Appendix 2

Supplementary Information

Normative Databases

In the absence of credible plan experience, a normative database can provide support for assumptions about the probability of future events or likely relationships between variables. Examples of normative databases include published mortality and disability tables, proprietary rate manuals, and experience on similar retiree group benefit plans. However, normative databases also have limitations, including the following:

1. normative databases lose relevancy over time;

2. a normative database may not be appropriate for the particular situation at hand; and

3. many normative databases have not been subject to rigorous development and review.

Measurements Using Premium Rates

A premium is the price charged by a risk-bearing entity, such as an insurance or managed care company, to provide risk coverage. The premium usually has a basis in the expected value of future costs, but the premium will also be affected by other considerations, such as marketing and profit goals, competition, and legal restrictions. Because of these other considerations, a premium for a coverage period is not the same as the expected cost for the coverage period.

The demographics of the group for which the premium was intended may be different from the demographics of the group being valued. When these two groups are different, the premiums are unlikely to reflect the expected health care costs for the group being valued, even if it is a subset of the total group for which the premium was determined. In particular, the expected value of future costs for a group of retirees is unlikely to be the same as for a group consisting of actives and the same retirees. Examples of this are shown in the "Participant Contributions" section below.

This standard notes numerous ways the demographics of two groups can differ, but a difference that is quite likely to have an effect on rates is a difference in average age, or age distributions, of two groups. This, of course, is particularly likely to occur when one group contains retirees and active employees while a second group consists only of retirees. But differences can also be significant within a group made up entirely of retirees, even retirees who are all eligible for Medicare. When a rate applies over a broad age range, it may misrepresent the average cost at applicable ages much older or younger than the central age of the range to which the rate applies. Consequently, many actuaries use a separate initial per capita health care rate assumption for each age within a range where there are wide variations, such as rates that differ for every age

from 60 to 75 or from 55 to 80. (This also may have an effect on costs in future years and is addressed again below in the "Health Care Trend Rate" section.)

The term "premium rate" is used for both insured group plans and self-insured group plans. In the case of self-insured plans, the "premium rates" may also be referred to as "budget rates" or "phantom premiums." Future changes in insured premiums are frequently affected by the experience of the insured group. When they are not directly affected by the experience of any one group, but rather by experience of a community of groups, the plans are referred to as "community-rated." Further comments about these common types of retiree group benefit plan premiums follow:

1. Self-Insured Premiums—Some self-insured plans have expenditures that the plan sponsor refers to as "premium rates." These rates may reflect the experience of retirees, active employees, or both. Also, the rates may reflect only expected claims experience, or may include other adjustments (such as administrative expenses and stop-loss claims and premiums). Furthermore, the rates may reflect the effect of the plan sponsor's contribution or managed care strategy.

2. Community-Rated Premiums—In some regulatory jurisdictions, community-rated premium rates are required by statute for some fully insured plans. There is variation in the structure of community-rated premium rates. For example, retirees not eligible for Medicare may be included with active employees in a community-rated premium category, while retirees eligible for Medicare may be included in a separate community-rated premium category. There are also different community-rating methodologies, some incorporating group-specific characteristics. Note that a community-rated premium including both retirees not eligible for Medicare and active employees probably understates the expected claim cost for the retirees alone. If the insurer appears to be committed to continuing such subsidy for the retirees, there is some justification for valuing future retiree costs for the postretirement plan sponsor with the community rate as the basis, although the plan sponsor may want to know of the apparent subsidy and the possibility that it might not be available in the future. There is also some justification for valuing future retiree costs with the higher expected claim cost for retirees as the basis, since the subsidy may disappear.

3. Other Fully Insured Plans—In addition to community-rated plans, there are other types of fully insured plans and there can be some variation in how actual plan experience affects the premiums. The same comments mentioned above for self-insured premiums apply here.

Health Care Trend Rate

The health care trend rate reflects the change in per capita health claims cost over time. The trend rate may differ by major cost components such as hospital, prescription drugs, other medical services, Medicare offsets, and administrative expenses. The health care trend rate is affected by the following interdependent factors:

1. Inflation—General economic inflation defined as price changes over the whole economy.

2. Medical Inflation—Changes in the per-unit prices of medical supplies and services covered by the plan.

3. Covered Charges—The definition of charges that are covered by the plan will determine how inflation and medical inflation affect per capita health care claims cost. For example, if the plan pays benefits based on a fixed schedule of benefits, the cost of services is controlled by the plan's schedule. If the services on the schedule and the dollar amounts are not changed, the underlying cost inflation of the plan will be zero.

4. Utilization of Services—This factor considers the change in frequency of health care by type of services over time, as well as the nature of services due to changes in medical practice and technology.

5. Leveraging Caused by Plan Design Features—The net plan cost under health plan designs with fixed-dollar cost-sharing will increase faster than the total costs. For example, for a prescription drug costing $50 today and a plan design with a $20 copay per prescription, a 20% increase in the cost of the drug (from $50–$60) will increase the net plan cost by 33%, from $30 ($50–$20) to $40 ($60–$20).

6. Aging—The aging of the covered population may have contributed to historical health care cost changes. The use of age-graded per capita health care rates for projecting future health care costs removes this aging component from the future trend assumption.

7. Participation—If a lower percentage of eligible individuals elect coverage (for example, because of increasing participant contribution rates or competing plans such as HMOs), per capita health care claims costs may increase due to adverse selection.

Interaction Between Trend and Plan Provisions

Plan provisions and health care trend rates in combination impact the projected net per capita health care rates. Examples of the interaction of plan provisions and health care trend rates include the following:

1. Covered charges can be affected by limits on allowable provider fees and the plan's Medicare integration approach. Benefit plan provisions may help in identifying these limits, as well as what services are covered.

2. Health plan deductibles may or may not be set at a fixed-dollar amount. Health care trend will, over time, erode the relative value of a fixed-dollar deductible.

3. Coinsurance payments may be expressed as a percentage or fixed-dollar amount. Again, over time, trend will erode the relative value of a fixed-dollar coinsurance.

4. The Medicare program provides coverage for most U.S. retirees over age 65; however, the retiree group benefits plan may cover a different mix of services than Medicare. Trend rates may differ between Medicare-covered services and the retiree group benefit.

5. Other payments or offsets may exist, such as subrogation recoveries or plans other than Medicare. These payments or offsets may change in the future.

6. Lifetime and other maximum dollar limits also affect claims costs, and the effect can change over time.

Participant Contributions

Participant contributions are very important to the financial understanding of how retiree health plans work. Plan sponsors must advise participants and plan administrators as to the specific dollar amounts of currently required contributions. Plan sponsors usually have administrative policies for determining future contributions (formulas, subsidy limits, or overall contribution philosophy). Based on the required contributions, an individual will decide whether to participate, which may result in adverse selection.

Formulas, subsidy limits, and the contribution philosophy of the plan sponsor are subject to different interpretations about what data and techniques are to be used in deriving the current monthly contribution used in the measurements of retiree group benefit obligations. Here are two examples:

1. The plan sponsor's stated policy is that retirees who are not yet Medicare eligible will contribute 50% of the cost of their health care benefits. However, the plan sponsor determines a retiree contribution of $100 per month ($1,200 per year) based on average annual per capita health care claims of $2,400 for active employees and pre-Medicare retirees combined. When the actuary evaluates the claims experience of pre-Medicare retirees separately from that of the active employees, the actuary determines that the average annual claim per retiree is $4,000. So the plan sponsor subsidy is really $2,800 or 70%, not the stated 50%.

2. A "defined dollar benefit" plan sponsor will pay $2,000 annually toward retiree health care coverage for retirees who are not Medicare eligible. The plan sponsor determines an annual retiree contribution of $500 based on average per capita claims of $2,500 for active employees and pre-Medicare retirees combined. However, when the actuary evaluates the claims experience for pre-Medicare retirees, the average annual claims per retiree is determined to be $4,500. The actual plan sponsor subsidy is $4,000 ($4,500 average claims per retiree less $500 retiree contribution)—double the "defined dollar benefit" of $2,000.

Once the contribution is determined for the current year, future increases can then be incorporated into the model. The contribution increase assumption is often a function of the

claims trend assumption. If the model assumes contributions increase at the same trend as assumed for age-specific claims rates, the projected contributions will not have a constant relationship to projected claims, due to the aging of the population.

Some plans impose conditions such that contributions will begin a certain pattern at some triggering point in the future. This can happen in a number of ways, but the most common may be the use of "cost caps," where the sponsor has limited its subsidy to an annual amount per capita that has not yet been reached. Participant contributions may or may not be required currently, but after the cap is reached participant contributions are to absorb all the additional costs. After the caps have been reached, this design is akin to the defined dollar approach, but before that point, the plan sponsor's costs will increase. The assumptions about future health care trend rates (interacting with the cost caps) will increase projected costs to a time when the caps are reached, and thereafter participant contributions will increase.

Finally, participation rates may be lower when contributions are required. Assumptions about lower participation rates can vary by small amounts and yet result in large differences in present values. Furthermore, lower participation may result in adverse selection on the part of participants. The combination of lower participation and adverse selection assumptions may or may not be significant in a measurement model.

Assets

Retiree group benefits are generally not subject to minimum funding requirements; however, a number of plan sponsors have, for various reasons, accumulated assets dedicated to fund the retiree group benefits. These assets provide some measure of financial security for the participants and reduce the plan sponsor's unfunded obligation, thereby reducing the future funding needs.

1. Dedicated Assets—Certain assets set aside to provide for the plan sponsor's modeled benefit may partially or completely offset the retiree group benefit obligation. Examples include the following:

    a. whole life insurance policies held by the plan sponsor to cover some of the plan sponsor's retiree death benefits;

    b. welfare benefit trusts (for example, VEBAs in the U.S.); and

    c. section 401(h) accounts in a qualified pension plan in the U.S.

2. Non-Dedicated Assets—Several plan sponsors have purchased life insurance policies (so called corporate-owned life insurance or COLI policies) with the intent that the proceeds of the policies will "fund" emerging retiree welfare benefits. Even though these policies may have been "earmarked" for funding retiree group benefits, they remain corporate assets and are not taken into account in measuring the plan sponsor's unfunded obligations.

Compliance with Other Requirements

The following provide guidance for the measurement of retiree group benefit obligations performed for specific purposes. The list represents rulemaking bodies and specific references as of the publication date of this standard, and is not intended to be exhaustive.

1. Financial Accounting Standards Board (FASB)—Accounting for financial statements for companies that comply with U.S. generally accepted accounting principles (GAAP). Current standards applicable to retiree group benefits include SFAS Nos. 88, 106, 132, and 135.

2. American Institute of Certified Public Accountants (AICPA)—The AICPA provides audit and accounting guidelines for its members. Current guidelines include the AICPA Audit and Accounting Guide, *Audits of Employee Benefit Plans*, and Statements of Position (SOP) 01-2, *Accounting and Reporting by Health and Welfare Plans*, and 94-6, *Disclosure of Certain Significant Risks and Uncertainties*.

3. U.S. Internal Revenue Code (IRC)—Various sections of the IRC govern the funding of retiree group benefits, including sections 401(h), 404, 419, 419A, 420, and 512, and the regulations and other rulings that interpret the code.

4. Cost Accounting Standards Board (CASB)—The CASB is responsible for developing accounting standards for U.S. government contracting. Current applicable standards are CAS 412, 413, 416, and the proposed CAS 419.

5. Federal Acquisition Regulations (FAR)—The FAR are regulations governing the acceptability of costs for U.S. government contracts. FAR 31.205-6 provides guidance for retiree group benefit costs.

6. Government Accounting Standards Board (GASB)—The GASB promulgates accounting standards for state and municipal governments. GASB 26 provides rules for disclosure of retiree group benefit obligations.

7. National Association of Insurance Commissioners (NAIC)—The NAIC provides model regulations for insurance company accounting that individual states may use directly or modify for their particular circumstances. The NAIC has issued Statement of Statutory Accounting Principles No. 14 that addresses rules for insurance companies with retiree group benefits.

8. International Accounting Standards Committee (IASC)—The IASC issues international accounting standards that each country's accounting profession may use as its GAAP. IAS 19 provides guidelines for retiree group benefit plans.

Appendix 3

Comments on the Exposure Draft and Task Force Responses

The exposure draft of this actuarial standard of practice was issued in October 2000, with a comment deadline of March 31, 2001. (Copies of the exposure draft are available from the ASB office.) Twenty-two comment letters were received. The Task Force on Retiree Group Benefits of the ASB carefully considered all comments received. Summarized below are the significant issues and questions contained in the comment letters and the task force's responses.

GENERAL COMMENTS	
Comment	Some commentators requested the reorganization of various sections and appendixes.
Response	The task force incorporated some suggestions into the standard. Other suggestions were inconsistent with ASB standard format and thus not implemented.
Comment	Several commentators suggested slight changes to the wording in nearly all sections of the standard.
Response	The task force implemented such suggestions if they enhanced clarity and did not alter the intent of the section.
Comment	Some commentators requested language to deal with specific SFAS No. 106 or SOP 92-6 accounting issues.
Response	The task force directs all readers to the accounting profession for clarification of specific accounting issues.
TRANSMITTAL MEMORANDUM	
In the transmittal memorandum of the exposure draft, the task force solicited comments on the key issues contained in the draft. These comments and the task force's responses to them have been incorporated in the applicable sections below.	
Comment	Some commentators requested that ACG No. 3 not be replaced by this revision due to the perceived need for the material pertaining specifically to SFAS No. 106 that is not retained in this revision.
Response	The ASB's current policy is to avoid publishing as a standard any material that is largely educational in nature, such as ACG No. 3. Educational material is included where appropriate in the appendixes. The task force understands the commentators' concern and wants to encourage the further development of educational material related to all aspects of retiree group benefits; however, we agreed with the ASB that such material should not be codified as a professional standard.
SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.2, Scope	
Comment	One commentator asked whether plan design projects should be included in the standard's scope.
Response	The task force recognizes that not all plan design projects involve the measurement of obligations; those that do would be within the scope of this standard. Therefore, the task force modified section 1.2(d) to expand that part of the definitions to explicitly include plan design projects that are cost-based.

Section 1.4, Effective Date	
Comment	One commentator requested a later effective date; other commentators pointed to the need to clarify the effective date language.
Response	The task force clarified the language regarding the effective date of the standard; however, the primary effective date was not changed.
SECTION 2. DEFINITIONS	
Section 2.1, Actuarial Cost Method	
Comment	One commentator suggested the deletion of the "more than one" phrase.
Response	The task force agreed and modified the definition accordingly.
Section 2.2, Adverse Selection (previously titled "Antiselection")	
Comment	One commentator suggested that "Antiselection" was a misnomer and that it be replaced with "Adverse Selection."
Response	The task force agreed and modified the name.
Section 2.7, Dedicated Assets (previously section 2.4)	
Comment	One commentator stated that the definition should be expanded to include assets held in trust.
Response	The task force modified the definition to broaden the scope.
Section 2.11, Medicare-Eligible Participant (previously section 2.8)	
Comment	One commentator thought this definition had extraneous wording.
Response	The task force agreed and removed the extraneous wording.
Section 2.12, Medicare Integration (previously section 2.9)	
Comment	Two commentators suggested that Medicare Supplement Plans be included in this definition.
Response	The task force agreed that Medicare Supplement Plans are prevalent; however, these plans are a supplement to Medicare and do not integrate with Medicare.
Section 2.14, Participant (previously section 2.11)	
Comment	Several commentators suggested that the definition of participant was too broad.
Response	The task force agreed and modified the definition. The task force also added a sentence to section 3.3 to clarify that open group measurements are permitted but not required.
Section 2.15, Retiree Group Benefits (previously section 2.12)	
Comment	Two commentators suggested changes to this definition. One was concerned that the definition was not clear that death benefits paid from a retirement income plan are not retiree group benefits.
Response	The task force believed that the definition was sufficiently clear and made no modifications.

Comment	One commentator questioned whether a plan is a retiree group benefits plan if all it provides is that participants are allowed to self-pay for coverage from their retirement date until Medicare eligibility.
Response	The task force intended such a plan to be a retiree group benefits plan, covered broadly in the definition, and did not believe a change in the definition was needed to convey that intent.
Section 2.19, Trend (previously section 2.16)	
Comment	Several commentators were concerned that the definition did not exclude aging or age-related morbidity.
Response	The task force chose not to narrow the definition, although it recognizes that "trend" can be defined to include or exclude age-related morbidity. The task force shares the commentators' concern that demographic changes due to the changing makeup of a population should not be included in a trend factor used to project the future cost when age-specific rates are being projected. Section 3.8.1(a) states that for the purposes of projection assumptions, trend should not include the effects of aging. For the purposes of determining the initial per capita health care rate from claim experience (section 3.4), however, the effect of aging in past trend is difficult to separate from other factors. The task force did not believe this standard should mandate the use of age-specific trend factors in analyzing past experience.
SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.2.1, Components of the Modeled Plan	
Comment	One commentator thought the list of major plan provisions should be expanded. Another thought that the list should not be included and that the actuary should determine the major plan provisions. A third commentator was concerned that the section contradicted the SFAS No. 106 requirement that no assumption with regard to future changes in government programs be made.
Response	The task force did not intend for the list to be all-inclusive; however, the task force believed that these are the minimum components that should always be modeled. In regard to the third commentator's concerns, the task force refers the commentator to section 3.2.1(f).
Comment	One commentator was concerned that section 3.2.1(a) required that a "gross claim" model be used.
Response	The task force modified the wording to remove such a requirement.
Comment	With respect to section 3.2.1(b), one commentator suggested that the standard should provide more discussion pertaining to the modeling of lifetime maximums.
Response	The task force believes that this is not a practice area where appropriate guidance has emerged.
Comment	One commentator expressed concern that section 3.2.1(c)(2) required the actuary to act as the auditor.
Response	The task force agreed and modified the section heading and wording accordingly.
Comment	With respect to section 3.2.1(c)(4), one commentator expressed concern about requiring the actuary to determine the year the limit is reached and the implications of reaching it.
Response	The task force disagreed with the commentator on the necessity of knowing when the limit will be reached. Such information is crucial to appropriately determining the obligation associated with such a cap. The task force, however, did agree that the "implications" wording was not clear and removed this language.

Comment	One commentator suggested that section 3.2.1(c)(5) be deleted since participation rates are covered in section 3.8.3(a).
Response	The task force agreed that participation rates are more appropriately addressed in the later section and deleted the paragraph.
Comment	With respect to section 3.2.1(f), two commentators stated that SFAS No. 106 allows for recognition of changes other than those that have been communicated.
Response	The task force agreed and modified the wording of this section to include changes that are the result of the continuation of a historical pattern.
Section 3.2.2, Historical Practices	
Comment	One commentator thought that section 3.2.2(a) was too onerous and that the actuary needs to establish only "a reasonable level of comfort" that the benefits provided are consistent with major plan provisions.
Response	The task force agreed and modified the language.
Comment	With respect to section 3.2.2(c), one commentator stated, "[I] do not believe it is the actuary's responsibility to determine whether a past practice or a pattern of regular changes indicates a commitment by the plan sponsor to make future changes to the plan."
Response	The task force agreed that the actuary should not be responsible for determining the plan sponsor's "commitment." The actuary, however, may include the continuation of such past practices in the model.
Comment	One commentator thought that section 3.2.2(d) did not belong in the "Historical Practices" section.
Response	The task force believed that the language on "Government Programs" was appropriately placed in the "Historical Practices" section, but it clarified the language.
Section 3.3, Modeling the Covered Population	
Comment	Several commentators noted that no mention was made of open group valuations, while others were concerned that the standard required the use of open group valuations.
Response	The task force revised the text to indicate that while the standard does not require the use of open group measurements, they may be used when appropriate.
Comment	A commentator suggested that the term "covered population" be included in the set of definitions.
Response	The task force agreed and added a definition.
Section 3.3.2, Employees Currently Not Accruing Benefits	
Comment	One commentator suggested section 3.3.2 be clarified to distinguish between employees who are not accruing service and never expected to do so, and those who, while not currently accruing service, are expected to do so in the future.
Response	The task force agreed and modified the language.
Section 3.3.3, Contingent Participants	
Comment	One commentator questioned the need to develop reentry assumptions when measuring contingent participants. The commentator suggested that the actuary should determine if any significant obligation exists and only when this is so should the obligation be reflected in the measurement. Otherwise, the actuary should disclose that reentry possibilities were left out of the measurement.
Response	The task force modified the language to clarify that appropriate measures should be taken when individuals may reasonably be expected to become participants. The task force believes that additional disclosures on this element of the model are not needed.

Section 3.3.4, Spouses and Survivors of Participants (previously titled "Spouses and Surviving Spouses of Participants")	
Comment	One commentator expressed concern about including spouses in the modeled population, when, based on the commentator's experience, these data often are not available.
Response	While the task force understands that complete information on spouses may not be available for all measurements, the importance of the spousal obligation to the measurement requires that the actuary model spouses and surviving spouses in the covered population. The task force believes the current language is sufficiently broad to allow the actuary to use both empirical data, where available, supplemented by reasonable assumptions where necessary.
Section 3.3.5, Dependents	
Comment	Several commentators found this section confusing.
Response	The task force redrafted the section to clarify the intent.
Section 3.3.6, Appropriateness of Pension Plan Data	
Comment	Several commentators suggested alternative language and additional examples of edits and adjustments to pension plan data to represent the retiree group plan covered population.
Response	The task force considered these suggestions and incorporated them in the revised text.
Section 3.3.7, Use of Grouping	
Comment	One commentator raised a concern about the requirement to disclose the use of grouping, which the commentator did not see as standard practice. Another commentator was concerned that the requirement to disclose the use of grouping techniques may be interpreted to imply that some imprecision results from grouping.
Response	The task force incorporated suggested text changes to clarify that grouping techniques may be appropriate when, in the actuary's judgment, this is not expected to unreasonably affect the measurement results.
Section 3.4, Modeling Initial Per Capita Health Care Rates	
Comment	One commentator suggested that the initial paragraph of section 3.4 include the word "credible" before "plan experience" in the third sentence.
Response	The task force made no change since it believes the last sentence of the paragraph appropriately addresses the issue of credibility.
Comment	Two commentators requested guidance on the use of plan experience for small plans. One commentator remarked that even if detailed claim information were available for small plans, it generally would not be credible.
Response	The task force did not revise the standard to address small plans specifically, but did expand the discussion of premium rates in appendix 2. The task force also notes that while plan experience for a small plan may not be fully credible, that does not mean the plan experience has no credibility. ASOP No. 25 is recommended for guidance in regards to assigning credibility to experience data.
Comment	One commentator noted that ASOP No. 31 also had relevance to ratemaking aspects of sections of the standard other than section 3.4.
Response	The task force agreed and modified that reference accordingly.

Comment	The task force received several comments regarding the development of the initial per capita health care rate and the actuary's responsibility to document that development.
Response	The task force addresses those comments below in relation to section 4.1. The task force believes development of per capita claim rates for measuring retiree health benefit obligations should be subject to a ratemaking process, whether the purpose is cost projections, financial reporting, or other actuarial work within the scope of this standard. The task force also notes that ASOP No. 31 is not a standard on ratemaking, but rather provides "guidance on documentation in the process of health benefit plan ratemaking."
Comment	One commentator suggested that the standard address situations where another person or organization gives the actuary the rates.
Response	The task force believes the standard addresses this by noting the handling of premium rates in section 3.4.5 and reliance on a collaborating actuary in section 3.12. The development of initial per capita health care rates for measuring retiree health obligations is an actuarial responsibility. Others will furnish information during the measurement process and tasks in the development process may be delegated to non-actuaries, but the professional judgment of an actuary is necessary in determining the initial per capita health care rates (section 3.4) and ensuring its consistency with the rest of the model (sections 3.6 and 3.12).
Comment	One commentator suggested that gender be added to the list of elements the actuary should consider. Another commented that spouse rates and disabled rates should be considered.
Response	The task force expanded the third paragraph to indicate examples of when multiple rates may be appropriate. The task force also notes that section 3.4.2 mentions gender.
Comment	One commentator suggested the section include material on expenses.
Response	The task force made no changes, noting that the first sentence mentions benefit costs rather than claim costs, and section 3.4.14 covers administrative costs.
Comment	One commentator disagreed that the second paragraph of section 3.4 outlined a process generally used, citing the use of actual-to-expected studies.
Response	The task force believes the standard accommodates other methods, which would include the use of normative databases and actual-to-expected studies, when plan experience is not sufficiently credible. The task force is aware there may be differences of opinion as to when, and to what extent, plan experience should be tempered with normative data. The task force believes this should be left to the actuary's judgment but that there should be a bias towards plan experience. Appendix 2 notes some of the limitations of normative databases. The second paragraph of section 3.4 was intended to outline the process, however, and not establish a requirement, so the task force deleted "the actuary should follow" from the opening sentence in this paragraph. Similarly, other wording in the first two paragraphs was modified to clarify the preference for credible historical plan claims experience and the use of alternative methods.

Section 3.4.1, Net Aggregate Claims Data	
Comment	Two commentators questioned whether the last sentence of section 3.4.1(a) implied that differences between paid claims and incurred claims for the same time period were always insignificant or that factors of trend and discount always offset each other.
Response	The task force believes the full paragraph adequately addresses the likely significance of the differences. The task force also recognizes that, while the usual objective of claims analysis is the development of an incurred rate, a valuation of future paid claims may be valid, since determination of the present value of long-term obligations is based on the principles of discounted cash flow. The standard guides the actuary reviewing past aggregate claims to acknowledge differences in paid and incurred claims, as well as the effects of trend and the time value of money, and make adjustments to enhance the ability to forecast likely future claims levels.
Comment	One commentator suggested the first sentence of section 3.4.1(b) was not clear.
Response	The task force clarified the language.
Comment	One commentator suggested that, "To the extent that net claims are used, the actuary should consider the effect of their use on other assumptions, (e.g., trend assumption)."
Response	The task force agrees that the actuary should consider the effect of trend assumption and other assumptions, regardless of whether the initial per capita health care rate is based on net or gross claims. The task force believes the issue is addressed in section 3.8, particularly in section 3.8.1(a), which mentions leveraging caused by plan design features that are not explicitly modeled.
Section 3.4.2, Exposure Data	
Comment	Three commentators suggested the need to compare exposure data and the census even though they are not expected to match exactly.
Response	The task force agreed and modified the language accordingly.
Section 3.4.3, Use of Multiple Claims Experience Periods	
Comment	Three commentators noted that more recent experience is not always more reliable.
Response	The task force agreed and modified the language accordingly.
Section 3.4.4, Credibility	
Comment	One commentator suggested that credibility adjustments should include those for differences in plan design.
Response	The task force agreed and modified the language accordingly.
Section 3.4.5, Use of Premium Rates	
Comment	One commentator noted that the second sentence of the section did not add clarifying value to the section.
Response	The task force agreed and combined the important elements of the sentence with the initial sentence.

Comment	One commentator suggested that section 3.4.5 pertain only to self-insured plans and that fully insured plans need not be subject to this section, particularly if they consist solely of reimbursing insurance premiums.
Response	The task force believes there is consensus among actuaries performing retiree group benefit measurements about the almost universal need for adjustments when using premiums as the basis for projected future cost, regardless of whether the plan is fully insured or self-insured. The "Measurements Using Premium Rates" section of Appendix 2 provides additional comments on this issue.
Comment	The same commentator suggested that the impact of aging is often effectively included in the trend rates.
Response	The task force believes that the future impact of aging on health care costs of a given population of actives and retirees does not have a strong enough correlation to trend to be effectively included in the trend assumption. The standard requires a separation of the impacts of age and trend through the use of age-specific per capita claims rates (see section 3.4.7).
Comment	Several comments were received about the second paragraph concerning community rates.
Response	The task force discontinued the use in the standard of the concept of community-rated premium after recognizing that the term was unlikely to have a satisfactory common definition. The task force modified the language concerning the use of premium rates as the basis for an initial per capita health care rate assumption to clarify the significance of age differences in determining rates and to exemplify the limited circumstances under which an unadjusted premium rate might be used and the disclosures appropriate for such use.
Comment	One commentator raised a question about a per capita rate that had been approved by an accounting firm.
Response	The task force notes that section 3.11 (previously section 3.8.8) and section 4.4 may be relevant to this question and that section 3.4.5 covers actuarial aspects of the use of premium rates.
Section 3.4.6, Impact of Medicare and Other Offsets	
Comment	Several comments were received regarding the requirement to confirm the Medicare integration approach.
Response	The task force did not intend this to be an audit requirement and deleted the confirmation wording, believing that recognition of the Medicare integration approach and need for consistency in section 3.7 adequately address the issue.
Comment	A commentator noted that while section 3.4.6 urged adjustments if Medicare changed, it was not clear on the timing or purpose of adjustments.
Response	The task force believes that adjustments for scheduled or proposed changes in Medicare are somewhat contingent upon the purpose of the measurement and modified the standard accordingly, while leaving to the actuary's judgment whether to anticipate changes before they become law.
Comment	A commentator noted that the requirement to develop separate rates for Medicare eligible participants may apply to benefits unaffected by Medicare and to those eligible for Medicare before age 65 by reason of eligibility.
Response	The task force agreed and modified the language to recognize these differences.

Section 3.4.7, Age-Specific Claims Rates	
Comment	Several commentators questioned the appropriateness of requiring, at a minimum, five-year age bands for claims rates. Most agreed with the general practice of age grading but some noted instances, such as dental care or medical benefits above age 90, where age grading was relatively flat and five-year age bands would not be appropriate.
Response	The task force withdrew the requirement that initial per capita health care rate assumptions use claims rates in age ranges not to exceed five years and substituted language requiring age bands that are appropriate and not overly broad.
Comment	Two commentators seemed to believe the standard required analysis of the specific claims experience to determine the rates at each age or age band.
Response	The task force clarified that the intent is not to subject claims experience to analysis by age bands but rather to ensure that rate projections account appropriately for the possibility of significant utilization and cost differences within small age bands. This will most likely be demonstrated by normative data.
Comment	Three commentators thought it was sufficient to have only two different claims rates, for non-Medicare eligible versus Medicare eligible ages, or for pre-age-65 and post-age-65 ages.
Response	The task force disagrees that a medical benefits model is likely to be sufficient with only two different claims rates for non-Medicare eligible versus Medicare eligible ages, or pre-age-65 and post-age-65 ages, since such wide bands would be overly broad for the likely age variation in claim rates for a retiree group with lifetime coverage.
Comment	One commentator thought that a defined dollar benefit would fall outside this requirement. Another believed that for a premium reimbursement plan only the premium rate experience would be relevant.
Response	The task force disagrees that this section will be irrelevant to the measurement process for these specific instances and notes that other sections, such as 3.2.1(c), 3.7, 3.8.1(c), and the "Participant Contributions" portion of appendix 2, offer guidance when sponsor financing has defined limits.
Section 3.4.8, Adjustment for Plan Design Changes	
Comment	A commentator suggested that this section be expanded to include plan design changes effective in the future.
Response	The task force agreed that, for some purposes, adjustment for future changes might be appropriate, but made no changes to the requirements of this section, feeling the matter is covered adequately in section 3.2.1(f) and 3.8.4.
Section 3.4.9, Adjustment for Administrative Practices	
Comment	Three commentators pointed out that these adjustments were most relevant when there had been changes in the administrative practice.
Response	The task force agreed that changes in administrative practice are the relevant concern for rate development, for both claims adjudication and enrollment practices, and changed the language accordingly.

Section 3.4.10, Adjustment for Large Individual Claims	
Comment	Three commentators were concerned about the plan sponsor's ability to supply large claim information, due to privacy concerns or other reasons, or whether the additional workload was justified by additional accuracy.
Response	The task force modified the language to clarify the actuary's duties but does not believe privacy laws will preclude the minimum duties.
Section 3.4.11, Adjustment for Trend	
Comment	A commentator noted that initial per capita claim rates were not always exactly congruent with the first year of the measurement period and suggested that language about trend adjustments should reflect that possibility.
Response	The task force agreed and modified the first sentence accordingly.
Comment	One commentator indicated the effect of trend on the plan's historic experience might not be credible.
Response	The task force agreed and clarified the language.
Section 3.4.12, Adjustment When Plan Sponsor is Also a Provider	
Comment	Three commentators asked for additional guidance on this topic.
Response	The task force believed this was not a part of the practice where appropriate guidance had emerged in succinct form, but did add consideration for reimbursements, such as Medicare, which might be received by the plan sponsor.
Section 3.5, Modeling the Cost of Death Benefits	
Comment	Two commentators pointed out that group term life premium rates often do not vary by age, which produces a reconciliation problem between accounting charges and the true cost of coverage.
Response	The task force believes that the model should still accurately measure true costs and that the accounting issues are not within the scope of this standard.
Section 3.6.1, Coverage and Classification Data	
Comment	One commentator suggested the phrase "merit further refinement" be changed to "require further refinement."
Response	The task force agreed and modified the language.
Section 3.6.2, Consistency	
Comment	Several commentators believed the requirement to "evaluate the operations of the plan" went well beyond the duties of the actuary, and that the actuary should be able to assume that the provisions are being properly administered unless data suggests otherwise.
Response	The task force did not intend the actuary to "audit" the plan operations, and has therefore amended the requirements on plan operations. The task force believes the actuary is in a unique position to observe the plan operations, and thus may discover inconsistencies in plan operations that affect the measurement. In such circumstances, the actuary is directed to section 3.7 for the appropriate actions.
Comment	One commentator suggested an additional example of situations where average claims costs that are secondary to Medicare are high in relation to average costs that are primary.
Response	The task force expanded the example to include the classification of covered spouses based on the retiree's age.

Comment	One commentator suggested the phrase "if significant" in section 3.6.2(d) should not apply just to dependents.
Response	The task force disagreed. While the obligation for spouses and surviving spouses can generally be expected to have a significant impact on the results, the obligation for dependents would do so only if the dependent coverage was extensive and dependents made up a significant proportion of the total covered population.
Section 3.7, Administrative Inconsistencies	
Comment	One commentator suggested that disclosure include "an illustration of the effects of recognizing such inconsistency on either the anticipated level of future claims or the determination of any special one-time cost."
Response	The task force did not believe this was a requirement for all measurements, although it may be appropriate for some.
Comment	One commentator suggested that section 3.7(c) be separated into two points.
Response	The task force agreed and modified the structure.
Comment	Four commentators were concerned that the language required an audit of the plan's administration.
Response	The task force agreed that was not its intent and modified the language of the first sentence to indicate that it addressed guidelines for an actuary who might come across administrative inconsistencies during the course of the measurement process.
Section 3.8.1, Economic Assumptions	
Comment	One commentator stressed that the consistent use of a general inflation component in each of the economic assumptions is a necessary but not sufficient condition so as to have consistent overall economic assumptions.
Response	The task force agreed and modified the wording of the first paragraph accordingly.
Comment	Another commentator suggested that since most employers have a consistent discount rate assumption for their SFAS No. 87 and SFAS No. 106 measurements, the new standard should mandate the use of the same discount rate for the pension and retiree welfare valuations.
Response	The task force believes that such a mandate would be excessively stringent and that there are certainly cases where varying the discount rates is quite reasonable, taking into account differences in duration between pension benefits and retiree group benefits.
Comment	One commentator suggested that educational material pertaining to health care cost trend rates be added to this standard.
Response	Actuarial standards of practice typically do not include educational material in the body of the standard, the task force included material in appendix 2 that provides commonly used definitions and illustrations of the factors that can affect health care cost trend rates.
Comment	Three commentators suggested that practitioners be allowed to utilize a single composite trend rate assumption.
Response	The task force agreed and added the following sentence to section 3.8.1(a): "Even if the actuary develops one aggregate trend rate, the actuary should consider these cost components when developing the rate."

Comment	One commentator suggested that there be separate recognition in the actuarial model of the health care trend rate and the plan design elements that may modify the trend.
Response	The task force appreciates the commentator's concern, but believes that the leveraging caused by plan design features can be reflected in the health care cost trend rate if it is not explicitly modeled.
Comment	One commentator suggested that there were two opposing statements in section 3.8.1(d)—that "this standard does not require the use of explicit assumptions about antiselection" and that "the actuary should consider an upward adjustment for antiselection."
Response	The task force modified some of the wording, but stresses that the second sentence to which the commentator referred should be read in its entirety. The task force agrees that the standard should not require the use of specific assumptions for adverse selection. If the actuary changes assumptions for adverse selection such as the participation assumption, however, the actuary should be aware that other assumptions (per capita health care rates) should be modified appropriately.
Comment	Another commentator expressed concern that section 3.8.1(d) allows the actuary to reflect possible antiselection through an implicit assumption.
Response	The task force modified the wording of this section to remove any ambiguity about assumptions for adverse selection.
Section 3.8.2, Demographic Assumptions	
Comment	One commentator suggested that it would be helpful to include some discussion about the potential interdependence of the various demographic assumptions. The commentator also suggested that discussion of the other factors that should be considered in choosing a retirement assumption be added.
Response	The task force agreed and modified sections 3.8.2 and 3.8.2(c).
Comment	One commentator questioned whether the ASB is mandating the use of disability assumptions.
Response	The task force directs the commentator to the second sentence of section 3.8.2(b), which states that the actuary should select disability assumptions if the actuary considers the disabled life coverage significant to the measurement.
Comment	One commentator believed that the definition of disability (and issues surrounding how it should be reflected) is amply handled in section 3.5.4(a) of ASOP No. 35.
Response	The task force agrees and notes that section 3.8.2 refers actuaries to ASOP No. 35 for guidance when selecting any of the demographic assumptions.
Comment	One commentator stated that the actuary may decide to use different mortality assumptions for medical (i.e., annuity) and life benefits.
Response	The task force agreed, but believed that no change was needed in section 3.8.2(d) to address this. The task force did, however, add wording to suggest that gender-specific mortality rates may be more appropriate for retiree group benefit obligation measurements rather than unisex mortality rates.
Comment	Another commentator suggested that projecting future mortality improvements could be overstating realistic expectations.
Response	The task force made no change since the second sentence of section 3.8.2(d) states "the actuary should consider." If, after consideration, the actuary determines that future mortality improvements are negligible, he or she should reflect this in the choice of mortality assumptions.

Section 3.8.3. Coverage Assumptions	
Comment	One commentator suggested that the guidance could include some consideration of future availability of options, particularly the reduction in availability of Medicare Risk HMO options. This commentator also stated that the actuary could be directed to consider the impact of plan rules on whether a spouse or dependent could be added after retirement.
Response	The task force agreed with both comments and modified the section accordingly.
Comment	One commentator stated that section 3.8.3(a) seems to assume a large group with credible experience while in many cases this will not be the situation.
Response	The task force added wording to stress that group-specific data be used in selecting assumptions when such data are available and credible.
Comment	Another commentator suggested that variations in participation may occur after retirement and thus may affect current retirees as well as future retirees.
Response	The task force agreed and modified sections 3.8.3(a) and (b) accordingly.
Comment	One commentator questioned whether some of the material in this section should be covered in section 3.3.
Response	The task force believes that these assumptions are relevant to future years and are appropriately discussed here.
Comment	One commentator believed that section 3.8.3(a) should be clarified to state that participation can vary by type of coverage when more than one type are available.
Response	The task force agreed and modified the language accordingly.
Comment	Another commentator suggested that, in addition to appropriate age assumptions for covered spouses, appropriate age assumptions should be made for non-spouse dependents.
Response	The task force agreed and modified section 3.8.3(c) accordingly.
Section 3.8.4, Effect of Plan Changes on Assumptions	
Comment	One commentator believed that the concept of the additional risk premium in the discount was not clear.
Response	The task force agreed and modified the language accordingly.
Comment	Another commentator expressed concern about the context in which the advice in this section is given.
Response	The task force agreed and modified the language of the second paragraph.
Comment	One commentator believed that the use of the term “professional judgment” in the second paragraph implies that actuaries should never allow anticipated plan change savings to continue into the future.
Response	The task force believes that the second sentence of the second paragraph does not restrict the actuary in recognizing plan change costs/savings in future years. The sentence does require the actuary to exercise judgment before making such a decision.
Comment	Two commentators questioned whether the assumption of the probability of plan termination is an acceptable practice.
Response	The task force believes that there are certain limited circumstances where the use of an assumption of the probability of plan termination should be permitted.

Section 3.8.6, Reviewing Assumptions	
Comment	Two commentators stated that the setting of assumptions for the measurement of costs does not always rest with the actuary (for example, SFAS No. 106 measurements).
Response	The task force agrees and refers the commentators to section 3.11, Prescribed Assumptions, Methods, or Other Model Components.
Section 3.8.7, Changes in Assumptions	
Comment	One commentator believed that this section should be modified to restrict consideration to other assumptions selected by the actuary, and that no such consideration is required for a change in assumptions not selected by the actuary.
Response	The task force believes that the actuary should review all assumptions, including client prescribed assumptions, where the actuary was asked to give advice, for continued reasonableness.
Section 3.9, Selecting a Cost Allocation Policy (previously titled "Selecting Actuarial Cost Methods")	
Comment	Several commentators suggested the section heading should be changed, as the amortization of plan amendments and actuarial gains and losses are not necessarily part of the actuarial cost method.
Response	The task force agreed, modified the section heading and wording accordingly, and added a definition of "cost allocation policy" in section 2.
Comment	One commentator suggested that cash flow adequacy criteria for selecting an appropriate cost allocation policy should be limited to apply solely to situations where only the existing assets will be used to pay benefits.
Response	The task force disagreed.
Section 3.9.2, Dedicated Assets (previously section 3.9.3)	
Comment	One commentator suggested that a different example be developed for section 3.9.2(b).
Response	The task force believes the example of a prescribed asset valuation method is relevant.
Section 3.10, Use of Roll-Forward Techniques (previously section 3.9.2)	
Comment	One commentator agreed with the limitation that roll-forwards should be limited to no more than two years after a prior measurement. Another questioned the selection of two years, and several commentators believed this was too restrictive, interpreting the standard to prohibit the use of a 1/1/2000 measurement for SFAS No. 106 12/31/2002 disclosures. A survey of one commentator's firm's clients found that, in addition to biennial re-measurements, triennial measurements were used for a fair number of clients. The survey did not find any situations where a measurement was performed less frequently than once every three years.
Response	The task force had intended the use of roll-forward techniques with triennial re-measurements and modified the text and example in section 3.10.2 (previously section 3.10(b)) to clarify this.
Comment	One commentator questioned the restriction on the length of the roll-forward period when the accounting standard to which the work applies has a requirement for an actuarial study that must, at a minimum, be updated every five years.
Response	The task force recognized that special circumstances could apply and modified the language accordingly.

Comment	One commentator interpreted the restriction on roll-forward techniques to imply that a complete experience analysis of every assumption and claim rate must be preformed at each re-measurement.
Response	The task force refers the commentator to section 3.8.6, which states, in part, that the actuary is not required to do a complete assumption study at each measurement date.
Comment	One commentator suggested the example in section 3.10.1 (previously section 3.10(a)) be clarified so that claim rates used at a prior measurement are trended forward.
Response	The task force agreed and modified the language accordingly.
Comment	One commentator noted that the term "significantly" in section 3.10.3 (previously section 3.10(c)) may cause debate among actuaries as to what is significant.
Response	The task force recognizes this issue, but did not modify the language, as it believes it is appropriate for the actuary to decide, based on professional judgment, whether a key model component has changed significantly since the last full measurement.
Section 3.11, Prescribed Assumptions, Cost Allocation Policies, or Other Model Components (previously Section 3.8.8, Prescribed Actuarial Assumptions)	
Comment	One commentator stated that this section should discuss what implications the prescribed assumptions have on the need for the actuary to use consistent assumptions.
Response	The requirement to use consistent assumptions, set forth in section 3.8.5, applies only to assumptions selected by the actuary.
Comment	Another commentator was pleased with the elimination of the language regarding disclosure of exceptions (ACG No. 3, section 6.2) and suggested that this point be more emphatically stated.
Response	The task force believes that the issue is adequately addressed in the fourth paragraph of section 1.2.
Comment	One commentator noted that an actuary cannot be responsible for assumptions prescribed by others or be responsible for the overall appropriateness of results where the prescribed assumption might not be considered appropriate. This commentator cited section 3.8.8, Prescribed Actuarial Assumptions (now section 3.11, Prescribed Assumptions, Methods, or Other Model Components).
Response	The task force agreed that this may be an important distinction in some cases and modified this section to acknowledge exceptions due to section 3.11.
Section 3.12, Reasonableness of Results (previously section 3.10)	
Comment	One commentator suggested the language regarding sample participants be clarified.
Response	The task force agreed and modified the language.
Comment	With respect to the requirement to compare expected claims with actual claims, several commentators believed that the requirement was excessive, that actual claims may not be credible, and that only significant differences should be evaluated.
Response	The task force agreed that the actuary should evaluate only significant differences, which may include the volatility of experience in small plans. In response to one commentator, the task force added the word "available."
Section 3.13, Sensitivity of Results to Chosen Assumptions (previously section 3.11)	
Comment	Three commentators pointed out that a 20% increase plus a 20% decrease produces a 4% decrease, not 0%.
Response	The task force agreed and made the change.

Section 3.14, Reliance on a Collaborating Actuary (previously section 3.12)	
Comment	Three commentators questioned the implications of this section. One wanted a statement to the effect that each of two actuaries could issue an actuarial opinion with respect to the part of the valuation for which he or she was responsible. Another wanted a statement on the role of the non-actuary who might be qualified by the nature of his or her professional experience, education and training. A third said that the standard implied that one actuary must have expertise in all aspects of the project.
Response	The task force recognizes in section 3.14 that two or more actuaries may collaborate on a project. One may have an expertise in health data analysis and another in long-term projections. Nothing in the standard prevents each from issuing an actuarial opinion with respect to his or her responsibility. Each of these expertises, however, is an actuarial expertise. Neither the task force nor the ASB is aware of any other profession where a practitioner is qualified by the nature of his or her professional experience, education and training to perform the health data analysis or long-term projections that are key to the measurement of retiree group benefit obligations. For an actuary to issue a professional opinion on such measurement and meet this standard, that actuary must take responsibility that all significant aspects meet this standard or disclose the deviation from standard. The standard does not require that one of the actuaries must have expertise in each and every aspect of the measurement, but does require at least one of the actuaries to take responsibility that the results of the health data analysis used for initial rate and other health care assumptions mesh appropriately with the assumptions and model used for long-term projections.
SECTION 4. COMMUNICATIONS AND DISCLOSURES	
Section 4.1, Documentation	
Comment	The task force received several comments regarding documentation of health care rate development. A commentator questioned the applicability of ASOP No. 31 to retiree health benefits, particularly since there seems to be a specific exemption in ASOP No. 31 for work related to SFAS No. 106.
Response	The sentence referred to in ASOP No. 31 contains a contingent exemption. It states, "The standard does not apply to work done in connection with [SFAS No. 106] unless ASOPs pertaining to SFAS No. 106 specifically call for application of this standard." That sentence is followed by the statement, "A task force is being created to address issues related to SFAS 106." The task force that was created recommended the revision of ASOP No. 6 and also believed it was appropriate for ASOP No. 31 to apply to SFAS No. 106, as well as other retiree group benefit measurements. The current task force agrees that ASOP No. 31 should apply to SFAS No. 106. The ASB affirms that ASOP No. 31 does apply to work performed in connection with SFAS No. 106. The contingent exemption in ASOP No. 31 relating to SFAS No. 106 is now erased. Documentation is an essential component of actuarial practice. ASOP No. 31 provides guidance on important aspects of documenting health benefit plan ratemaking. Not every issue covered by ASOP No. 31, however, applies to every development of rates. The actuary developing or using rates for a retiree health valuation should comply with those aspects of ASOP No. 31 relevant to the case at hand.
Comment	A commentator suggested that claim rates used in retiree health valuations differ from other actuarially derived claim rates and are not subject to the same outside review as the ratemaking covered under ASOP No. 31.
Response	The task force believes this may be a misreading of the purpose of ASOP No. 31, which is not a standard on ratemaking, but rather provides "guidance on documentation in the process of health benefit plan ratemaking." The task force believes development of per capita claim rates for measuring retiree health benefit obligations clearly falls within the ratemaking process, whether the purpose is plan design, cost projections, or financial reporting. ASOP No. 31 also clearly states that it is not a standard on pricing, which may be subject to extensive regulatory review.

Comment	Another commentator suggested this standard should include a requirement that documentation regarding development of health care rates be made available to another actuary upon the client's request and that it not be withheld as proprietary.
Response	ASOP No. 31 states that "Documentation should be available to the actuary's client or employer, and it should be made available to other persons when the client or employer so requests and provided such availability is not otherwise improper." The task force believes this accurately states the actuary's need to cooperate with others who have an appropriate role in determining the rationale for a particular assumption about per capita health care rates. While there may be software that is proprietary, the actuary's cooperation should encompass source data and methods. Differences of opinion on what is proprietary might be referred to the Actuarial Board for Counseling and Discipline (ABCD).
Comment	One commentator noted that ASOP No. 31 also had relevance to ratemaking aspects of sections of the standard other than section 3.4.
Response	The task force agreed and modified that reference accordingly.
Comment	Several commentators objected to the documentation requirements of the standard as being "excessive," "inappropriate," "severe," or "burdensome." One commentator suggested that the proposed requirements were beyond the normal documentation requirements.
Response	Upon review, the task force believes that the extent of the documentation required by this standard is consistent with other, contemporaneous standards. In addition, the documentation required seems to be the minimum level necessary "so that another actuary qualified in the same field could assess the reasonableness of the work." Furthermore, the task force notes that some commentators appear to have confused documentation with disclosure requirements, which is the difference between one's work papers and the communication of one's work product.
Section 4.2, Disclosure	
Comment	One commentator questioned the meaning of the word "significant" throughout this section.
Response	The task force identified the items subject to disclosure, but leaves it to the professional judgment of the actuary to decide the appropriate extent of such disclosure, given the purpose of the measurement and the expected use of the disclosure material.
Comment	Two commentators requested a clarification of terms used in section 4.2(a).
Response	The task force added references to sections in the standard.
Comment	One commentator said that the last paragraph was too restricting, in that it limits external references to only actuarial communications.
Response	This paragraph is intended to reduce the repetition of previously disclosed actuarial material in a current document; it should not be seen as limiting any other external references to commonly available documents.