



**ACTUARIAL STANDARDS BOARD**

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**• EXPOSURE DRAFT •**

**Proposed Revision of  
Actuarial Standard of  
Practice No. 6**

**Measuring Retiree Group Benefits Obligations and Determining  
Retiree Group Benefits Plan Costs or Contributions**

**Comment Deadline:  
July 15, 2012**

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

**Approved for Exposure by the  
Actuarial Standards Board  
April 2012**

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**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 Plan Costs or Contributions

**FROM:** Actuarial Standards Board (ASB)

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

This document is an exposure draft of a revision of ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Plan Costs or 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](mailto: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  
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: **July 15, 2012**

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### **Background**

The original ASOP No. 6, *Retiree Group Benefit Obligations*, 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.

In 1999, the ASB convened a special task force of knowledgeable practitioners in the retiree group benefits field to draft a revision of this standard. The Task Force on Retiree Group Benefits updated ASOP No. 6 and, after revisions were made to reflect comments on the exposure draft, the ASB adopted it in December 2001. ACG No. 3 was repealed.

Since the update of ASOP No. 6 in 2001, practice has continued to evolve. 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*, which include guidance on selecting assumptions for both pensions and retiree group benefits, have been revised. A proposed revision of ASOP No. 27 was released earlier this year as an exposure draft. ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*, which is an “umbrella” standard for pension plans parallel to the role that ASOP No. 6 serves for retiree group benefits plans, also has been revised and was released earlier this year as an exposure draft. The ASB appointed a Retiree Group Benefits Subcommittee to the Pension Committee and tasked it with the responsibility for updating ASOP No. 6 and, where appropriate, making it consistent with ASOP No. 4. The following are the areas of major changes in the ASOP.

### **Level of Guidance and Education Provided**

The prior version of ASOP No. 6 included more educational content than is typically included in standards. The proposed standard continues to include a greater amount of educational content because many actuaries are relatively new to this practice area.

### **Key Proposed Changes to ASOP No. 6**

#### ***Definition of Plan***

The concept of “plan” is complicated for retiree group benefits plans. The term is commonly used to mean many different things. This proposed revision distinguishes among retiree group benefits plan, benefits plan and optional benefits. The retiree group benefits plan being valued may consist of several different benefit plans (such as medical, dental, and prescription drug plans), each of which may include one or more optional benefits.

#### ***Community Rating***

The ASB believes that employers participating in fully pooled health plans for both active participants and retirees, for example, have an implicit subsidy unless the premium charged to retirees is age-rated. In the course of researching this matter, three large statewide health insurance pools for state and local governmental employers were surveyed. Responses indicated such pools would be willing to provide actuaries with the pool-wide age-gender distributions of

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plan member counts. Actuaries could then use this information in deriving age-adjusted claims costs for retiree group benefits valuations performed on behalf of employers participating in fully-pooled health plans covering actives and retirees. The ASOP was therefore revised to make it clear that the actuary should use the full age-specific costs even if the plan is described as being community-rated.

### ***Trend Rates***

A key assumption in retiree group benefits plan valuations is the trend rate, the assumed rate of increase in the underlying per capita costs. The draft provides additional guidance in this area, particularly regarding the factors an actuary should consider in setting the ultimate trend rate and the select period.

### ***Definition of Dependents***

The existing version of ASOP No. 6 made a distinction between the spouse of a participant and that participant's dependents. This distinction was deemed not necessary and the standard revised to use "dependents" to refer to both types of individuals.

### ***Acceptance, Lapse, and Re-Enrollment Rates***

More guidance is provided on the selection of acceptance, lapse and re-enrollment rates.

### ***Guidance on Medicare Benefits***

Actuaries providing services in this area need to determine which participants are covered by Medicare and which are not. In addition, Medicare now provides prescription drug subsidies to some retiree plans. The standard was revised to provide guidance in both areas.

### ***Dedicated Assets***

The language regarding dedicated assets has been modified to clarify that, when legal or accounting requirements don't conflict, dedicated assets may include assets such as earmarked book reserves or Rabbi Trusts that are not part of an irrevocable trust.

### ***Consistency with ASOP No. 4***

As noted earlier, changes to ASOP No. 4 are being proposed in an exposure draft released earlier this year. Changes have been made in this exposure draft to make the guidance parallel on issues covered in both standards. These include adding definitions of "funded status," "fully funded," as well as "immediate gain and spread gain actuarial cost methods," and providing guidance on their use. In addition, present values based on plan assets and present values not based on plan assets were distinguished. The definition of "prescribed assumption or method" was also revised. Guidance was added on the purpose of a measurement, gain sharing and other valuation issues, the assessment of a contribution allocation procedure, and the assessment of contributions set by contract or law. Readers may wish to review the transmittal letter for the ASOP No. 4 exposure draft for more information on these parallel changes.

To improve consistency, the ASB may make further modifications to ASOP Nos. 4 or 6 based on comments received regarding these two exposure drafts.



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### Request for Comments

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

1. Is the level of guidance and educational content appropriate?
2. Is the distinction among retiree group benefits plan, benefit plan, and optional benefits helpful to the actuary or not? Could it be further clarified?
3. Is the revised guidance regarding the use of the “community-rated concept” appropriate? Are there any challenges that an actuary could encounter in deriving age-specific claims costs for employers participating in fully pooled health plans covering active participants and retirees? For those respondents who can do so, please provide specific examples of any challenges encountered in obtaining information from managers of pooled health plans.
4. Are the changes to the standard to make it consistent with ASOP No. 4 appropriate?
5. Are there any other areas in which the guidance should be revised?

The ASB voted in April 2012 to approve this exposure.

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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.*

**ACTUARIAL STANDARD OF PRACTICE NO. 6**

**MEASURING RETIREE GROUP BENEFITS OBLIGATIONS AND DETERMINING  
RETIREE GROUP BENEFITS PLAN 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 plan and determining costs or contributions for such plans. This standard provides guidance on assumptions that are specific to retiree group benefits plans. In addition, it addresses broader measurement issues, actuarial 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 plan.
- 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 plan:
- a. measurement of obligations. Examples include determinations of funded status, assessments of solvency upon plan termination, market measurements and measurements for use in pricing benefit provisions;
  - b. assignment of the value of plan obligations to time periods. Examples include contributions, accounting costs, and cost or contribution estimates for potential plan changes;
  - c. development of a cost allocation procedure;
  - d. development of a contribution allocation procedure used to determine contributions for a plan, including the determination of plan sponsor or participant contributions when such contributions are based on expected retiree group benefits costs;
  - e. determination as to the types and levels of benefits supportable by specified cost or contribution levels; and
  - f. projection of retiree group benefits obligations, plan costs or contributions, and other related measurements. Examples include cash flow projections and projections of a plan's funded status.

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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 or contribution allocation procedure includes giving advice on developing or modifying a cost 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 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 in advance of the time benefit payments are due, usually in the form of a normal cost and an actuarial accrued liability (sometimes referred to as a funding method).

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- 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 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 plan (sometimes referred to as antiselection).
- 2.7 Amortization Method—A method under a contribution 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 plan, 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—A potential payment to pre-fund the retiree group benefits plan, 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.
- 2.13 Contribution Allocation Procedure—A procedure for determining the periodic contribution for prefunding a retiree group benefits plan. It may produce a single value, such as normal cost plus twenty-year amortization of the unfunded actuarial accrued liability, or a range of values. This term does not relate to the process of determining the participant's share of the annual claims cost.

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- 2.14 Cost—The portion of plan obligations assigned to a period for purposes other than funding. In many situations, this is for accounting purposes.
- 2.15 Cost Allocation Procedure—A procedure for determining the periodic cost for a retiree group benefits plan (for example, the procedure to determine the net periodic postretirement benefit cost under accounting standards).
- 2.16 Covered Individual—An active participant, retiree, dependent, or surviving dependent.
- 2.17 Covered Population—Active and retired participants, participating dependents and surviving dependents of participants who are eligible for benefit coverage under a retiree group benefits plan. The covered population may also include contingent participants.
- 2.18 Dedicated Assets—Assets designated for the exclusive purpose of satisfying the retiree group benefits obligations. Examples include the following:
- a. life insurance policies held by the plan sponsor to cover some of the plan sponsor’s retiree 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.
- 2.19 Dependents—Individuals who are covered under a retiree group benefits plan by virtue of their relationship to a participating employee or retiree.
- 2.20 Fully Funded—A phrase that indicates that a particular measure of plan assets equals or exceeds a particular measure of plan liability. Any other phrase that conveys a similar message must meet the requirements in this standard for the use of the phrase fully funded. Disclosure requirements for an actuarial work product that contains this phrase or an equivalent phrase are contained in section 4.1(s).
- 2.21 Funded Status—A comparison of a particular measure of plan assets to a particular measure of plan liabilities. The comparison is often shown as a ratio of the asset measure to the liability measure or as the amount by which the asset measure exceeds or falls short of the liability measure. A plan’s funded status can be measured in many different ways and the measurement can easily be misunderstood or misinterpreted. Because of the role that funded status often plays in the conclusions a user derives from the actuary’s work product, the actuary should describe what any measure of funded status represents in accordance with sections 4.1(q), 4.1(r), and 4.1(s).

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- 2.22 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 plan, rather than as part of the normal cost of the retiree group benefits plan.
- 2.23 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).
- 2.24 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 receives the final benefit.
- 2.25 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.
- 2.26 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.
- 2.27 Normative Database—Data compiled from sources that are expected to be typical of the retiree group benefits plan, 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 plans.
- 2.28 Participant—An individual who (a) is currently receiving benefit coverage under a retiree group benefits plan or (b) is reasonably expected to receive benefit coverage under a retiree group benefits plan upon satisfying the plan’s eligibility and participation requirements.
- 2.29 Participant Contributions—Payments made by a participant to support a retiree group benefits plan.

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- 2.30 Plan Sponsor—An organization that establishes or maintains a retiree group benefits plan. Examples of plan sponsors include employers and Taft-Hartley Boards of Trustees.
- 2.31 Premium—The price charged by a risk-bearing entity, such as an insurance or managed care company, to provide risk coverage.
- 2.32 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 plan 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.
- 2.33 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, or other legally binding authority). For this purpose, an assumption or method set by a governmental entity for a plan 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.
- 2.34 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.
- 2.35 Retiree Group Benefits Plan—The plan specifying retiree group benefits: including eligibility requirements, contributions, and the design of the benefits being provided.
- 2.36 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 plan.
- 2.37 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).
- 2.38 Surviving Dependent—A dependent who qualifies as a covered individual under the retiree group benefits plan following the death of the associated participant.
- 2.39 Trend—A measure of the rate of change, over time, of the per capita expected benefit payments.



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### Section 3. Analysis of Issues and Recommended Practices

- 3.1 Overview—Measuring retiree group benefits obligations and determining retiree group benefits plan costs or 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 assumptions or methods prescribed by applicable law or selected by others.

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 or contribution allocation procedures, and provides guidance for coordinating and integrating all of these elements of an actuarial valuation of a retiree group benefits plan. 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 plan costs or 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 retiree group benefits plan provisions 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

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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. determine relevant actuarial present value types (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 the relationship between procedures used for measuring assets and obligations (section 3.15);
  - k. select an actuarial cost method, if applicable (section 3.16);
  - l. select a cost or contribution allocation procedure, if applicable (section 3.17);
  - m. assess the overall implication of the contribution allocation procedure or contributions set by contract or law, if applicable (section 3.17);
  - n. consider the use of approximations and estimates (section 3.18);
  - o. consider sources of significant volatility (section 3.19);
  - p. review and test the results of the calculations for reasonableness (section 3.20);  
and
  - q. evaluate prescribed assumptions and methods selected by another party, if applicable (section. 3.21).
- 3.3 Purpose of Measurement—When measuring retiree group benefits obligations and determining plan costs or 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, benefit plan 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

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may be interested in 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, the actuary should consider the risk or uncertainty inherent in the assumptions and methods when determining an appropriate approach to the measurement.
- 3.4 Measurement Date Considerations—When measuring retiree group benefits obligations and determining retiree group benefits plan costs or 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 3.23 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 Retiree Group Benefits Plan Provisions—In modeling the known provisions of the retiree group benefits plan, 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 Plan—The actuary should incorporate the significant elements of the known retiree group benefits plan provisions 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

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benefits), and other monetary benefits (such as Medicare premiums or defined dollar benefits).

- b. Eligibility Conditions—All relevant eligibility requirements should be considered. These include, but are not limited to, conditions related to age, service, 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 plans require contributions from participants as a condition for their continued eligibility for plan 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 rates.
  - 1. Participant Postretirement Contribution Formula—In modeling the retiree group benefits plan, the actuary should reflect actual participant contribution levels. 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 retiree claims costs, and amounts based on combined costs for active participants and retirees).
  - 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 plan 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 costs.
  - 4. Contributions as Defined by Limits on Plan Sponsor Costs—Some retiree group benefits plans place an upper limit on the plan sponsor cost 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 cost in any current or future

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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 plan.

- e. **Payments from Other Sources**—The cost of coverage in some retiree group benefits plans 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 plan’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 costs.
- 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, 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 plan (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 costs

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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 benefit plan integrates with them.

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

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; plan 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 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 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

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situations where retirees have opted out of medical coverage at the time of retirement, but may later elect to resume 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 plan's eligibility conditions and benefit levels for dependents and surviving dependents may differ from the plan's eligibility conditions and benefit levels for retirees. Benefit coverage for the dependent of a retiree 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 retiree, or a limiting age), or may cease when the retiree dies.

The actuary should generally model dependents (other than dependent children) separately from retirees because of differences in the timing of Medicare eligibility and in mortality between the retiree and the dependent. For 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 plans that have liberal early retirement eligibility conditions, dependent children coverage can significantly increase the overall number of covered individuals 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 plan databases may furnish pension plan data to represent the retiree group benefits plan covered population. 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 Plan but Not Receiving Pension Benefits**—Former employees may be participants in the retiree group benefits plan, but may no longer be participants in the pension plan (such as employees who received lump-sum pension payments). Dependents and surviving dependents of retirees may be eligible for the retiree group benefits plan, but may not be in the pension plan census data.
  - b. **Retirees Receiving Pension Benefits but Not Covered by the Retiree Group Benefits Plan**—Retirees may be participants in the pension plan, but may not be covered by the retiree group benefits plan (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 plan or may have waived coverage for certain or all of the underlying retiree group benefits.

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- 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 plan.

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 plan 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(h)).

3.6.7 Hypothetical Data—The actuary may use hypothetical data as appropriate for the purpose of the measurement.

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, retirees vs. dependents).



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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 retiree 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

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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 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 program administration (see sections 3.7.7 and 3.7.8 for adjustments to an age-specific basis).

If premium rates, adjusted or unadjusted, are used as the basis for initial per capita rates 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 rates, the actuary should develop separate rates for Medicare-eligible participants. Such rates 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 retirees 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

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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 increase by age. Therefore, 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 pool with other groups, additional analysis relating to age-specific costs may be needed. For example, if the pool comingles the experience of active participants and retirees, and the fully pooled premium rate for non-Medicare retirees does not reflect their full age-specific cost, the pool'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 pool. To the extent the premiums are based on the demographics of the pool, the actuary performing a retiree group benefits valuation for a group should use age-specific costs based upon the pool's total age distribution and the pool'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. The actuary may base the age-specific costs on a distribution table for the total number of covered health plan members in the pool by age, or by age and gender, provided by the health plan. Alternatively, the actuary may base the age-specific cost on manual rates or other sources relevant to the plan of benefits covering the group's members.

In some very limited cases, the use of the pooled premium rate may be appropriate without regard to adjustments for age. 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.

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- 3.7.9 Adjustment for Plan Design Changes—The actuary should adjust the claims costs to reflect significant differences, if any, between the 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 plan (for example 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 be based on experience from outside the health plan.

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

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- 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(k)). 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 plan. 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 rates 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 retiree 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 retiree group benefits plan provisions, covered population, per capita health care rates, 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

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retirees) 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 retiree group benefits plan provisions, 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(u)).

- a. Retiree Group Benefits Plan 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, 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 plan. 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 plan 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

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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. Examples of areas of possible inconsistencies include: participant contribution determinations that combine claims for active participants and retirees 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 plan 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(u)).

3.11 **Types of Actuarial Present Values**—An actuarial present value of a retiree group benefits obligation will vary with two fundamental factors: the proportion of the projected benefits included in the calculation, as determined by the actuarial cost method, and the types of actuarial assumptions used, as addressed more fully in ASOP Nos. 27 and 35. The actuary should select the type of actuarial present value of a retiree group benefits obligation that is appropriate for the purpose of the measurement.

3.11.1 **Present Values Based on Dedicated Assets**—Dedicated-asset-based present values of retiree group benefits obligations vary with the allocation of the assets used to fund the obligation, and are typically based on a discount rate that reflects the expected return on dedicated assets. While dedicated-asset-based present values can be used for many purposes, they are typically used as funding targets to assess

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funded status and to determine pre-funding contribution amounts such that, if the return on asset assumption is realized, assets would be expected to be adequate to provide for future benefits.

3.11.2 Present Values Not Based on Dedicated Assets—Present values of retiree group benefits obligations that are not based on dedicated assets do not vary with the allocation of the assets used to fund the obligation, and the discount rate does not reflect the expected return on dedicated assets. Present values that are not based on dedicated assets can be based on a variety of different types of discount rates consistent with the purpose of the measurement. Examples include the following:

- a. present values that vary with the risk of non-payment of scheduled benefits, which might depend on the amount of collateral in the form of plan assets and on the credit-worthiness of the plan sponsor;
- b. present values that are based on a particular external yield curve, the choice of which does not vary with the risk of non-payment of scheduled benefits; and
- c. present values that estimate the amount necessary to purchase contracts to settle the benefits accrued in a plan.

3.11.3 Market-Consistent Present Values—Market-consistent present values of retiree group benefits obligations are types of present values not based on plan assets. A market-consistent present value is one that is consistent with the price at which expected plan benefit payments 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 plan cash flows or for entire retiree group benefits plans is not a prerequisite for this present value measurement. A market-consistent present value of a retiree group benefits obligation may vary depending on the purpose of the measurement.

If the actuary calculates a market-consistent present value, the actuary should use assumptions that are consistent with assumptions behind market valuation of cash flows with term structure, credit quality, liquidity, and payment options that are similar to the retiree group benefits plan cash flows being measured. In this calculation, the actuary will typically need to use estimates for valuation parameters that cannot be readily observed in the marketplace; for example, a discount rate for very long-dated retiree group benefits plan cash flows. Additional considerations include, but are not limited to, the following:

- a. If the actuary uses a market-consistent measurement for assessing plan solvency, the actuary should measure benefits earned as of the measurement date and should not reflect payment default risk;



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- b. If the actuary uses a market-consistent measurement for assessing ongoing funded status or contribution requirements, the actuary should assume an ongoing plan sponsor, should use professional judgment regarding the benefits to be measured and should not reflect plan sponsor default risk; and
- c. If the actuary uses a market-consistent measurement for assessing the economic value of a retiree group benefits plan, the actuary should measure benefits earned as of the measurement date and should reflect payment default risk.

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 cost rates 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 claims rates”). 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

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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 cost rates 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 plan, the measurement may require an assumption for the rate of change in participant contributions. For some retiree group benefits plan, this may be a function of health care trend rate or other economic assumptions. For some other retiree group benefits plan, 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 plan 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 plan 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 valuation, either implicitly or explicitly. The actuary should document how that adverse selection is reflected in the valuation.

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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 plans 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 plan. 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.

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- 3.12.3 Participation and Dependent Coverage Assumptions—In addition to covering eligible retirees, many retiree group benefits plans also cover dependents of retirees. Also, retiree group benefits plans may offer some or all participants benefit options, such as HMOs, PPOs, and POS plans. The magnitude of the retiree group benefits plan 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 Plan Participation**—For retiree group benefits plans 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 plan 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 plans 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 retirees. 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 plan and make appropriate assumptions regarding the coverage of dependents. The actuary should consider the impact of the retiree group benefits plan'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 retiree contribution rates for dependent coverage. If the gender mix of future retirees 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

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generally select an assumed age difference between participant and dependent for purposes of projecting future dependent coverage.

- 3.12.4 Effect of Retiree Group Benefits Plan Changes on Assumptions—When selecting assumptions, the actuary should consider the impact of relevant retiree group benefits plan 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 for a portion of its retiree group, 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 plan will continue indefinitely even though many plan sponsors have reserved the right to change unilaterally or terminate their retiree group benefits plans. The actuary should include assumptions in the measurement model that attempt to quantify the probability that the current plan 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 Plan Assets—In measuring the unfunded obligation and allocating costs to time periods, the actuary should take into account dedicated retiree group benefits plan assets, 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.

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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 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;
- 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 death, disability, or other ancillary 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 severely 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 Relationship Between Procedures Used for Measuring Assets and Obligations—The actuary should measure assets and obligations on a consistent basis as of the measurement date. For example, if a participant was due a payment before the measurement date, but such payment had not been paid from plan assets as of the

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measurement date, the actuary should either include the participant's benefit due in obligations or exclude it from the asset value used in the measurement.

3.16 Actuarial Cost Method—When assigning plan costs or 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 employees' 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. Expenses should be considered when assigning costs or contributions to time periods. For example, 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 an actuarial cost method that does not directly calculate an actuarial accrued liability, the sum of the actuarial value of assets and the unfunded actuarial liability, if any, should be considered to be the actuarial accrued liability.

3.17 Allocation Procedure—The cost or contribution allocation procedure typically combines an actuarial cost method, an asset valuation method, and an amortization method to determine the plan cost or contribution for the period. When selecting a cost 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 costs or contributions, or a desire to achieve a target funding level within a specified time frame.

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3.17.1 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 contributions would be scheduled to occur too late to make plan benefit payments when due.

3.17.2 Actuary Selects Contribution Allocation Procedure—When performing professional services with respect to 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 contributions when due.

3.17.3 Actuary Does Not Select Contribution Allocation Procedure—In some circumstances, the actuary's role is to determine the contribution, or range of 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 contributions when due, the actuary should disclose this in accordance with section 4.1(o).

3.17.4 Assessment of Overall Implications of Contribution Allocation Procedure—Regardless of who selects the contribution allocation procedure, the actuary should qualitatively assess the expected cost progression implications of the assumptions and methods selected. If the use of such assumptions and methods would be expected to result in either declining future funded status measures or increasing future contribution requirements, such expectation should be disclosed as described in section 4.1(o). For this purpose, contribution increases associated with expected increases in participant compensation need not be considered an



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increasing future contribution requirement.

3.17.5 Contributions Set by Contract or Law—In some circumstances, contributions are not based on the contribution allocation procedure, but are based on rates set in law or by contract, typically a collective bargaining agreement. In those circumstances, the actuary should assess the expected cost progression implications of the contributions set by contract or law. If the use of such contributions would be expected to result in either declining future funded status measures or increasing future contribution requirements, such expectation should be disclosed (see section 4.1(o)).

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

3.18 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 benefits being valued to represent only a minor part of the overall retiree group benefits obligation or plan cost.

3.19 Volatility—If the scope of the actuary's assignment includes an analysis of the potential range of future retiree group benefits obligations, plan costs, pre-funding 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 cost or funding 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

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- e. patterns of rising or falling cost expected when using a particular actuarial cost method for the plan 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 factors (including internal consistency among these factors) and in selecting a methodology by which to analyze them, consistent with the scope of the assignment.

- 3.20 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 plan, or could review the results for sample participants for reasonableness.

- 3.20.1 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 small benefit plans), and consider the impact of those differences on the reasonableness of the measurement results.

- 3.20.2 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.

- 3.21 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.

- 3.21.1 Prescribed Assumption or Method Set by Another Party—The actuary should evaluate whether a prescribed assumption or method selected by another party (as defined in section 2.32) is reasonable for the purpose of the measurement, except as provided in section 3.21.3. 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

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methods are not necessarily limited to those the actuary would have selected for the measurement.

- 3.21.2 Evaluating Prescribed Assumption or Method—When evaluating a prescribed assumption or method selected 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(b).
- 3.21.3 Inability to Evaluate Prescribed Assumption or Method—If the actuary is unable to evaluate a prescribed assumption or method selected 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.
- 3.22 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, each actuary issuing the actuarial opinion is responsible for the overall reasonableness of the analysis, assumptions, and results.
- 3.23 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 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 measurement.
- 3.23.1 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 rates developed for the prior measurement trended forward to the current measurement date coupled with updated census data.
- 3.23.2 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 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.]**

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3.23.3 Appropriateness—The actuary should not use full roll-forward techniques when the population, retiree group benefits plan 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, where 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 plan provisions (such as types of benefit plans provided, benefit eligibility conditions, retiree and dependent coverage options, and participant contribution requirements), a description of any known significant retiree group benefits plan 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 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 retiree group 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

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equivalent) rates and any adjustments to those rates (see section 3.7.5) should be included;

- i. a description of the future health care cost trend rates used (see section 3.12.1(a));
- j. a description of all other significant assumptions (including, but not limited to, participation and dependent coverage assumptions);
- k. 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;
- l. the type of actuarial present value contained in the actuary's work product (plan-asset-based or not based on plan assets as described in section 3.11) and a general description of the implications of the chosen actuarial present value type. For example, if the present value is asset based, the actuary may include a statement that the use of such values may create incentives to adopt riskier investment policies that increase expected return and lead to lower reported cost or improve the plan's reported funded status. As another example, if the actuarial present value is not based on plan assets, the actuary may include a statement that such present values are often volatile from one year to the next and may create incentives to adopt investment policies that attempt to track the movement of the actuarial present value measurement;
- 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 and contribution allocation procedures 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);
- 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 3.17, or a statement regarding the expectation of declining future funding status or increased plan sponsor contribution requirements, if applicable;
- p. a description of the types of benefits regarded as vested and accrued 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;

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- q. funded status based on the market value of assets if the actuary discloses a funded status based on a value of assets that is not equal to the market value of assets;
- r. 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 method used for this purpose should be disclosed in accordance with section 4.1(m);
- s. a description of the particular measures of plan assets and plan obligations that led the actuary to describe a plan as fully funded or describe a plan in a way that conveys a similar message (for example, 100% funded). The actuary should accompany this description with each of the following additional disclosures:
  - 1. whether the plan's market value of assets equals or exceeds the estimated cost to settle the benefit obligations;
  - 2. that fully funded is a temporary measure at a particular point in time;
  - 3. whether there is significant risk that the plan could cease to be fully funded; and
  - 4. that additional contributions to the plan may be required if the plan is fully funded relative to the present value of accrued benefits but not relative to the present value of projected benefits.
- t. a brief description of the roll-forward method, if any, used in the calculations (see section 3.23);
- u. significant and unresolved inconsistencies in data or administration, such as those mentioned in sections 3.9 and 3.10;
- v. a statement, appropriate for the intended users, indicating that future measurements (for example, of obligations, costs, 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 plan 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 plan 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."

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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.
- w. 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 set by another party (as described in section 2.33) and are not prescribed by law (as described in section 2.34), the actuary should include an explanation of the information and analysis that led to those changes. For all changes in cost or contribution allocation procedures, 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 cost, pre-funding contribution, funded status, or other measures, by words or numerical data, as appropriate; and
- x. 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. This situation may occur if, for example, calculations must be done quickly to accommodate the requirements of a principal.

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

- a. the disclosure in ASOP No. 41, section 4.2, for any material prescribed assumption or method set by law, as defined in section 2.33;
- b. the disclosure in ASOP No. 41, section 4.3, for any material prescribed assumption or method set by another party, as defined in section 2.32;
- c. 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
- d. 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.

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

### **Appendix**

#### **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 the thousands of U.S. GAAP pronouncements into roughly 90 accounting topics which present all topics using a consistent structure. Under Codification, ASC715-60 — 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*;



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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. Cost, Plan Sponsor Contribution, and Benefit Recommendations—Calculations may be performed for purposes of determining actuarial cost, plan sponsor contribution, and benefit recommendations and related information. Examples are calculations related to the following:
  - a. recommendations as to the assignment of costs or contributions to time periods for retiree group benefits plans;
  - b. recommendations as to the type and levels of benefits for specified cost or plan sponsor contribution levels;
  - c. plan sponsor contributions required under standards imposed by statute, regulations or other third party requirements;
  - d. maximum 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

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accrued 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 accrued benefits;
  - b. actuarial present value of future benefit accruals;
  - c. actuarial present value of benefits payable to currently retired participants or active participants eligible to retire; and
  - d. information required with respect to plan mergers, acquisitions, spin-offs, and business discontinuances.
3. Projection of Cash Expense—Calculations may be done for the sole purpose of projecting the annual cash expense of retiree group benefits obligations. Examples are calculations related to the following:
  - a. Time horizon to exhaust trust assets; and
  - b. Projections of participant costs or changes in participant costs.
4. Evaluations of the Impact of Government or Third Party Funding—Calculations may be performed to estimate the value 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

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expected claims with an associated probability distribution, while other models use separate age-specific per capita claim rates 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 rates (for Medicare eligible participants and for participants who are not yet eligible for Medicare), and developing initial per capita health care rates 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 plan 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 rates 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; or
6. The impact of expected future participant contribution increases on future participation and projected per capita claim rates of participants may not be appropriately reflected.

### ***Possible Data Inconsistencies***

As part of the development of the model, the actuary may notice that the eligibility and payment data received conflicts significantly with information received about known retiree group benefits plan 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 retiree'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 retirees 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 "retirees."

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 retirees is unlikely to be the same as for a group consisting of active participants and the same retirees. 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 plan 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 retirees, 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.
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, retirees not eligible for Medicare may be included with active employees in a community-rated premium category, while retirees 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

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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 rates. 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 plan 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 plans 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 retirees 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

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retirees separately from that of the active employees, the actuary determines that the average annual claim per retiree 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 retirees 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 retirees combined. However, when the actuary evaluates the claims experience for pre-Medicare retirees, the average annual claims per retiree is determined to be \$4,500. The actual plan sponsor subsidy is \$4,000 (\$4,500 average claims per retiree 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 rates, 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 or not these requirements apply will depend on if a plan is a retiree-only plan or not. These effective dates also may depend on whether a plan is grandfathered or not.

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Because these market reforms do not apply to retiree only medical plans, the actuary needs to understand whether or not 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).

There are also some plans that 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,

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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.