Comment #2 – 6/19/12- 4:11 p.m.

ASOP 6 EXPOSURE DRAFT - COMMENTS

I would like to offer the following comments on the Exposure Draft for ASOP 6, approved for exposure in April, 2012.

I write as one who provides GASB 45 valuations to several school districts in the State of New York.

I Scope

On page 2, it states that the "standard highlights health and death benefits because they are the most common forms…".

> Comment: In my limited experience, dental and vision are much more prevalent than death benefits. Rather than "highlight", the standard should address all OPEBs explicitly, considering the materiality of the lesser-valued coverages.

II Definitions

Mathematicians have a strong and universal tradition of uniquely defining their terms; so "set", "group" and "theorem" mean the same thing anywhere in the world of mathematics. We actuaries, not so much.

The cost of failure to maintain this discipline is often a lack of clarity and misunderstanding.

Section 2 offers 39 definitions. My concern is illustrated as follows:

> Comment: In 3.1, which immediately follows the definitions, the first paragraph ends with the words "amortization methods". Since there is no visual indication, I cannot be certain that this is the same as the "Amortization Methods" defined in 2.7 .
>
> The same issue arises within the definitions themselves: the definition of "Contribution" in 2.12 refers to a "plan sponsor", but does not necessarily refer to "Plan Sponsor" as defined in 2.30 .
>
> I suggest that when a defined term is being used, there should be a visual indication (such as capitalization or italicization) to the reader.
>
> I further suggest that the defined terms be presented in an order that reflects how they build on each other, rather than in alphabetical order.

III Initial Per Capita Claim Costs

Since valuations are assumption driven, it is of great value to uniquely define the initial per capita claim costs, which are derived from past events.

Under the current rules, I follow what I understand to be standard practice:

1. Community-rated plans: I use the premium rates. This applies to all fully insured HMOs, Medicare Advantage plans and a large pooled PPO known as "NYSHIP".

2. All other plans: I develop aggregate claim costs from retiree claims data, and then credibility-weight the result with a National Average ("normative database"); finally, I distribute the result into 5-year age bands using the client's age distribution and other factors.

As a life insurance actuary by training, I appreciate the value of uniquely defining my "valuation premium". However, whether NYSHIP is community-rated depends on the size of the plan being valued. So, NYSHIP is community-rated for my (small) school districts, but it is <u>not</u> considered community-rated by the actuaries for the State of New York, whose employees represent over 50% of NYSHIP's participants. This is somewhat ambiguous, but I can live with it.

The exposure draft is much less clear as to its requirements.

> Comment: First, 3.7.5 says that while a retiree claims analysis is preferable, premium rates may be used. Then 3.7.7 says that age-specific costs should be used. Which of these has the priority?

Then 3.7.8 causes me further confusion, as follows:

> Comment:
> (a) The term "Pooled Health Plan" is not defined in the standard. In NY, there are about 30 health consortia in which school districts participate. Is such a consortium a Pooled Health Plan?
>
> One of my health consortia has 20 school districts and about 3,000 lives, which is at the edge of 100% credibility. Does classification as a Pooled Health Plan depend on the number of covered individuals?
>
> (b) The term "Community-rated Plan" is not defined in the standard. Does the current practice, ambiguous as it is, continue?
>
> (c) If a consortium is a Pooled Health Plan, then 3.7.8 requires that I obtain retiree claims data for all participating districts. This overlooks the

practical reality that I need each district's permission to receive its data, and not all districts in the consortium are my clients.

(d) Does 3.7.8 (age-banded costs for Pooled Health Plans) have priority over 3.7.5 (premium rates may be used)?

In the Transmittal Memorandum, the authors suggest that community-rated plans are willing to provide sufficient information to develop age-banded costs. This implies that they have determined which plans are community-rated.

Comment: If this is the case, I would prefer that AAA have all community-rated plans provide nothing less than the age-banded costs for actuaries to use, just as AAA provides thousands of economic scenarios for life insurance actuaries to use.

Comment: I suggest that 3.7.5, 3.7.7 and 3.7.8 be merged into a consistent set of requirements. If the intent is to always used age-banded costs, then it should say so unambiguously.

Comment: Sections 3.7.7 and 3.7.8 refer explicitly to Health costs, and do not address the other coverages. Interestingly, 3.7.5 does not limit itself to Health costs. I suggest that all coverages be addressed explicitly. In particular, I would support the option to use premiums or premium equivalents as the initial per capita claim costs for all non-Health coverages due to their lesser materiality.

IV Types of Actuarial Present Values

What this section 3.11 is seeking to address is not clear to me.

Actuarial Present Value is defined in 2.3. The definition does not suggest that there are multiple types of Actuarial Present Value.

Comment: I can only construe that 3.11 is discussing the selection of a discount rate. If so, I suggest it be characterized as such and integrated in to 3.12.1 (Economic Assumptions).

Comment: 3.11.3 starts with a definition of "market-consistent". Consistent with the overall structure of the standard, I suggest the definition be moved to Section 2.

Thank you.

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