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ASB Comments – ASOP No. 6 Revision (Second Exposure)
Actuarial Standards Board
1850 M Street, NW, Suite 300
Washington, DC 20036
August 30, 2013

Dear Sir or Madam:

This letter documents the response of Towers Watson to the Proposed Revision of Actuarial Standard of Practice (ASOP) No.6, Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Prefunding Contributions, as requested in the Second Exposure Draft of March 2013. Towers Watson is a global human capital and financial management consulting firm specializing in employee benefits, human capital strategies, and technology solutions. Towers Watson employs approximately 14,000 associates on a worldwide basis, over 1,100 of whom are members of U.S. actuarial bodies subject to the standards. The undersigned have prepared our company's response with input from others in the company.

As we have stated previously, our comments generally support four central themes that we believe should apply to the Actuarial Standards of Practice.

- The ASOPs should be built upon the fundamental premise that an actuary needs to apply judgment based on the facts and circumstances of each particular situation. No written standard can anticipate every situation that actuaries will confront. In recognition of this fact, the standards should not be overly prescriptive and should not seek to substitute rules for the actuary's reasonable professional judgment.

- The ASOPs should set forth minimum professional standards, not best practices. The ASOPs can and will be used against members of our profession in litigation. Incorporating best practices into the ASOPs will inevitably lead to characterization of those practices as minimum acceptable standards in litigation and client disputes. This places actuaries at unnecessary and significant risk. While we support the efforts of the actuarial profession to encourage the use of best practices, we do not believe that the ASOPs are the appropriate means to achieve that objective.

- The ASOPs should not impinge upon the terms of the engagement between an actuary and his or her Principal. Actuarial services subject to the standards are already highly regulated by governmental and other authoritative bodies. The terms of engagement are based upon a mutual understanding of those requirements by the actuary and the Principal. The ASOPs should not require the actuary to perform additional work that is outside the scope of the engagement, is not requested by the Principal, and for which the actuary is unlikely to be compensated.

- The ASOPs should not be written or interpreted in a manner that allows readers to presume that actuaries serve the "general public." Our company's actuaries are engaged to serve the company's clients. While members of the public who are not our clients may benefit from our work, we nevertheless perform and deliver this work only for our client. No other person or entity can expect to rely on our work. We strongly believe that any ASOP that explicitly provides for or allows a presumption that actuaries perform work for the general public will expose actuaries to unwarranted and unmanageable risk.

We are pleased to see that you incorporated many of our suggestions from the review of the first exposure draft – thank you for your time and effort. Our specific comments on the Second Exposure Draft are below, organized according to the questions listed on p. x of the Draft.

1. Does the use of bold font to identify defined terms improve the readability and clarity of the standard? If not, what suggestions do you have to improve the recognition of defined terms in the standard?

We found your approach to be a good solution to the problem, which we identified in our earlier review. All terms (even commonly-used terms) must be clearly defined up-front, and then used in a consistent manner throughout the ASOP. You have accomplished this.

2. Is the revised guidance regarding pooled health plans clear, sufficient, and appropriate? If not, how should it be changed?

We note that this section was originally focused on the "community-rated" concept and has now shifted to focusing on "pooled health plans." As we said earlier, we continue to believe that the topic here is really age-related costs and when and how to use them, not community rating or pooled health plans *per se*. We do not disagree with any of the new wording–we simply find it to be more complicated than necessary. (We have only one minor quibble with the wording, see below.) Accordingly, we believe that sections 3.7.7 and 3.7.8 could be replaced by one (or more) sections that would make the following key points (which are essentially the same as we offered earlier):

- Certain welfare benefits demonstrate costs that vary, on average, with age, due to variations in the types of services utilized and/or the levels of utilization. For example, non-drug medical costs (before Medicare offsets) tend to rise with age. Dental costs tend to fall with age, as do prescription drug costs at advanced ages.

- In situations where these age-related benefits are being valued and changes in the average age of the group would be expected to affect the benefit cashflow materially, explicit recognition of this aging effect should be made via age-related per capita costs. The effect of aging generally should not be reflected implicitly through adjusted trend rates.

- For example, an uncapped employer obligation toward a self-insured medical plan covering a closed group of retirees should incorporate per capita costs that reflect expected variations in cost by age. Even if these retirees are pooled with active employees of the same employer for rate-setting purposes (e.g., to lend stability to contributions or for some other purpose), the underlying cost of the retirees should be reflected in the valuation, and costs should be age-related to reflect that fact that costs are expected to rise as the average age of the retiree group rises (above and beyond trend increases).

- On the other hand, coverage for a retiree group may be secured via a community-rated, fully insured plan, or through a pool that combines the experience of several employers (perhaps for active as well as retiree coverage). In these situations, costs may be expected to vary with the average age of the entire pool, but not directly with the average age of the group alone. As long as the group's own experience does not materially affect the premium rates paid for coverage, the aging of the group's population alone does not affect the program's cost, and age-related costs therefore are likely not appropriate for the valuation. However, to the extent that future aging of the entire pool is expected, the effect of such aging should be reflected in the valuation, if it can be reasonably estimated.

- In practice, note that plans that are referred to as community-rated are frequently still dependent on the individual group's demographics and/or past claims experience (e.g., "community rating by class"). It is important to assess the true nature of the pooling mechanism in order to select the proper aging treatment in the valuation model.

Our only specific suggestion for the wording is the reference at the end of 3.7.8 to "…Medicare Advantage plan that is an employer group waiver plan…" Strictly speaking, a MA plan is medical-only, and an MA-PD plan includes an EGWP. The point here (we believe) is that the medical portion of the MA-PD does not deserve aging, but the Rx portion does. Alternatively, you may have meant to say "employer group health plan."

3. Are the revised disclosure requirements regarding funded status clear, sufficient, and appropriate? If not, how should they be changed?

The revised requirements seem to be simply carried over from ASOP 4 and many of them deal with funded percentages, contributions and changes therein. These are generally inappropriate for the majority of retiree group plans, since they are unfunded. Even some of those that are funded are done so on an ad hoc basis at the sponsor's discretion, again making the disclosures of questionable value. These requirements should either be removed or there should be a broad "if appropriate" exemption that applies to each individual item.

4. Some disclosures now require a qualitative assessment rather than a quantitative assessment. Do you feel that a qualitative assessment is reasonably practical for the actuary relative to a quantitative assessment, and reflects an appropriate level of disclosure in light of the effort required to make the assessment?

We see the term "qualitative" used only in conjunction with disclosing the implications of the contribution allocation procedure, sponsor funding policy, or contributions set by contract or law (section 4.1(p)). To the extent that the actuary has the information necessary to make such a disclosure, it is useful information. We would not, however, want this to be construed to imply that all valuations require prefunding forecasts. We believe that prefunding forecasts are inappropriate for most plans for the reasons cited under our answer to #3 above, and this disclosure requirement is again simply a carry-over from ASOP 4.

5. Is the coordination of guidance on market-consistent present value measurements in the second exposure draft of ASOP No. 6 and the working version of ASOP No. 27 appropriate?

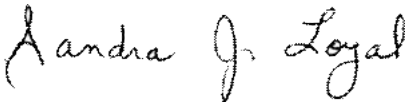
We understand the desire to have coordinated guidance between ASOPs 6 and 27. However, the concept of market-consistent present values for traditional retiree medical obligations is very abstract as no such market exists (as opposed to pensions where a market does exist, at least on a limited basis). This fact should be noted and appropriate flexibility granted in ASOP 6 if the market-consistent present value terminology remains.

6. Section 3.13(a) of the second exposure draft of ASOP No. 4 has a somewhat less restrictive definition of a reasonable actuarial cost method than that used in section 3.17(a) of this exposure draft. The Pension Committee intends that the language in the two standards will ultimately be consistent. Which language do you believe is more appropriate? For example, is it inappropriate to use the Aggregate Cost Method for a frozen plan with active employees?

Currently we note that the ASOP 6 definition uses language that may be clear in the pension context ("frozen plan," "no employees accruing benefits under the plan") but which is ambiguous or (often) meaningless in the retiree welfare plan context. Consistent definitions may be possible, but only if words are chosen to make sense in both contexts.

Thank you for this opportunity to comment on this Second Exposure Draft. If you have any questions concerning our comments, please contact us directly.

Sincerely,



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