

Comment #15 – 7/14/-12 – 5:44 p.m.

My comments are related to the calculation of implicit rate subsidies and community rating.

I have more than 30 years group health experience – both on the insurance company side and employer consulting side. My consulting firm, TCS, Inc. is primarily focused on California public entities. In the last 20+ years I have performed one or more GASB 43/45 compliant valuations for well over 500 public agencies of all sizes. Beginning in 1995, California had as part of its Education Code a requirement for school districts to have a triennial actuarial valuation if they provided health benefits to retirees beyond age 65. This provided TCS with considerable experience in public sector retiree health valuations before GASB 43/45 became effective.

I recognize that this ASOP must serve the purposes of actuaries performing valuations under various accounting standards as well as for other purposes. Clearly, the ASOP should not be drafted to work well for some purposes but not for others. Furthermore, if accounting standards are drafted in a way that conflicts with the ASOP's purpose, it is not strictly the responsibility of the ASB to compensate for the effects of these accounting standards. At the same time, inasmuch as accounting standards directly or indirectly incorporate an ASOP by reference, it would be irresponsible for the ASB to ignore the impact that changing a particular ASOP would have on the affected accounting standards.

My concerns with the ASOP as proposed are as follows:

- 1) The ASOP would have one or more of the following impacts on thousands of small employers participating in “blind” pools depending on the method used by the actuary to determine “age-adjusted premiums”: a) severely distort liabilities; b) disconnect active and retiree costs from actual premiums; and/or c) base costs on an arbitrary guess about the cost level. (A blind pool is one where the participating employer is unable to get information about the claims and enrollment of the pool and/or the employer's own claim experience. A blind pool is not necessarily insured.)
- 2) The ASOP focuses disproportionately on age as a factor that determines claim costs.
- 3) The ASOP does not take into account the impact on employer obligations if the plan were, in actuality, to be rated on an age-adjusted basis.

I agree with Lou Filliger that the ASOP should be as unambiguous as possible. The current ASOP allows considerable latitude among actuaries and can result in two actuaries arriving at results that are 50% or more different depending on whether the GASB 45 community-rating exception is invoked. Unlike the current ASOP, the new ASOP should be practical to apply based on information readily available from the

employer. It is unreasonable to implement an ASOP that relies on obtaining information from a third party that is not under the control of the client. The goal should be to set the stage for consistent, reasonable results no matter which actuary is performing the valuation.

In the private sector, few small employers have retiree health plans. Large employers providing retiree health benefits are overwhelmingly likely to provide those benefits through a self-funded, partially self-funded or experience-rated insured plan. In these instances, the employer has access to claim information that makes it viable to estimate retiree health costs directly. Just as important, in these cases the employer pays the full cost of the coverage except to the extent that certain risks – such as large individual claims – are insured. This latter point is crucial because reallocating health care costs between an employer’s subgroups only makes accounting sense if the employer is bearing the costs.

Even for “refunding” insured policies, the impact of the refunding mechanism is largely to shift costs from one policy year to another. In setting long-term liabilities, these temporary shifts are not material and it is perfectly appropriate to assume that the employer pays its own claim costs. In these instances, developing separate age/sex factors for different subgroups, reallocating costs and normalizing the results to reproduce the actual premium is a reasonable approach.

The current ASOP was developed long before GASB 45 and was almost certainly developed, not intentionally, based on the private sector environment. In that context, the ASOP worked reasonably well. However, the public sector is very different. It is not unusual for an employer with thousands of employees to obtain coverage through a blind pool. Inasmuch as the public sector creates the largest part of the retiree health valuation need, the public sector environment must be seriously considered in developing the ASOP.

In a pooled environment where an employer’s claims are NOT used to determine the employer’s premium rates, there can be significant subsidies between participating employers. Unless these subsidies are appropriately considered, the proposed ASOP can result in a dramatic overstatement of liability. An example can probably best illustrate this. This example is not contrived but is based on an actual client.

Example Facts:

Employer with one employee and no retirees

Employee is male, age 62 with single coverage

Medical coverage is provided through the CalPERS health plan (same rates used for all active employees and non-Medicare retirees in a particular region).

Monthly premium rate: \$500.00

Let’s further assume that the age factor for a male age 20 to 24 is 0.55 and the age factor for a male age 60 to 64 is 2.20.

Example 1a) Let's first assume that the employee retires and a new employee is hired who also elects single coverage. Let's first assume the new employee is a male age 61. The premium for the new employee is \$500. The age/sex factor is the same 2.2 for active employees and retirees. Normalizing relative costs to reproduce premium would result in no implicit rate subsidy.

Example 1b) On the other hand, let's assume the new employee is a male age 23. Now we have an age factor of 0.55. If the actuary calculates relative costs and normalizes them to reproduce the actual paid premium, s/he would get an age-adjusted premium of \$200 for the active employee and \$800 for the retiree. This would result in a 60% liability increase. In this example, should the retiree die, the employee's assumed premium would increase two-and-a-half-times from \$200 to \$500 although there was no change in plan, enrollment, or the employee's age.

This example illustrates that it is inappropriate to follow this approach for a one person group. How inappropriate this approach is depends on the size of the group relative to the size of the rating pool. As group size increases, the distortion is likely to reduce for two reasons. First, as size increases there is less likelihood that the age/sex distribution will be tipped at an extreme level. Second, as the group size increases relative to the pool size, the group represents more of the claim experience underlying the rates and the rates for the pool and employer will converge.

While it is true that, as group size increases, group and pool rates will tend to converge, there are factors that can cause significant subsidies to persist even for fairly large groups. In California, for example, it is common for there to be joint power authorities (JPA's) and trusts operating blind pools and that cover only school groups. There are consistent demographic characteristics of different types of school groups that can be expected to generate significant claim differences and to persist over time. For example, high school district certificated groups are about 50% male and 50% female while the ratio for elementary school districts is closer to 20% male and 80% female. Age factors are very different for males and females if only due to the impact of maternity claims. While spouse costs may offset to some extent, the offsetting impact is muted or eliminated depending on the circumstances. For example, many retiree plans do not pay for any dependent benefits, so there is no offset. The offsetting effect is always muted because not all retirees have spouses. The effect is further muted to the extent participation rates decrease with increasing retiree contributions that are required.

The above suggests a second major problem, which is that the ASOP virtually ignores non-age cost determinants in setting the initial claim cost under blind pools. These factors can include area, industry and other factors well known to actuaries. And, even when all common rating factors are taken into account, there are still other factors that can dramatically affect claims – thus the reason for experience-rating.

Let's take only one of these factors: area. For many years, CalPERS had one set of rates that applied statewide. Over time, it became widely known that Southern

California employers were subsidizing Northern California employers. The amount of the subsidy wasn't known, but the extent of the subsidy was great enough that it became apparent. As a result, Southern California employers – even without having access to any claim information, were willing to risk pulling out of CalPERS despite the unquantifiable risk of paying their own claims. As the results of these pioneering efforts became known, the number of Southern California employers leaving CalPERS increased.

In response to this, CalPERS established regional rating. In 2013, for example, the Bay Area Blue Shield non-Medicare rates are nearly 50% higher than Los Angeles Area rates. Without having complete demographic information, it isn't possible to say how much factors other than area contribute to this difference. However, it is likely that the vast majority of the difference is due to area. Using only age to calculate differences between pool and individual rates arbitrarily focuses on one of many important factors. In the most recent valuation I performed, the implicit rate subsidy attributable to age/sex was only 31% for employee coverage. Obviously, area can make more of a difference than age. So why the almost exclusive focus on age?

These types of differences aren't random and can combine to have extreme effects. Area differences plus gender differences result in even bigger distortions.

The core problem in the above is that normalizing age-adjusted premiums to actual paid premium can result in using costs that are substantially different from any reasonable cost estimate that could be developed from claim and demographic information if available. The ASOP seems to anticipate this in paragraph 2 of 3.7.8. This suggests that costs be based on obtaining the overall pool's demographics and developing relative costs based on the group's versus the pool's age or age/sex distributions. At a minimum, this should be rewritten to also require recognition of area, industry and other factors that can significantly affect claim costs.

However, there are two other major problems in implementing the ASOP as proposed.

First, despite assurances obtained by the ASB from unnamed large pools that they would be willing to provide pool demographics, I am extremely skeptical that this will happen, in practice. Let's look forward to what will happen if pools release such info – at least here in California. Because most public agencies provide some degree of retiree health benefit, the new ASOP will result in virtually every employer having age-adjusted premiums. Brokers and consultants will obtain this information and use it to identify employers who appear to be "overpaying" for their coverage. They will "cherry pick" the low-cost employers, placing them with other programs. This will set off an assessment spiral for the pool that released the data, resulting in the death of that pool.

The above phenomenon is well-understood by the operators of these pools and only the suicidal would release these statistics. As the actuary for many JPA's in California, I would strongly advise my clients not to release pool demographics under

any circumstances and, because these clients are likely to heed my advice, I can say with a great deal of certainty that statistics will not be available for many California agencies. The only way I can see such demographics being released would be in cases where participation in a particular pool is mandated by law.

Despite the fact that many if not most pools will not be willing to release information to allow a reasonable estimation of retiree costs, the proposed ASOP provides no real guidance for the actuary when this information is NOT available. There is simply a sentence indicating the actuary should use manual rates or other age factors, but compared to what? This raises the extremely serious issues mentioned earlier.

Based on the above, I think it is wrong to require age-adjusted premiums for blind pools unless ALL pool demographics related to all major cost determinants are publicly available – particularly for small employers. But there is another problem that this practice causes regardless of whether pool demographics are available. This is the fact that basing retiree costs on relative group versus pool demographics disconnects costs used in the valuation from actual premiums paid, the amount of which is an accounting certainty.

To the extent that initial per capita claim costs are not normalized to equal premiums paid, there will be a gap that, assuming claim costs are appropriately estimated, will quantify the subsidy from other pool members. This could be a positive or negative amount. How should this subsidy be treated? Should it be reflected in the initial claim cost? How? Any method has problems.

I believe it is for some of the above reasons that the original GASB 45 Exposure Draft did not include an implicit rate subsidy. To the extent that the actuarial profession played a role in convincing GASB to incorporate implicit rate subsidies, I believe it is incumbent on the profession to make sure that this will only be done where an actuary can reasonably establish that there is an employer subsidy (rather than a pool subsidy) and that there is a reasonable way to estimate the amount of the subsidy. The proposed ASOP fails in this regard. Otherwise, I think that using the community rating exception is the least bad of the two options.

Finally, the point of most valuations is to determine the employer's liability for retiree benefits. Establishing an underlying cost should take into consideration what the impact would be on the employer should rating be based on actual underlying cost. Increasingly employers are capping what they pay for both active and retiree health coverage. In my practice, I am seeing an increasing number of cases where both active and retired employees make a substantial contribution to the cost of health benefits.

If all active and retired employees are making contributions; and if premiums were to be reallocated to eliminate subsidies and all employees and retirees would still be required to make contributions after the reallocation; then the subsidy is actually provided by employees not by the employer. In fact, if costs were actually changed to eliminate subsidies, there would probably be a reduction in retiree participation and the

liability would decrease. Yet under GASB 45, the subsidy must be considered as an employer subsidy and the liability would be increased. This does not make sense.

The ASB cannot be held accountable for this flaw in GASB 45, but at least the ASB could allow use of the community rating exception to mitigate this problem.

Conclusion and Recommendation:

I recommend that the community-rating exception be retained but that the conditions for its use be restricted to

- 1) Those instances where an employer participates in a blind pool and information is not publicly available to evaluate ALL significant rating factors for the pool; or
- 2) Where applying the implicit rate subsidy would not result in a change in cost-sharing between the employer and employee

The above would allow every actuary to base initial cost on information that should be available from the client; result in consistent treatment between actuaries for a given employer based on that information; result in costs that track more closely with accounting data in most instances. An issue to be resolved is how or whether to reflect the amount of pool subsidies in any instances where adjusted costs rather than premiums be used for blind pool participants.

As a modification of #1, an additional factor could be introduced based on the size of the group. Since this is a plan-specific issue, it would apply on a plan-by-plan basis. (E.g., if an employer offers Kaiser, Blue Shield PPO and Blue Cross HMO, the size criteria would apply to each plan separately.) If a size threshold is introduced, I recommend that the level be set no lower than 100 plan participants and, preferably, 200.