallel language is included in ASOP Nos. 4 and 6, changes made to ASOP No. 4 in response to those comments were reflected in this second exposure draft.

Summarized below are the significant issues and questions contained in the comment letters and the responses.

The term "reviewers" in appendix 2 includes the subcommittee, the Pension Committee, and the ASB. Also, unless otherwise noted, the section numbers and titles used in appendix 2 refer to those in the first exposure draft.

GENERAL COMMENTS	
Comment	In the transmittal letter of the first exposure draft, commentators were asked whether the distinction among retiree group benefits plan, benefit plan and benefit options was helpful and whether it could be further clarified. Some commentators expressed the opinion that it was helpful while others that it was not. One commentator thought it was helpful but could be further clarified by using the phrase retiree group benefits program instead of the phrase retiree group benefits plan.
Response	The reviewers considered the different viewpoints expressed and concluded that making the distinction was helpful. They also agree with the suggestion to replace the phrase retiree group benefits plan with the phrase retiree group benefits program. The title of the proposed revision to the standard was changed to be consistent.
Comment	A few commentators opined that retiree group benefit actuaries serve clients and not the public at large. In this view: • Actuaries serve clients and prepare work for the client's benefit and at the client's behest; • No party other than the client should expect to benefit or draw any inference from the actuary's work; • Other entities in society provide regulations that serve the public interest; • As a result of the prior bullets, the standards should not require any work or disclosure that is intended to benefit interested parties in the public at large.

Response	The reviewers considered this viewpoint but concluded the current paradigm for self-governance established by the *Code of Professional Conduct* requires the ASOPs to reflect the profession's responsibility to the public and made no change.
SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.1, Purpose	
Comment Response	One commentator said that the expansion of this section from the current standard was too broad and would be confusing to the user. The commentator noted that the changes appeared to have been made to make the standard parallel to the first exposure draft of ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*, but was not appropriate in this situation. The reviewers believe that the expansion is appropriate given the many different types of professional services performed in connection with retiree group benefit programs and that this is an area where having parallel language to the exposure draft of ASOP No. 4 is appropriate. The reviewers made no change.
Comment Response	One commentator noted that the last sentences of this section of the exposure drafts of ASOPs No. 4 and 6 were different in that the first exposure draft of ASOP No. 4 referred to "plan" while the exposure draft of ASOP No. 6 referred to "a retiree group benefits plan." The commentator raised the concern that some users might misinterpret ASOP No. 4 as also covering "retiree group benefits plans." The reviewers note that a change was made in the second exposure draft of ASOP No. 4 to refer to "pension plan." In addition, as noted in the General Comments above, the phrase "retiree group benefits plan" was replaced by the phrase "retiree group benefits program" throughout the standard to add clarity.
Section 1.2, Scope	
Comment Response	One commentator said that the statement "health and death benefits…are the most common forms…" was inaccurate as dental and vision benefits are much more prevalent than death benefits. The reviewers note that health benefits would include dental and vision benefits and made no change.
Comment Response	One commentator disagreed with the use of language parallel to ASOP No. 4 in this section, stating that it gave "less significant aspects of RGB valuations…more prominence than is warranted." The reviewers considered this comment but decided to leave this section as is, noting that although in certain practice areas some of the identified types of calculations were not as prevalent, in other practice areas they were.
Comment Response	One commentator noted that section 1.2(d) included additional language that was not included in ASOP No. 4 and that this language created some confusion as to whether determining one-year retiree contributions are within the scope of the ASOP. The reviewers agree that the additional language might create confusion, and deleted the additional language.
Section 1.4, Effective Date	
Comment Response	One commentator expressed the opinion that using roll-forward techniques would not be appropriate for measurements performed in actuarial work covered by this standard. The reviewers considered this comment, noted that using roll-forward techniques was a common and appropriate practice in this area, and did not change the language.

SECTION 2. DEFINITIONS	
Comment Response	Several commentators expressed concerns about the number of defined terms. They also suggested that when defined terms are used in the rest of the standard, the defined terms be identified in some way. The reviewers considered these comments and made some changes in the defined terms but concluded that defining these terms would be helpful to the user. They agreed with the suggestion that defined terms be identified in the rest of the standard and used bolding to do so.
Comment Response	One commentator suggested that defined terms be presented in an order that reflects how the terms are related rather than in alphabetical order. The reviewers considered this suggestion but concluded that for later references to the defined terms alphabetical order would be more helpful and did not change the order.
Section 2.12, Contribution	
Comment Response	One commentator suggested that the defined term “contribution” be replaced by “funding contribution” or “sponsor funding contribution” to avoid confusion with contributions made by participants. The reviewers considered this suggestion and agree that there might be confusion. The defined term “contribution” was replaced by “prefunded contribution” to reduce the possibility of confusion.
Section 2.13, Contribution Allocation Procedure	
Comment Response	One commentator suggested a change to the definition of “contribution allocation procedure” to use the defined term “participant contribution” instead of “participant’s share of the annual claims cost.” The reviewers agree with this suggestion and made the change.
Section 2.17, Covered Population	
Comment Response	One commentator suggested changes to the definition. The reviewers believe that the definition as written is clear and appropriate, and made no change.
Section 2.18, Dedicated Assets	
Comment Response	One commentator suggested changes to the definition. The reviewers believe that the definition as written is clear and appropriate, and made no change.
Section 2.20, Fully Funded and Section 2.21, Funded Status	
Comment Response	One commentator indicated that these definitions were not needed and were not relevant to retiree group benefits valuations. The reviewers agree that “fully funded” is not needed and deleted it. The reviewers disagree that “funded status” would not be applicable to retiree group benefits valuations in all circumstances but simplified the definition.
Section 2.23, Measurement Date	
Comment Response	One commentator suggested removing the parenthetical reference to “valuation date.” The reviewers feel that the parenthetical reference adds clarity and did not delete the parenthetical reference.

Section 2.24, Measurement Period	
Comment	One commentator suggested modifications to the definition to add the word "expected."
Response	The reviewers agree and made the change.
Section 2.25, Medicare Integration	
Comment	One commentator suggested that "Medicare supplement plans" could be discussed in this definition.
Response	The reviewers disagree, noting that although these plans supplement Medicare, they are not relevant for how the term "Medicare integration" is used in the standard, and did not make any change.
Section 2.31, Premium	
Comment	One commentator suggested that the inclusion of risk-bearing in the definition was contradicted by language in the appendix and suggested that some clarification be added throughout the standard on the usage of "cost," "premium," and "rate."
Response	The reviewers believe that the definition is appropriate and that the language in the appendix is clear for the user of the standard. The reviewers did make changes throughout the standard on the usage of the words "cost," "premium," and "rate" to improve clarity.
Section 2.39, Trend	
Comment	One commentator felt that the definition of "trend" was not fully consistent with sections 3.7.1(b) and 3.12.1(a).
Response	The reviewers disagree and made no change.
SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Comment	One commentator felt that the section should be reordered and that the length of the section should be shortened, noting that it was longer than the corresponding section of the exposure draft for ASOP No. 4.
Response	The reviewers made some edits to the ordering of the section and note that one of the reasons why ASOP No. 6 is longer than ASOP No. 4 is that ASOP No. 6 also provides guidance on needed assumptions that is not provided in ASOP Nos. 27 and 35.
Section 3.1, Overview	
Comment	One commentator thought that it was unclear whether ASOP No. 4 applied to retiree group benefits valuations.
Response	The reviewers note that the title of ASOP No. 4 refers only to "pension plans" not "retiree group benefits programs," and made no change.
Comment	One commentator suggested adding additional text to clarify the level of the involvement of the actuary in the method/assumption selection process.
Response	The reviewers believe that the current guidance is sufficiently clear and made no change.
Section 3.2, General Procedures	
Comment	One commentator expressed the opinion that the inclusion of this section might confuse the user of the standard.
Response	The reviewers feel that section 3.2 provides the user of the standard with a roadmap to the guidance provided in section 3. Changes in the sequence of the procedures were made to assist the user.

Section 3.3, Purpose of Measurement	
Comment Response	One commentator felt that the list of examples places too much emphasis on types of calculations that are not common. The commentator also suggested that it might be appropriate to state the standard does not provide guidance for one-year calculations of participant costs and contributions. The reviewers considered the first comment and concluded that the list was appropriate and made no change. They also noted that changes had been made in section 1.2(d) to eliminate perceptions that this standard provides guidance on determining one-year retiree contributions.
Section 3.3.3, Risk or Uncertainty	
Comment Response	One commentator expressed the opinion that this section might need more clarification. The reviewers note that this language is in ASOP No. 41, *Actuarial Communications*, and do not believe it needs more clarification. They made no change.
Section 3.4.2, Events after the Measurement Date	
Comment Response	One commentator opined that the phrase "…need not be reflected…" ought to read "…should not be reflected…." The reviewers believe that the current language is appropriate and made no change.
Section 3.5.1(b), Components of the Modeled Retiree Group Benefits Plan (Eligibility Conditions)	
Comment Response	One commentator suggested adding the words "date of hire or" before the word "service." The reviewers agree with adding the concept and changed the section to include "date of hire."
Section 3.5.1(d)(4), Components of the Modeled Retiree Group Benefits Plan (Participant Contributions)	
Comment Response	One commentator suggested expanding the guidance on considerations when the plan sponsor has incorporated caps on employer costs. The reviewers believe that the guidance provided is sufficient and made no change.
Section 3.5.3, Reviewing the Modeled Retiree Group Benefits Plan	
Comment Response	One commentator felt that the guidance in this section and in section 3.7.6 overlapped with the guidance provided in section 3.10 and that the two sections should be combined with section 3.10. The reviewers believe that it is appropriate to keep this guidance in the separate sections and made no change.
Section 3.6, Modeling the Covered Population	
Comment Response	One commentator suggested adding language to explicitly include non-retired former employees who may be eligible for benefits in the future. The reviewers agree and added the proposed language.
Section 3.6.4, Dependents and Surviving Dependents of Participants	
Comment Response	One commentator suggested adding language to explicitly reference disabled adult dependent children as their costs may differ significantly. The reviewers agree and added the proposed language.

Section 3.6.7, Hypothetical Data	
Comment	One commentator noted that this language differed from that in the ASOP No. 4 exposure draft and recommended deleting it.
Response	The reviewers believe that the section is appropriate but replaced the language with the corresponding language from the second exposure draft of ASOP No. 4.
Section 3.7, Modeling Initial Per Capita Health Care Costs	
Comment	One commentator noted that “health care costs” had replaced “health care rates” and thought this usage might be confusing.
Response	The reviewers note that the defined word “cost” had been replaced by “periodic cost” in order to reduce the risk of confusion and made no change.
Section 3.7.1(a), Net Aggregate Claims Data (Paid Claims)	
Comment	One commentator asked whether the language required the actuary to review a claims triangle before setting the starting claim cost assumption, noting that such a requirement would increase the time and cost required with at most a minimal improvement in the quality of the estimate.
Response	The reviewers believe that the language does not dictate a specific approach and that the approach taken is a matter of the actuary’s professional judgment, and made no change.
Section 3.7.6, Impact of Medicare and Other Offsets	
Comment	One commentator asked if it would be more appropriate to use “medical” instead of “health” in this section because only medical plans are integrated with Medicare.
Response	The reviewers note that it is possible for a prescription drug program to integrate with Medicare Part D and made no change.
Section 3.7.8, Pooled Health Plans (including Community Rated Plans)	
Comment	One commentator suggested renaming this section along the lines of “Identification and Measurement of Hidden Subsidies” and suggested that the guidance make a distinction between self-insured plans and fully insured plans.
Response	The reviewers note that the guidance provided in this section is not intended to cover all of the other areas of possible subsidies and made no change.
Comment	One commentator suggested defining “pooled health plan” and “community-rated plan.”
Response	The reviewers agree with the suggestion to define “pooled health plan” and added it to section 2. They note that the phrase “community-rated plan” in the heading was intended to be helpful but is not used in the guidance and did not add a definition.
Comment	Several commentators responded to the transmittal letter question regarding whether the guidance in this area was appropriate and whether there would be any challenges that an actuary could encounter in deriving age-specific claims costs for these types of plans. Some said that the language should be strengthened, some indicated that the guidance was appropriate, and others responded that the guidance was not appropriate and that age-specific claims costs should not be used for these types of plans (or in a subset of these types of plans). Some commentators said that they were not sure what this section required them to do. One commentator suggested that it would be appropriate to allow for a transition between non-age-specific claims to age-specific claims. A few commentators identified practical difficulties that an actuary might find in applying the guidance. Finally, several commentators suggested changes in the text to make it clearer.

Response	The reviewers considered the comments and concluded that in regard to these types of plans it is appropriate practice for an actuary to apply age-specific claims costs. The reviewers revised the language to make it clearer that this approach should be used. The reviewers also added guidance to the actuary on how to handle some of the challenges identified by the commentators. The reviewers agree with some of the text edit suggestions and made them or slightly revised versions of them. In other situations, they disagree with the suggestions and made no change.
Comment Response	One commentator expressed the opinion that, if age-related claims costs are not used, the actuary should be required to disclose this fact. The reviewers believe that the disclosure requirements regarding the development of the per capita claims costs are sufficient and made no change.
Section 3.7.9, Adjustment for Plan Design Changes	
Comment Response	One commentator suggested adding the word “benefit” to the title of this section. The reviewers agree and made the change.
Comment Response	One commentator made several suggestions for changes in the text in this section. The reviewers agree with some of the suggestions and made those changes.
Section 3.7.12, Adjustment for Trend	
Comment Response	One commentator recommended that the language regarding the basis for the adjustments for trend should require the actuary to take into account experience from outside the health plan. The reviewers note that in some situations it may be appropriate to consider only the experience of the health plan. The reviewers did modify the text slightly.
Comment Response	One commentator recommended that the guidance be revised to say that the actuary “may consider using separate trend rates” instead of “should consider using separate trend rates.” The commentator noted that there may be cases where this is outside the scope of the assignment and/or the purpose of the measurement. The reviewers considered the suggestions but made no change. They note that the scope of the assignment or purpose would determine what is needed and the actuary would take those considerations into account.
Section 3.7.13, Adjustment When Plan Sponsor is Also a Provider	
Comment Response	One commentator recommended that the standard advise the actuary to check internal controls and to analyze charges and reimbursements. The reviewers believe that the current level of guidance is appropriate and made no change.
Section 3.10, Administrative Inconsistencies	
Comment Response	One commentator recommended that additional guidance be provided on the steps the actuary should take if administrative inconsistency is discovered. The reviewers believe that the current level of guidance is appropriate and made no change.

Sections 3.11, Types of Actuarial Present Value	
Comment	One commentator felt that this section was in the wrong location in the standard and recommended that it be deleted.
Response	After careful consideration of the comments received and the objectives of the guidance, the reviewers removed nearly all of the present value type language from the proposed standard. The concept of a market-consistent present value remains in the proposed standard and is now a defined term, with some guidance in section 3.15. The market-consistent present value language now references broad economic and demographic assumptions inherent in observable market pricing of relevant cash flows.
Section 3.12.1(a), Economic Assumptions (Health Care Cost Trend Rate)	
Comment	One commentator thought the guidance should be expanded to discuss the mix of services pre and post age 65, the length of a select period, and distinctions between the trend rates for total claims and the trend rates for net claims. Another commentator suggested providing more general guidance on reflecting lifetime maximums.
Response	The reviewers believe that the level of guidance provided is appropriate and made no change.
Section 3.12.1(d), Economic Assumptions (Adverse Selection)	
Comment	One commentator suggested expanding the guidance provided in this section.
Response	The reviewers believe that the level of guidance provided is appropriate and made no change.
Section 3.12.2, Demographic Assumptions	
Comment	One commentator thought the guidance should be expanded regarding the need for consistency among assumptions. Several commentators suggested some text edits.
Response	The reviewers believe that the level of guidance provided is appropriate and that the guidance is clear, and made no change.
Section 3.12.3, Participant and Dependent Coverage Assumptions	
Comment	Several commentators made suggestions on text changes in this section.
Response	The reviewers believe that the language is clear and the level of guidance is appropriate and made no change.
Section 3.12.4, Effect of Retiree Group Benefit Plan Changes on Assumptions	
Comment	One commentator made suggestions on text changes in this section.
Response	The reviewers modified the language to make the intent clearer.
Sections 3.14, Measuring the Value of Accrued or Vested Benefits	
Comment	One commentator recommended that this section be deleted as possibly giving users the mistaken impression that a retiree group benefit program must have accrued or vested benefits.
Response	The reviewers revised the guidance provided to make it clearer that it is possible that the retiree group benefits are not accrued or vested.

Sections 3.15, Relationship Between Procedures Used for Measuring Assets and Obligations	
Comment	One commentator recommended that this section be deleted as not being relevant to retiree group benefits valuations. Another commentator suggested clarifications regarding its intent.
Response	The reviewers revised the title of this section and clarified the language to make it clearer that this section was not intended to require market-consistent measurements but rather to require that actuaries not double-count or leave out obligations. For example, it would not be appropriate to reflect claims incurred but not reported both as a separate liability on the balance sheet of a plan sponsor and as a part of an obligation of the retiree group benefits program on the same balance sheet.
Section 3.16, Actuarial Cost Method	
Comment	One commentator noted that the language regarding administrative expenses does not make it clear that they may be included in the per capita costs as discussed in section 3.7.15 and which is a common industry practice.
Response	The reviewers agree and added language explicitly permitting expenses to be included in the per capita costs.
Sections 3.17, Allocation Procedure	
Comment	One commentator felt that this section should be combined with section 3.16. Another commentator suggested some text changes.
Response	The reviewers believe that separating this guidance from the guidance on cost methods provides clarity and made no change.
Section 3.18, Approximations and Estimates	
Comment	One commentator suggested adding another example to this section. The commentator also suggested adding a cross-reference to a disclosure requirement.
Response	The reviewers note that the list of examples is not intended to be exhaustive and made no change. The reviewers also note that the use of approximations and estimates is common in actuarial practice and that no specific cross-reference is needed.
Section 3.19, Volatility	
Comment	One commentator recommended that this section be deleted.
Response	The reviewers believe that this section provides appropriate guidance and made no change.
Section 3.20.1, Modeled Cash Flows Compared to Recent Experience	
Comment	One commentator suggested changes in the text to clarify that it is the credibility of a plan's experience rather than its size that is relevant for purposes of this section.
Response	The reviewers agree and made the suggested change.
Section 3.22, Reliance on a Collaborating Actuary	
Comment	One commentator expressed concern about the notion that all signing actuaries are responsible for the overall valuation results. The commentator requested clarification that each actuary is only responsible for aspects of the valuation that he or she can certify based on the actuary's area of expertise.
Response	The reviewers considered the issues raised and concluded that the language in the existing standard is more appropriate and reverted to that language.

SECTION 4. COMMUNICATIONS AND DISCLOSURES	
Comment Response	One commentator suggested additional disclosure requirements regarding the assumption that the retiree group benefits program will continue indefinitely. The reviewers believe the current disclosures are sufficient and made no change.
Comment Response	Several commentators expressed concern about the added disclosure requirements regarding "fully funded" and "funded status." The reviewers agree with concerns regarding "fully funded" and removed the proposed disclosures regarding such statements. However, the reviewers retained and modified the language of this section applicable to measurements of funded status. The modified language makes it clearer that the standard does not require the disclosure of "funded status," only what is required if an actuary does disclose a plan's "funded status."
APPENDIX 1	
Comment Response	Several commentators suggested changes in the text. One commentator suggested deleting several sections in the Current Practices section of the appendix. The reviewers agree that some of the proposed edits add clarity and made those edits. The reviewers disagree with the suggestion to delete those sections but made some text edits to make the language clearer.