Comment #3 – 8/14/13 – 6:55 p.m.

My thanks to the ASB Retiree Group Benefits Subcommittee for their work on the revisions to the standard. As a practitioner in the retiree group benefits area for over 20 years (and a prior ASOP 6 task force member) I offer the following comments

Bold font for definitions. This is helpful.

Revised guidance on pooled health plans. While helpful and an improvement, this continues to be an area where individual circumstances need to be taken into account by the actuary in developing the most appropriate initial per capita health care costs. One way to address this might be to state the preferred approach (paragraphs 1 and 2 of 3.7.8) and then add a requirement that if the actuary deems the pooled health plan's premium rates to be the most appropriate bases to be used (without adjustments for age or geography or gender mix), then the reason for using this approach is to be documented and disclosed.

Actuarial Cost Methods. The actuarial cost method should fit the purpose of the valuation. For accounting purposes, that will generally mean a method that treats retiree group benefits as a form of deferred compensation, with the expectation that accrual of the present value of expected benefits be completed by the date at which the employee completes rendering service. If the actuary has been retained to help the plan sponsor develop a funding policy or funding amounts, then to be "actuarially sound" that may result in a more limited set of cost (allocation) methods than might be appropriate for a pension plan. I would prefer that the standards (4 and 6) err on the side of "reasonable" actuarial cost methods rather than consistency for its own sake.

Section 3.12

Since the last revision to ASOP 6, one area of practice that has improved is the selection of long-term health care cost trend rates, aided in no small measure by the research work of the SOA and the publication and maintenance of the SOA-Getzen model. This model contains four main input assumptions (inflation[cpi], real GDP[per capita increase], income multiplier, and taste/technology) and two regulators (percent of GDP when resistance to growth will start, and year when healthcare growth will match CPI); while the third paragraph of 3.12.a. only mentions three (growth in per capita GDP, wage inflation, and health care expenditures as a percent of GDP). I recommend that this paragraph be revised to account for the common usage of the SOA-Getzen model. It may also be time to revise the phrase "select period for transitioning" as there will be times (such as the current period) where health care cost trend rates can reasonably be expected to increase for a few years and then decline towards a long-term ultimate rate.

Section 3.21.1

For plans with credible claims experience this test – modeling the first year projected cash flows to the most recent history of the plan – is a critical step in the measurement

process, and one I observe has been overlooked too often. I would therefore recommend strengthening the language by adding or modifying the "should". If there is a significant difference, then the actuary should consider adjustments to the model, as needed, to ensure the reasonableness of the results. There may be solid explanations for disconnects between the recent past and the near future (e.g. valuation systems that have maximum retirement ages, forcing all employees over the last retirement age to commence retiree medical coverage immediately, or valuation systems that have a beginning of year retirement decrement) as well as unknown reasons (e.g. , any mismatches between the data source used for per capita claims cost development and the census data provided for covered participants include in the measurement). Given the importance of this step to confirming the reasonableness of the results, I would propose that the ASOP include a requirement to compare the results and document the difference (whether it is an increase or a decrease – as a decrease in cash flow can occur if a plan covers retirees before and after Medicare eligibility and a large number of retirees become Medicare-eligible in one year, as is now happening with baby boomers).

Adam J Reese, FSA, FCA, MAAA, EA
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