July 12, 2012 - Comment #7 - 4:24 p.m.

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

Re: ASB COMMENTS -- ASOP No. 6 Revision

To the Members of The Actuarial Standards Board and the Subcommittee on Retiree Group Benefits:

I am writing on behalf of Buck Consultants to present comments on the Proposed Revision of Actuarial Standard of Practice (ASOP) No. 6, *Measuring Group Benefit Obligations and Determining Retiree Group Benefits Plan Costs or Contributions*. We wish to comment on the proposed change related to the use of community rates in measurements covered by this ASOP.

Buck Consultants employs actuaries in more than 20 offices across the United States, including more than 200 members of the American Academy of Actuaries. Our firm produces hundreds of retiree group benefit valuations each year, from plans that cover a single person to plans that cover a half a million participants. Our "OPEB" clients include corporate plan sponsors, governmental sponsors and a range of non-profit entities.

One of the more complex areas in our retiree medical valuation practice is the implicit subsidy that results from using claims pools that do not segregate by age. It is difficult for our clients to grasp the idea that retiree plan costs are affected by the age of the participant, even though they think of the costs as a set of rates that varies only by whatever tiering structure had been used in the development of the rates. We do manage to explain to self-insured clients the fact that including older, sicker retirees in the pool results in blended rates that overstate the cost of covering their active employees and understate the cost of covering retirees not on Medicare. Clients whose insured rates depend on their own experience also ultimately can understand that costs depend on age. We explain that the underlying economics of these arrangements mean that the employer is actually paying more for its retirees than its stated premium. In those situations, our ASOP and good financial management require that we reflect the additional cost of the aged retirees (the implicit subsidy) in our retiree medical calculations.

The situation is different for "community rated" plans, both from an economic standpoint and under our current ASOP. Currently, the ASOP specifically says that "the actuary may use a single unadjusted premium rate applicable to both active employees and non-Medicare-eligible retirees if the actuary has determined that the insurer would offer the same premium rate if only non-Medicare-eligible retirees were covered."[1] We believe that this has allowed actuaries to better measure the economic obligation involved, and that this concept, referred to as the community rated exception, should be continued.

Let us examine the economics of the paradigm which engendered this language, i.e., the large statewide health insurance pools run for some state and local government employees. These arrangements can cover as many as a million participants, with hundreds of participating

[1] ASOP No. 6, Measuring Retiree Group Benefit Obligations, §3.4.5.

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employers, some of which may cover only a handful of employees and even fewer retirees. In this situation, there is an implicit subsidy being provided for the retiree who is covered by the pool. But that subsidy is truly part of the economics of the transaction. The rate that is being charged to that employer will not be any different whether or not its dozen active employees or couple of retirees enrolls in the state system. To that employer, the cost of that coverage really is the stated premium. Why should that employer reflect a liability on its books that is based on costs 50% or 100% greater than it actually will pay? As far as we see it, the only justification for recording a liability based on "artificially high" premiums is that there is a belief that there would be a change to current financing mechanism. In other words, the proposed change is saying that the employer is committing to provide this level of retiree insurance, no matter what financing mechanisms are available. We believe this is in direct contrast to what the employer believes they have committed to, which is to provide benefits using the current arrangement, where those age-related costs are effectively being paid by hundreds of other organizations as a price of their admission to group purchasing power.

The same implicit subsidy as part of the premium is often used in measuring HMO costs. The educational material in the current ASOP and the Exposure Draft does imply that some community rated HMOs actually use premium rates that reflect the demographic characteristics of a particular employer group, or even the actual claims experience in the covered group. In those situations, we agree that costs should reflect age adjustments for that particular employer in some manner because the rate that the employer pays is affected by the fact that they are covering some older retirees along with their active workers. But there are other situations where HMO rates really are true community rates, where the costs do not vary for different employer groups. In those situations, the employer's economic costs are not affected by the age of the particular group enrolled.

We do believe that employers should reflect the cost of their commitment to provide this benefit. But if the commitment of employers who do not have material experience to affect the pool is only to provide what is effectively deep discounted merchandise, why should we as a profession require them to ignore that discount? If these employers can no longer reflect the community rated premiums in their obligations, the measurement of those obligations will increase significantly, while the underlying cost remains as it had been previous to the change in the ASOP. That could cause some employers to reduce or eliminate the retiree medical benefits that they currently provide. Other employers could be harmed by the unexpected huge increase in their liabilities, which could potentially cause other financial difficulties (for example, reduction in bond ratings or breach of loan covenants).

In many cases, there is a move to begin to fund these benefits into trusts that restrict the use of funds to retiree benefits. If the employer contributions to the trust are determined reflecting implicit subsidy amounts, while community rated premiums paid from the funds do not reflect any implicit subsidy, we wind up with an inconsistency between the contribution allocation procedure and the payments. While we as actuaries tend to worry about having too little assets, building up too much assets can cause problems. For example, there may be tax consequences of excess funding, and in some cases, no practical way of using the excess assets for any other purpose.

The above discusses the economics of the situation, arguing that the implicit subsidy should not be part of the measurement of group benefit obligations for many employers. But there is also a practical aspect to this potential new requirement. In many situations, we will not have the information to adjust the premium rates involved. The exposure draft suggests dealing with pooled health plan costs by use of a distribution table for covered members or by use of manual

rates. The introductory comments state that 3 large statewide pools responded that they would be willing to provide such distributions. This is a very small sample, and involved larger pools. Other pooled plans may not be willing to provide such data. Smaller pools may be appropriately concerned about privacy matters[2]. Moreover, even if particular surveyed individuals involved with a pooled plan express willingness in theory to provide such distributions, there may be other individuals who would be required to approve actually providing such data. In my own experience of working with such pools, I have been in situations where it initially appeared that similar data would be available, but someone in the chain of required permissions said no.

In absence of the demographic distribution of the pool, the ASOP suggests that claim costs would best be estimated by manual rates. The manual costs are not likely to be a very good match to the costs of the plan. We all recognize that health claim experience can vary dramatically from costs produced by any such rate manual.

We do acknowledge that the Exposure Draft might be read to continue to allow some limited use of community rates in such situations where no age rating is permitted by law. The example relates to commercial Medicare Advantage plans (not EGWPs), and could readily be read to include HMOs in states where community rates are not allowed to be adjusted for demographics or group experience. However, we feel that the structure of the exception in the Exposure Draft implies such limited use that it may inadvertently preclude use of pooled rates where they might be appropriate. Thus, we strongly advocate for more explanation of where the use of pooled community type rates may be appropriate. We also suggest that the current standard is an appropriate starting place for that explanation. If the rate is not affected by the experience of the active or non-Medicare retiree participants from a particular employer, then the employer is not providing any implicit subsidy to its retirees. Yes, that situation may involve an implicit subsidy from others, but not from the employer whose obligation is being measured.

Please let us know if you have any questions.

Very truly yours,

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[2] Under HIPAA, information that could indicate whether a particular individual is covered in a health plan is protected health information. The regulations even go so far as to protect certain summarized information such as covered head counts by age, depending upon the number of individuals involved.