



AMERICAN ACADEMY of ACTUARIES

Comment #5 – 3/31/10 – 5:25 p.m.

March 31, 2010

ASOP No. 35 Revision
Actuarial Standards Board
1850 M Street NW, Suite 300
Washington, DC 20036-4601

Re: Comments on Proposed Revision of ASOP No. 35

To Whom It May Concern:

The American Academy of Actuaries'¹ Joint Committee on Retiree Health would like to offer the following comments on the exposure draft of Actuarial Standard of Practice (ASOP) No. 35 that includes proposed changes related to mortality improvement recognition. We understand the changes being exposed are quite limited and are intended for an audience of pension actuaries, but given the nature of ASOPs and retirement practice, we believe it is important to comment on some general approaches and crossover effects found in the exposure draft. We are not responding specifically to the questions posed in the *Request for Comment* section of the draft, but we do agree with much that is noted in the comments submitted by the Academy's Pension Committee.

Our comments are from the perspective of employee benefit valuation actuaries who deal with mortality assumptions for benefits other than pensions (OPEBs), primarily retiree life and health benefits. When pension ASOPs were reorganized 10 years ago, the ASB made the decision to revise ASOP No. 6, the OPEB ASOP, in a fashion that reduced its length by simply referencing other ASOPs that dealt with economic and non-economic assumptions for pension plans (i.e., ASOPs No. 27 and No. 35). Thus, our comments regarding the exposure draft are of two types: those that refer to actuarial standards in general and those that refer to the effect on OPEB valuations.

General comments regarding standards

Mandating an assumption in an actuarial model is one of the most important functions an ASOP serves. The proposed change states that if a mortality assumption is used, an assumption about expected future mortality improvement should be included. In essence, the change makes improvement scales a necessary part of valuations using mortality, which is to say, most retirement benefit valuations. As written, the exposure draft is not clear that an actuary can be in compliance by simply stating the mortality table does not contain provision for mortality

¹ The American Academy of Actuaries is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

improvement or by including a well-considered margin adjustment. In short, this seems to be a mandate without an intelligible opt-out.

The use of the word “improvement” is all-encompassing and does not allow for the possibility that at some future point there will not be expected improvements in mortality. The wording makes it imperative that future ASBs monitor the mortality situation, in particular, so that the profession does not have a standard that is unrealistic. We do not think a standard should have language that so strongly implies the optimistic and disregards the “black swans.” We suggest the ASB find a term other than “improvement” that acknowledges change might move in either direction.

Comments regarding OPEBs and mortality improvements

As to the relevance to OPEB valuations, inclusion of assumptions about mortality improvement has an effect, so mandating improvement assumptions will certainly complicate the modeling of OPEB benefit projections. Retiree life insurance is straight forward; if cohort mortality is expected to improve, the death benefit will be paid later, and, all other things being equal, the discounted present value will be lower.

For retiree health insurance, the situation is more complicated. Mortality improvement is almost certainly correlated positively with health improvement. The binary nature of mortality is not, however, matched formulaically with the health care payments that are the basis for actuarial valuations of retiree health benefits. Additional health costs may be associated with additional years of life (may, in fact, even be the reason for improved mortality), but it is not evident that an expected improvement in mortality can be added to a retiree health valuation (such as for FAS 106 compliance) model without other adjustments in aging factors or trend to maintain accuracy. The effect of age is significant; an 85 year old will have a higher expected one-year cost than a 65 year old. Actuarial valuations of retiree health benefits quantifiably measure the cost difference due to age, and that quantification of age factors is a valuation assumption. Current assumptions about the health care cost associated with aging are not necessarily appropriate for next-generation mortality—it may be that increases would be less steep with mortality improvement. The interconnection is unlikely to be a straightforward relationship.

When ASOP No. 6 was revised in 2001, the standard was expanded to describe the standard projection model and allowed for the use of other modeling techniques (3.4.13), including an actuarial model that separately values the high costs in the last year of life, and the lower “maintenance” costs that are incurred by survivors. ASOP No. 6 set out that when using such a model, the actuary should disclose the method used and comment on its applicability.

Retiree group benefit measurements that incorporate the last year of life model could accommodate the use of projected improvements in mortality. This type of model is rarely used today. If the proposed changes to ASOP No. 35 are implemented, the actuary conducting a retiree group benefit measurement would be faced with a dilemma: use a mortality assumption different than the pension assumption for the same group of retirees, attempt to adjust the per capita claims costs to reflect the expected change associated with the mortality improvement, or produce a valuation that includes an unintended liability bias.

The foregoing discussion about mortality improvement and health care costs does not invalidate any conclusions the ASB may have about the use of mortality improvement in pension valuations. It does indicate, however, that the relatively efficient wording change in ASOP No. 35 to reflect those conclusions for pension valuations will probably not suffice to explain the situation for retiree health valuations. In other words, the link from ASOP No. 6 to ASOP No. 35 will become more complicated if ASOP No. 35 requires a mortality improvement assumption.

The Joint Committee on Retiree Health appreciates the continued efforts of the Actuarial Standards Board in ensuring that the standards of the actuarial practice are current. If you have any questions about these comments or if you need additional information, please contact Heather Jerbi, the Academy's senior health policy analyst (Jerbi@actuary.org; 202.785.7869).

Sincerely,

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