Comment #7 – 8/30/13 – 10:16 a.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 March, 2013.

1. Age-Specific Costs, Section 3.7.7

Originally, ASP 6 required the use of age-specific costs except for community-rated plans. In this Second Exposure Draft, the guidance is that the actuary should (i.e. must) use age-specific costs in all cases, except Medicare Advantage plans.

I believe that this is too strong, and may have unintended consequences. I would like to provide a counterexample which will demonstrate that removing the option to consider using the premium could inevitably cause under-funding.

In this example, the provider charges $800 premium per month at all ages. While in most "normal" situations, the premium decreases at age 65 due to Medicare, this situation is not uncommon among HMOs, in my experience. The numbers are loosely based on a case I valued recently.

Retiree age-specific costs and premium

Age Band	Age-Specific Cost $	Premium $
50-54	825	800
55-59	850	800
60-64	900	800
65-69	450	800
70-74	500	800
75-79	550	800
80-84	600	800
85+	600	800

As part of my valuation process, I use the valuation assumptions to estimate "Contributions Made", the amount spent on retiree benefits for year 1:

Estimated Contribution for year 1 based on Age-specific costs $1,500,000

Then, I ask the client to provide me the amount actually spent:

Actual Contribution for year 1 based on Premium $2,000,000

Both the estimate and the actual include an implicit subsidy, applicable to the pre-65 retirees.

My concern was: why was the actual so much higher than the estimate?

The answer lies in the relationship between the age-65+ age-specific costs and the premium.

It is clear to me that the benefits being funded, on a year-by-year basis, are lower than the benefits actually expected to be paid. I demonstrate this for year 1, but it certainly is true for every future year as well, assuming the same trend applies to both the premium and the age-specific costs.

I infer that, if I am not permitted to use the age-65+ premium, then full funding of the benefit is impossible. Consequently, I believe that the actuary needs the option to consider using the premium.

Unfortunately, if this Exposure Draft is simply modified from "should" to "should consider", we will have less guidance than we currently have, and it might lead to wider variation in practice.

2. A Seeming Contradiction – Section 3.18

In 3.18, there are several references to the actuary considering the circumstances of the plan sponsor in selecting an allocation procedure, as examples:

1. "The actuary should consider relevant input received from the principal…"
2. "The actuary should select a **contribution allocation procedure** that … is consistent with the … plan sponsor or other contributing entity will make prefunding contributions when due."

These references seem inconsistent with the paragraph in 1.2 indicating that the standard "does not require the actuary to evaluate the ability of the **plan sponsor** to make **prefunding contributions** to the plan when due."

Also, the term "principal" is rarely used, and might be replaced by "**plan sponsor**".