ACTUARIAL STANDARDS BOARD

Actuarial Standard
of Practice
No. 6

Measuring Retiree Group Benefit Obligations

Revised Edition

Developed by the
Task Force on Retiree Group Benefits of the
Actuarial Standards Board

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March 2001

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Measuring Retiree Group Benefit Obligations

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice (ASOP) No. 6

This booklet contains the final version of the revision of ASOP No. 6. The original title, *Measuring and Allocating Present Values of Retiree Health Care and Death Benefits*, has been changed to *Measuring Retiree Group Benefit Obligations*. This standard supersedes Actuarial Compliance Guideline (ACG) No. 3, *For Statement of Financial Accounting Standards No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions*, which has been repealed.

Background

The original ASOP No. 6 was effective October 17, 1988. ACG No. 3 was originally effective December 1, 1992. During the time these documents were being developed, the Financial Accounting Standards Board was raising the visibility of financial issues related to retiree group benefits with its development of Statement of Financial Accounting Standard (SFAS) No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*. Prior to the issuance of SFAS No. 106, most plan sponsors provided and accounted for retiree group benefits on a pay-as-you-go basis. The move to accrual accounting necessitated greater actuarial involvement. ASOP No. 6 and ACG No. 3 were written with a high level of educational content because the measurement of retiree group benefit obligations was an emerging practice area that would be new to many actuaries.

In the 1990s, the ASB adopted standards related to data quality (ASOP No. 23), credibility procedures (ASOP No. 25), documentation in health benefit plan ratemaking (ASOP No. 31), and the selection of pension assumptions (ASOP Nos. 27 and 35). As provided in this ASOP, these other ASOPs have application to actuaries measuring retiree group benefit obligations.

Although the measurement of retiree group benefit obligations continues to develop as an actuarial field within the profession, the ASB believes that practice in this field has developed sufficiently to permit codification of acceptable current practices in a revised ASOP No. 6. Thus, in 1999, the ASB convened a special task force of knowledgeable practitioners in the retiree group benefits field to draft the revision of this standard. The Task Force on Retiree Group Benefits was charged with (1) updating ASOP No. 6 to provide guidance to actuaries regarding acceptable practices and to reduce the amount of educational material; (2) determining whether there was a continuing need for ACG No. 3; and (3) evaluating the applicability to retiree group benefits of ASOPs written since the original adoption of ASOP No. 6.

Key Issues

As discussed in the exposure draft, this standard not only replaces the previous ASOP No. 6, but also supersedes ACG No. 3. In addition, this revised standard represents the following changes from the original ASOP No. 6:

1. This standard uses a model-building approach to the measurement of retiree group benefit obligations, as representative of contemporary practice.

2. The measurement model described in this standard includes the following three key components:

    a. the modeled plan provisions;

    b. the modeled population expected to receive retiree group benefits; and

    c. the model of current and projected benefit costs.

3. The standard requires that each of these three components be appropriately developed so as to sustain the integrity of the measurement. This generally requires the following:

    a. expertise in both the development of health care claims rates and the long-term projection of the covered population; and

    b. exclusion of very simplified methods or assumptions used in modeling complex plans and processes.

4. The standard emphasizes the use of the plan's experience for health care measurements, but allows for the use of appropriately adjusted premium rates or normative claim databases when the plan's experience is not fully credible.

5. The standard requires the actuary(s) issuing the actuarial opinion to take professional responsibility for overall appropriateness of the analysis, assumptions, and results.

6. The standard requires the actuary to use appropriate age bands if the claim rates are expected to vary significantly by age.

7. The standard allows the use of roll-forward measurement techniques to measurement dates that are less than three years after the original measurement date.

8. The standard places increased emphasis on the modeling of participant contributions in retiree group benefit measurements.

9. The standard calls for the application of ASOP Nos. 25, 27, 31, and 35 to the measurement of retiree group benefits.

10. The standard requires the actuary to compare projected claims to recent actual claims.

11. The standard includes guidance on the handling of differences between actual administrative practices and stated plan provisions.

12. The standard places increased emphasis on considering expected changes in plan design and covered population.

13. The standard requires the actuary to consider using different trend assumptions by line of coverage.

Exposure Draft

The exposure draft of this standard was issued in October 2000 with a comment deadline of March 31, 2001. The Task Force on Retiree Group Benefits carefully considered the twenty-two comment letters received. For a summary of the substantive issues contained in these comment letters, please see appendix 3.

The changes since the exposure draft that were incorporated into this standard include the following significant items:

1. The language regarding the appropriateness of the use of premium rates in setting the initial per capita claim rates was changed to allow more flexibility in using this approach, and the material on premium rates in appendix 2 was revised.

2. The requirement to use five-year age bands in the initial per capita health care rate was replaced by a more flexible requirement.

3. The language regarding the actuary's responsibility when actual administrative practices are not consistent with stated plan procedures was clarified to remove any apparent burden on the actuary to audit administrative practices.

4. The effective date of the standard was clarified, especially with respect to roll-forward measurements.

5. Several subsections of section 3 regarding the use of roll-forward techniques and the use of prescribed assumptions, methods, and other model components were moved to different areas of section 3.

The task force thanks all those who commented on the exposure draft. The task force also thanks John Stenson for his assistance during the drafting of this standard.

The ASB voted in December 2001 to adopt this standard.

Task Force on Retiree Group Benefits

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ACTUARIAL STANDARD OF PRACTICE NO. 6

MEASURING RETIREE GROUP BENEFIT OBLIGATIONS

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries when measuring obligations under a retiree group benefits plan.

1.2 Scope—This standard applies to actuaries when measuring any type of retiree group benefit obligation. Included in the scope of this standard are measurements made for the following purposes:

a. financial reporting, such as measurements made for purposes of compliance with SFAS No. 106;

b. cash-flow analyses;

c. plan funding, including the determination of participant contributions when such contributions are based on expected retiree group benefit costs;

d. cost projections, including those made in conjunction with establishing or modifying the plan's design; and

e. determinations of actuarial present values.

This standard highlights health and death benefits because they are the most common forms of retiree group benefits. This standard can provide guidance in situations involving other types of benefits, but does not apply to measurements of pension obligations or social insurance programs.

Throughout this standard, any reference to selecting assumptions, selecting a cost allocation policy, or to modeling also includes giving advice on selecting assumptions, selecting a cost allocation policy, or modeling. For instance, the actuary may advise the plan sponsor on selecting assumptions for Statement of Financial Accounting Standards (SFAS) No. 106, but the plan sponsor is ultimately responsible for selecting these assumptions. This standard applies to the actuarial advice given in such situations, within the constraints imposed by the relevant accounting standards.

If applicable law, regulation, or accounting standards contain requirements for a measurement of retiree group benefit obligations that conflict with this standard, the

actuary should comply with the requirements of such applicable law, regulation, or accounting standards. Compliance with such applicable law, regulation, or accounting standards is not considered to be a deviation from this standard, provided the actuary discloses that the measurement was performed in compliance with applicable law, regulation, or accounting standards. Most of the current applicable laws, regulations, or accounting standards that may apply to specific measurements of retiree group benefit obligations are listed in appendix 2 under "Compliance with Other Requirements."

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard will be effective for measurements of retiree group benefit obligations with measurement dates on or after January 1, 2003 or, if roll-forward techniques are used, three years after the last full measurement before January 1, 2003.

Section 2. Definitions

The definitions below are defined for use in this actuarial standard of practice.

2.1 Actuarial Cost Method—A procedure for allocating the actuarial present value of future plan costs over time periods.

2.2 Adverse Selection—The actions of plan participants who are motivated directly or indirectly to take financial advantage of plan provisions, such as the choice of plan.

2.3 Contingent Participant—An individual who is not currently a participant but who may reasonably be expected to become a participant through his or her future action.

2.4 Contributions—A payment made by a participant to support a retiree group benefit plan. While plan sponsors and employers will contribute funds to subsidize retiree group benefits, in this standard *contributions* refer to periodic payments required from participants for their plan coverage.

2.5 Cost Allocation Policy—An actuarial cost method combined with defined procedures to account for plan assets (if any) and amortization of changes in plan obligations (such as those arising from plan changes, experience gains and losses, assumption changes, or changes in actuarial cost methods).

2.6 Covered Population—Active and retired participants, participating spouses and surviving spouses of participants who are eligible for benefit coverage under a retiree group benefit plan. The covered population may also include dependents and contingent participants.

2.7 Dedicated Assets—Assets designated by the plan sponsor for the exclusive purpose of satisfying the retiree group benefit obligations.

2.8 Dependents—Individuals, other than spouses, who are covered under a retiree group benefits plan by virtue of their relationship to a participating employee or retiree.

2.9 Measurement Date—The date as of which the retiree group benefit obligation is determined (sometimes referred to as the *valuation date*).

2.10 Measurement Period—The period subsequent to the measurement date during which the chosen assumptions or other model components apply.

2.11 Medicare-Eligible Participant—A participating individual who is entitled to Medicare benefits.

2.12 Medicare Integration—The approach to determining the portion of a Medicare-eligible claim that is paid by the plan, after adjustment for Medicare reimbursements for the same claim. Types of Medicare integration include the following:

a. Full Coordination of Benefits (Full COB)—The plan pays the difference between total eligible charges and the Medicare reimbursement amount, or the amount it would have paid in the absence of Medicare, if less.

b. Exclusion—The plan applies its normal reimbursement formula to the amount remaining after Medicare reimbursements have been deducted from total eligible charges.

c. Carve-Out—The plan applies its normal reimbursement formula to the total eligible charges, then subtracts the amount of Medicare reimbursement.

2.13 Normative Database—Data compiled from sources that are expected to be typical of the retiree group benefit plan, rather than from plan-specific experience. Examples of normative databases include published mortality and disability tables, proprietary premium rate manuals, and experience on similar retiree group benefit plans.

2.14 Participant—An individual who (a) is currently receiving benefit coverage under a retiree group benefit plan, or (b) is reasonably expected to receive benefit coverage under a retiree group benefit plan upon satisfying the plan's eligibility and participation requirements.

2.15 Retiree Group Benefits—Health, death, and other benefits (excluding retirement income benefits) that are provided during retirement to a group of individuals, on account of an employment relationship.

2.16 Spouse—A husband, wife, or domestic partner eligible for retiree group benefits.

2.17 Stop-Loss Coverage—Insurance protection providing reimbursement of all or a portion of claims in excess of a stated amount. Stop-loss coverage may be either individual or aggregate (sometimes referred to as *excess loss coverage*).

2.18 Survivor—A spouse or dependent who continues as a participant under the retiree group benefit plan following the death of a participating employee or retiree.

2.19 Trend—A measure of a rate of change, over time, of the per capita health care rates.

Section 3. Analysis of Issues and Recommended Practices

3.1 General Overview—When measuring retiree group benefit obligations, the actuary should do the following:

a. develop a model that represents the following:

1. known plan provisions as they currently exist and as they are anticipated in the measurement period (see section 3.2);

2. the population covered by the benefits in question, which should reflect the current population and the anticipated population in the measurement period (see section 3.3); and

3. current and projected benefit costs (see sections 3.4 and 3.5).

b. evaluate the quality and consistency of data used in construction of the model, and make appropriate adjustments (see section 3.6);

c. identify any significant administrative inconsistencies and make appropriate adjustments in the model or disclose the unresolved inconsistency (see section 3.7);

d. select projection assumptions in addition to the assumptions developed as part of step (a) above (see section 3.8);

e. measure the obligations and, when allocating costs to time periods, use an appropriate cost allocation policy (see section 3.9); and

f. review and test the results of the calculations (see sections 3.12 and 3.13).

Additionally, the standard contains guidance on using roll-forward techniques (see section 3.10), using prescribed assumptions, methods, or other model components (see section 3.11), and reliance on a collaborating actuary (see section 3.14).

Retiree health cost projections generally can be expected to vary within a large range of reasonableness. Notwithstanding the variability of reasonable results, the actuary should select each element of the model to sustain the integrity of the measurement.

3.2 Modeling Plan Provisions—In modeling the known provisions of the plan, the actuary should give appropriate consideration to the written plan documents, historical practices, administrative practices of the plan sponsor, governmental programs, communications to participants, and, depending on the purpose of the measurement, plan sponsor decisions and expected future benefit plan designs, as described in sections 3.2.1 and 3.2.2 below.

3.2.1 Components of the Modeled Plan—The actuary should incorporate the significant elements of the known plan provisions into the model. The major components of the modeled plan include, but are not limited to, covered benefits; benefit limitations, exclusions, and cost-sharing provisions; participant contributions; health care delivery system attributes; and optional benefits. In some cases, it may also be appropriate to consider future changes and limits on plan sponsor costs. These considerations are discussed in more detail below.

a. Covered Benefits—Covered benefits may include reimbursements for covered services, fixed-dollar payments for covered events (such as death benefits), and other monetary benefits (such as Medicare premiums or defined dollar benefits).

b. Benefit Limitations, Exclusions, and Cost-Sharing Provisions—Benefit limitations and exclusions (such as a lifetime maximum benefit in a medical plan) may affect plan payments, and such effects will change over time. The actuary should also consider participant cost-sharing provisions (such as deductibles, copayments, coinsurance, and out-of-pocket limits).

c. Participant Contributions—Many plans require contributions from participants as a condition for their continued eligibility for plan coverage. The actuary should reflect the participant contributions in the model, as discussed below. In addition, participant contributions may affect both participation rates and adverse selection, thus affecting per capita claim rates.

1. Contribution Formula—In modeling the plan, the actuary should reflect actual contribution levels. There is a wide variation in how plan sponsors determine participant contributions (examples include flat amounts, amounts based on credited service at retirement, amounts based on retiree claims costs, and amounts based on combined active and retiree costs).

2. Contribution Reasonableness—The actuary should compare for reasonableness the stated basis for participant contributions to what

has been implemented. See section 3.7, Administrative Inconsistencies, for further guidance.

3. Preretirement Active Employee Contributions—A plan may require preretirement contributions from active employees for them to earn eligibility for retiree group benefits. The actuary should consider how this may affect future benefit eligibility and plan sponsor costs.

4. Contributions as Defined by Limits on Plan Sponsor Costs—Some plans place an upper limit on the plan sponsor cost by designating a maximum average per capita amount to be paid in a year (these limits are commonly known as "caps"). Other plans limit total plan sponsor cost in any current or future period. The actuary should consider whether the limits will have a significant impact on the obligation. The actuary should consider how the plan sponsor is expected to implement these limits, when these limits are expected to be reached, their impact on participant contributions, and, thus, future participation, and, if appropriate, incorporate these limits into the modeled plan.

d. Health Care Delivery System Attributes—The actuary should consider that various health care delivery system attributes can affect costs differently. For example, certain delivery systems may "lock in" costs for an extended period of time because of their provider contracts.

e. Optional Benefits—The actuary should consider the effect of optional benefits. Optional benefits include coverage options (for example, choice of medical plans) and additional coverages (for example, contributory dental coverage). Optional benefits may require participant contributions, but also incur plan sponsor costs.

f. Anticipated Future Changes—After discussion with the plan sponsor, and depending upon the purpose of the measurement, the actuary may take into account future changes that the plan sponsor has represented an intention to implement or that are required by law to be implemented within a specified period. However, for some purposes, such as for compliance with SFAS No. 106, the actuary may consider only changes that have been communicated to plan participants or that result from the continuation of a historical pattern.

3.2.2 Historical Practices—When appropriate, the actuary should consider historical practices of the plan in developing the model. Historical practices include the following:

a. Claims Payment Practices—The actuary should consider whether there is significant inconsistency between the benefits provided and the plan sponsor's representation to the actuary of the terms of the plan. See section 3.7 for further guidance.

b. Cost-Sharing and Contribution Levels—The actuary should consider the plan sponsor's past pattern of cost-sharing and participant contributions.

c. Pattern of Plan Changes—The actuary should consider the plan sponsor's past practice or a pattern of regular changes in the retiree group benefit plan (such as benefits, cost-sharing, and participant contribution levels). Depending on the purpose of the measurement, the continuation of such past practices or patterns may warrant inclusion in the model.

d. Governmental Programs—For some purposes, to the extent that the plan integrates with Medicare and other governmental programs, the actuary should consider the historically enacted legislative and administrative policy changes in these programs.

3.2.3 Reviewing the Modeled Plan—For each measurement, the actuary should consider whether the model continues to reflect actual known plan provisions and practices. If the administration of the plan has significantly deviated from the plan as modeled, the actuary should consider whether this deviation is temporary or should be treated as a permanent plan change.

3.2.4 Measurement Results by Category—The actuary should consider whether the measurement results may need to be examined by category (for example, medical vs. dental, union vs. nonunion, retiree vs. spouse; plan paid vs. participant paid; payments before Medicare eligibility age vs. payments after Medicare eligibility age). This need may arise from either the nature of the assignment or from assessing the integrity of the measurement model.

3.3 Modeling the Covered Population—The projected size and demographic composition of the covered population has a significant impact on the measurement. The actuary should consider the need to model variations in the covered population (for example, when benefit eligibility varies by type of coverage). This standard does not require the use of open group measurements, although such measurements may be used when appropriate. These issues are discussed below.

3.3.1 Census Data—The actuary should collect sufficient census data in order to make a reasonable estimate of the obligation. In certain circumstances, grouped data may be appropriate; in others, individual census data are required. For example, to ascertain the optional benefits elected by the retiree, the actuary may need to collect individual census data, including retiree contribution amounts.

3.3.2 Employees Currently Not Accruing Benefits—Depending on the purpose of the measurement, the actuary should consider whether some or all of the employees currently not accruing service toward retiree group benefit eligibility may accrue service in the future and whether some or all of the employees currently not making required preretirement contributions may contribute in the future, and make appropriate allowance for them in the modeled population.

3.3.3 Contingent Participants—The actuary should examine the census data and take appropriate measures to reflect individuals who are not current participants, but may reasonably be expected to become participants through their future actions. For example, the actuary may need to make a reentry assumption in situations where retirees have opted out of coverage at the time of retirement, but may later reenter the plan.

3.3.4 Spouses and Survivors of Participants—The actuary should include in the modeled population participating spouses and survivors who are eligible for coverage. In doing so, the actuary should take into account that the plan's eligibility conditions and benefit levels for spouses and survivors may differ from the plan's eligibility conditions and benefit levels for retirees. Benefit coverage for the spouse of a retiree may continue subject to a contribution, continue for a limited period (for example, until Medicare eligibility or one year after the death of the retiree), or cease when the retiree dies. The actuary should generally model spouses separately from retirees because of differences in the timing of Medicare eligibility and in mortality between the retiree and spouse.

3.3.5 Dependents—The actuary should consider whether the dependent obligation is significant and, if so, model dependents appropriately. For example, for plans that have liberal early retirement eligibility conditions, dependent coverage can significantly increase the overall number of covered individuals and, therefore, have a significant effect on the size of the covered population.

3.3.6 Appropriateness of Pension Plan Data—Plan sponsors who do not maintain separate retiree group benefit plan databases may furnish pension plan data to represent the retiree group benefit plan covered population. In such cases, the actuary should make appropriate edits and adjustments. Examples of the types of edits and adjustments that may be required are discussed below.

a. Retirees Covered for Retiree Group Benefits but Not Receiving Pension Benefits—Employees may be participants in the retiree group benefits plan, but may no longer be participants in the pension plan (such as employees who received lump-sum pension payments). Spouses, dependents, and survivors of retirees may be eligible for retiree group benefits, but may not be in the pension plan census data.

b. Retirees Receiving Pension Benefits but Not Covered for Retiree Group Benefits—Employees may be participants in the pension plan, but may not

be covered for retiree group benefits (such as employees who terminated with vested pension benefits now in payment status). Employees may be eligible for pension benefits upon retirement or disability, but may not satisfy the eligibility conditions or may have waived coverage for retiree group benefits.

c. Provisions Affecting Certain Employees—The pension plan may be frozen for a certain group of employees or may exclude employees due to age or service eligibility requirements, which might not affect their eligibility for other retiree group benefits.

3.3.7 Use of Grouping—The actuary may use grouping techniques when, in the actuary's judgment, grouping is not expected to unreasonably affect the measurement results. One such technique is to group participants based on common demographic characteristics (for example, age and service), where the obligation for each participant in the group is expected to be similar for commonly grouped individuals.

Another technique is to group plans with similar expected costs and features. A plan sponsor with multiple plan designs (for example, through various collective bargaining agreements) may not require separate measurement for each individual plan. Under such circumstances, the actuary, after evaluating the eligibility conditions and range of benefits provided, may decide it is appropriate to combine plans that have similar expected costs and group the covered populations of those plans. The actuary should disclose such combining of plans and grouping of populations.

3.4 Modeling Initial Per Capita Health Care Rates—The actuary should develop assumed per capita health care rates to be the basis of the initial annual benefit costs for estimating the future health care obligations. The accuracy of the measurement model depends in large part on its ability to forecast annual claims costs for the plan. In the actuarial development of health care rates, plan experience is generally considered the best predictor of future claims experience, preferable to sole reliance on normative claims databases or other measures. Therefore, preferred methods involve development of annual per capita health care rates from the claim experience of the retiree group benefit plan. In the absence of credible retiree group benefit plan experience data, the actuary may use other methods (such as methods that use premium rates and normative claims databases) to develop the per capita rates.

The ratemaking process generally involves (a) quantifying aggregate claims costs; (b) quantifying a measure of exposure to risk, usually the count of participants who were eligible for the plan during the period the claims were incurred; and (c) applying other information such as normative databases and premium rates as appropriate.

Multiple initial per capita health care rates may be appropriate due to the modeling of known plan provisions (section 3.2) and covered population (section 3.3) as well as

claims experience (for example, different rates by gender, healthy vs. disabled, retirees vs. spouses or dependents).

The actuary should document the methods and procedures followed in developing the initial per capita health care rates, such that another actuary qualified in this practice area could assess the reasonableness of the initial per capita health care rates. The actuary should also document any significant actuarial judgments applied during the modeling process. ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*, provides relevant guidance to the actuary.

The sections that follow address aspects of ratemaking that are particularly important when projecting benefit costs for a long period. The actuary should consider the following elements, but is not required to include all these elements in the model.

3.4.1 Net Aggregate Claims Data—In most cases, the actuary's objective is the development of a net incurred claims rate. The actuary should, however, recognize the factors involved in distinguishing net claims from gross claims and incurred claims from paid claims, as discussed below.

a. Paid Claims—Aggregate claims data received by the actuary will usually be grouped by the dates of payment, not by the dates on which claims were incurred. The actuary should analyze the data for the likely difference between the level of paid claims for a period and the level of incurred claims for the same period. When the differences are significant, the actuary should make an adjustment, either to the historical paid claims or to the initial claims assumption, to account for the likely future level of claims activity. To the extent the difference may be due to the trend or the time value of money, the significance of the difference to the measurement of retiree group benefit obligations may be reduced, because the plan sponsor will usually have the use of the money between the time a claim is incurred and when it is paid.

b. Gross Claim Components—Aggregate claims data received by the actuary may show only net payments or may include cost-sharing components (such as deductibles and copayments), reimbursements, costs not covered, or other elements of gross claims. The actuary may determine the initial claims rate assumption from the net payments or the gross amounts.

3.4.2 Exposure Data—In developing an initial per capita health care rate, the actuary should obtain exposure data for the same time periods as the claims experience data that will be used. Since exposure data are historical in nature, the exposure data typically will be different from the census data used in modeling the future covered population. If the differences are significant, the actuary should review the data sets for consistency (see section 3.6).

It may be appropriate to segment the exposure data by age and gender or by retiree, spouse, or dependent. The actuary should obtain information to properly segment the population or employ reasonable assumptions as appropriate.

3.4.3 Use of Multiple Claims Experience Periods—The actuary should consider the use of multiple claims experience periods and adjust the experience of the various periods to comparable bases as described in sections 3.4.8, 3.4.10, and 3.4.11. When combining multiple experience periods, the actuary should consider the applicability of each period based upon elapsed time and changes required to adjust to comparable bases.

The actuary may consider smoothing the results to account for historical irregularities. The actuary may weight the experience periods as appropriate.

3.4.4 Credibility—There will be times when plan data are not available or wholly credible. In those instances, the actuary should make use of relevant normative databases or active plan experience on the same group, adjusted for age and expected differences in such items as utilization and plan design. The actuary may use these supplementary data and professional judgment to validate, adjust, or replace the plan experience data.

ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*, provides guidance to the actuary when assigning credibility to sets of experience data.

3.4.5 Use of Premium Rates—Although an analysis of the plan sponsor's actual claims experience is preferable, the actuary may use premium rates as the basis for initial per capita health care rates, with appropriate analysis and adjustment for the premium rate basis. The actuary who uses premium rates for this purpose should adjust them for changes in benefit levels, covered population, or program administration. The actuary should consider that the actual cost of health insurance varies by age (see section 3.4.7), but the premium rates paid by the plan sponsor may not. For example, 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.

If, in the actuary's professional judgment, the unadjusted premium rate significantly understates or overstates the expected claim cost for retirees, the actuary should disclose this possibility in any communication regarding a measurement using an unadjusted premium rate as an initial per capita health care rate.

If premium rates, adjusted or unadjusted, are used as the basis for initial per capita rates in the measurement, the actuary should make an appropriate disclosure and consider the factors described in other sections of 3.4.

3.4.6 Impact of Medicare and Other Offsets—Where Medicare as the primary payer has a significant impact on the per capita health care rates, the actuary should develop separate rates for Medicare-eligible participants. Such rates should reflect the plan's Medicare integration approach or how the plan supplements Medicare. The actuary should also adjust for other offsets, such as workers' compensation and auto insurance, if their impact is considered to be significant.

The actuary should consider whether there is a significant inconsistency between the Medicare integration approach being applied by the claims administrator and the plan sponsor's representation to the actuary of the terms of the plan. See section 3.7 for further guidance.

Medicare and other governmental programs are subject to continual legislative revisions. The actuary should be aware of significant changes and make adjustments as necessary to fit the purposes of the measurement.

3.4.7 Age-Specific Claims Rates—The actuary should consider the variation in rates by age for the benefits being modeled and use appropriate age bands if the rates vary significantly. The age bands should not be overly broad, based on the expected rate variations within the bands. If rates vary significantly by age, it is inappropriate to assume a single per capita rate that does not vary by age. The relationship between the rates at various ages is an actuarial assumption that may be based on normative databases.

3.4.8 Adjustment for Plan Design Changes—The actuary should adjust the claims rates to reflect significant differences, if any, between the benefit plan designs in effect for the experience period and those in effect during the initial year of the measurement period.

3.4.9 Adjustment for Administrative Practices—Changes in plan administrative practices affect how costs emerge. The actuary should make appropriate provisions in the model for changes in administrative matters such as the following:

a. Claims Adjudication—The actuary should consider how overall costs and utilization rates may be influenced by the method by which enrollees and providers submit claims (for example, provider electronic submission vs. enrollee paper submission of claims) and the manner in which claims are reviewed.

b. Enrollment Practices—The actuary should consider the effect enrollment practices (for example, the ability of participants to drop in and out of the plan) have had on participation and health care costs.

3.4.10 Adjustment for Large Individual Claims—The actuary should recognize the significance that large claims may have with respect to claims experience and make appropriate adjustments. The actuary should review the frequency and size of large claims when data are available and consider whether the prevalence of large claims is expected to be significantly different in the future. Future periods may have a higher or lower incidence of such claims than past experience periods under examination. The actuary should review both stop-loss coverage and other large claims, as described below.

a. Stop-Loss Coverage—The actuary should consider the financial impact of stop-loss insurance in all projections.

b. Other Large Claims—The actuary should also consider large claims that may be below the stop-loss coverage level.

3.4.11 Adjustment for Trend—When adjusting earlier claim period experience to the initial year of the measurement, the actuary should reflect the effect of past trend. An adjustment of the initial per capita health care rate to reflect recent past trends may include experience from outside the plan.

The actuary should consider using separate historical trend rates for major cost components (for example, hospital, physician, drug costs, and plan administration).

3.4.12 Adjustment When Plan Sponsor is Also a Provider—The retiree group benefits plan sponsor may also be a provider under the plan, as may happen in cases where the plan sponsor is a hospital, medical office, clinic, or other health care provider. In these situations, the plan sponsor pays itself, in effect, for services it provides its own members. Therefore, the actuary should analyze the charges incurred and reimbursements received by the plan sponsor-provider and make appropriate adjustments in the measurement model to properly reflect the underlying transactions.

3.4.13 Use of Other Modeling Techniques—Health care costs may be modeled and projected using techniques in addition to those mentioned above. When using an alternative approach, the actuary should disclose the method used and comment on its applicability. Examples of alternative approaches include models that project a distribution of expected claims with an associated probability distribution and models that assign different claims costs for the last year of life.

3.4.14 Administrative Expenses—In addition to the cost of claims, the plan sponsor is usually responsible for the cost of administering the retiree group benefit plan. The actuary should consider administrative expenses when performing the measurement. The actuary may model administrative expenses in various ways. For example, administrative expenses may be included in claims rates or expressed on a per capita basis, as a percentage of claims, or as fixed amounts.

3.5 Modeling the Cost of Death Benefits—Death benefits may be provided directly by the plan sponsor upon the death of a retiree or may be paid by an insurance company through a life insurance program. The life insurance program may be either participating or nonparticipating with respect to policy dividends. The modeled death benefit cost should appropriately reflect the financial arrangement through which the benefits are provided, including dividends, retiree contributions, carrier administrative expenses, and risk charges.

When selecting assumptions and measurement methods regarding death benefits, the actuary should consider that the actual cost of life insurance varies by age, but the insurance rates paid by the plan sponsor may not. The actuary should reflect appropriate costs by age in the projection model.

3.6 Model Consistency and Data Quality—Before proceeding with the measurement, the actuary should review the modeled plan provisions, covered population, per capita health care rates, and death benefit costs as a whole to evaluate their consistency. The actuary should evaluate the relevancy of any data received and the significance of all data used for actuarial purposes. ASOP No. 23, *Data Quality*, provides guidance on selecting and reviewing data and making appropriate disclosures regarding the data. Additional data quality requirements that are particularly applicable to the retiree group benefit area are mentioned below.

3.6.1 Coverage and Classification Data—The actuary should consider the importance of coverage distinctions (such as HMO vs. indemnity plans) and classification distinctions (such as hourly vs. salaried, or benefits that vary among different groups of retirees) that result in variations in the benefit availability among participants. The actuary should consider whether such differences are significant enough to require further refinement of the model. The actuary should document the coverage and classification distinctions incorporated in the model.

3.6.2 Consistency—If the actuary finds data elements that appear to be significantly inconsistent with known plan provisions, other data elements, or data used for prior measurements, the actuary should take appropriate steps to address such apparent inconsistencies before proceeding with the measurement, as discussed below. To the extent that significant inconsistencies cannot be reconciled, the actuary should disclose them.

a. Plan Operations—The actuary should determine whether eligibility and payment data received conflict significantly with information received about known plan provisions or administration. See section 3.7 for further guidance. Examples of inconsistencies include the following:

1. Average claims costs that are secondary to Medicare are very high in relation to average costs that are primary. This might reveal that the carve-out method of integration with Medicare may not have

been used, despite the sponsor's indication of that method, or that the classification of the covered spouse is based on the retiree's age.

2. Individual contribution amounts for participation before Medicare eligibility are so low as to make it unlikely that plan sponsor subsidies are as limited as the sponsor may indicate.

3. The ratio of spouses to retirees in total or for a subgroup (for instance, those who are not eligible for Medicare) is inconsistent with expectations. This might mean that it is unlikely surviving spouse coverage is as stated, that coding of spouse ages is inaccurate, or that survivors were coded as "retirees."

4. Known plan provisions include benefit maximums, but the actuary's analysis of claims data indicates a likelihood that claims are in excess of the maximum.

b. Medicare-Related Data—Data concerning Medicare eligibility and age may be inaccurately and inconsistently coded for both claims and covered population. The actuary should make and document any appropriate adjustments in this regard.

c. Demographic Distinctions—The actuary should consider demographic breakdowns (such as age, gender, geography, and hourly/salaried classifications), which may reveal results that are inconsistent with prior data or the actuary's prior expectations.

d. Data for Spouses, Survivors, and Dependents—The actuary should scrutinize coverage and classification information for spouses and survivors and, if significant, for dependents, with as much care as for employees and retirees due to the significant impact they may have on the results of the measurement.

3.6.3 Sources of Data—The actuary should consider the various types and sources of data available for the covered population, for the coverage and classification of participants, and for benefit costs, as discussed below.

a. Census Data—In most cases, the plan sponsor or administrator will supply the eligibility and demographic information about participants in the plan. A participant census used for underwriting or pension purposes may contain useful information about the covered population. The actuary should determine whether these sources represent plan participation with sufficient accuracy (see sections 3.3.6 and 3.4.2) and, if not, seek more accurate census information.

b. Claims Payment Data—Various sources of data are available for establishing per capita rates, including normative claims databases and experience data specific to the plan sponsor. The actuary should review plan experience relative to normative ranges of value, but also recognize the legitimacy of plan sponsor experience, to the extent it is credible, and the limitations of applying normative data to an unrelated situation. ASOP No. 25 provides guidance in the assignment of credibility values to data.

c. Data Quality at Each Level of Usage—Data that may be of appropriate quality for determination of certain assumptions within a model may not be of appropriate quality for determination of other assumptions. When data are combined or separated, the actuary should review the data for suitability to the purpose. For example, data from an individual employer may be sufficient for setting an aggregate per capita health care rate, but not be of sufficient size to set per capita health care rates by location.

3.6.4 Reliance on Data Supplied by Others—ASOP No. 23 provides guidance regarding the use, review, and disclosure of reliance on data supplied by others.

3.7 Administrative Inconsistencies—In the course of performing the measurement, the actuary may find that the plan is being administered in a manner that is inconsistent with the plan documents, stated plan sponsor policies, or participant communications. Inconsistencies most often arise with respect to participant contribution determination (see section 3.2.1(c)(2)), claims payment practices (see section 3.2.2(a)), Medicare integration (see section 3.4.6), and plan operations (see section 3.6.2(a)). When the actuary becomes aware of a significant inconsistency between administrative practice and plan documents, stated plan sponsor policies, or participant communications, the actuary should do the following:

a. discuss the inconsistency with the plan sponsor or administrator;

b. adjust the model appropriately, consistent with the purposes of the measurement (in making these adjustments, the actuary may rely on the plan sponsor's representations);

c. document the resulting steps taken by the actuary in developing the model; and

d. disclose any significant unresolved inconsistency.

3.8 Projection Assumptions—In selecting projection assumptions, the actuary should consider the following:

3.8.1 Economic Assumptions—With respect to any particular measurement, each economic assumption selected by the actuary should be consistent with every other economic assumption selected by the actuary to be used over the measurement period. The actuary should reflect the same general economic

inflation component in each of the economic assumptions selected by the actuary. The relationships among economic assumptions should be reasonable relative to the underlying economic conditions expected throughout the projection period.

The actuary should comply with the guidance contained in ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations*, when selecting the inflation assumption, discount rate, investment return assumption, and compensation scale (when needed for benefits such as life insurance) to be used in measuring retiree group benefit obligations. In applying ASOP No. 27, the actuary should take into account the purpose and nature of the measurement, and the differences between the characteristics of retiree group benefit obligations and the characteristics of pension benefit obligations. For example, the discount rate selected for measuring pension benefit obligations for purposes of SFAS No. 87 (*Employers' Accounting for Pensions*) may not be appropriate for measuring retiree group benefit obligations for the purposes of SFAS No. 106, because the payment patterns may be different.

Economic assumptions not covered by ASOP No. 27 that are typically required for measuring retiree group benefit obligations include the following:

a. Health Care Cost Trend Rate—The health care cost trend rate reflects the change in per capita health claims rates over time due to factors such as medical inflation, utilization, plan design, and technology improvements. The actuary should consider separate trend rates for major cost components such as hospital, prescription drugs, other medical services, Medicare integration, and administrative expenses. Even if the actuary develops one aggregate trend rate, the actuary should consider these cost components when developing the rate. The actuary should consider the following key components in setting the health care cost trend rate: inflation, medical inflation, definition of covered charges, frequency of services, leveraging caused by plan design features not explicitly modeled, and plan participation. The actuary should not consider aging of the covered population when selecting the trend assumption for projecting future costs.

b. Other Cost Change Rates—The actuary should consider other costs that may change in the future, such as the cost of life insurance and long-term care insurance.

c. Participant Contribution Changes—Depending on the modeled plan, the measurement may require an assumption for the rate of change in participant contributions. For some plans, this may be a function of health care trend rate or other economic assumptions. For some other plans, there may be no contributions currently but plan limits and assumed trend rates may make it likely that contributions will be required in future years. In those cases, and depending upon the purposes of the measurement, the

actuary should determine when contributions are expected to be required during the measurement period, and model subsequent increases accordingly.

d. Adverse Selection and Changing Participation—When a retiree group benefits plan requires a contribution as a condition of continued participation, those choosing to participate may have a higher average benefit cost than those not participating. When a retiree group benefits program requires a contribution or offers a choice of plans, it can be expected that, over time, the process of adverse selection will have an impact on plan costs.

The actuary should consider whether adverse selection will result from such items as decreasing participation. Because the impact of any adverse selection is very difficult to quantify over the long periods customary in a retiree group benefits measurement, this standard does not require the use of assumptions about adverse selection in measurement models. But if the measurement assumptions project a significant decrease in the proportion of eligible retirees who participate, the actuary should consider an upward adjustment for adverse selection in per capita health care rates, or, alternatively, moderate the assumed decrease in participants. The actuary should document any adjustments made for adverse selection.

3.8.2 Demographic Assumptions—With respect to any particular measurement, each demographic assumption the actuary selects should be consistent with the other demographic assumptions the actuary selects. For example, if the mortality assumption anticipates increasing life spans, the actuary should consider whether the retirement assumption should reflect the fact that individuals may choose to retire later because they are healthier or because they may not have sufficient accumulated savings to afford a lengthened retirement period.

The actuary should comply with ASOP No. 35, *Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations*, when selecting the retirement, termination, mortality, and disability assumptions to be used in measuring retiree group benefit obligations. In applying ASOP No. 35, the actuary should take into account the purpose and nature of the measurement and the differences between the characteristics of retiree group benefit obligations and the characteristics of pension benefit obligations. More refined demographic assumptions may be required to appropriately measure retiree group benefit obligations than are required to measure pension obligations. In determining whether demographic assumptions developed primarily for pension benefit measurements are appropriate for retiree group benefit measurements, the actuary should consider the following:

a. Assumptions Based on Pension-Liability-Weighted Experience—Pension plan termination and retirement rates may have been developed based on

pension-liability-weighted experience, which will reduce the effect of participants terminating or retiring with smaller pension benefits. The actuary should determine whether the pension plan termination and retirement assumptions are appropriate for retiree group benefit plans and, if not, modify the assumptions appropriately.

b. Disability—Assumptions regarding disability incidence, recovery, mortality, and eligibility for Social Security disability benefits should be consistent with the coverage provided to disabled participants under the plan. When the actuary considers disabled life coverage significant to the measurement, the actuary should select assumptions that appropriately reflect when benefits are payable to disabled participants, the definition of disability, and how the benefits are coordinated with other programs.

c. Retirement—The retirement assumption is critical in retiree health plan measurements because of the higher level of primary coverage a retiree receives prior to becoming eligible for Medicare. The actuary should select explicit age-related retirement rates. A single average retirement age is generally not appropriate.

d. Mortality—When the per capita health care rates are expected to increase during the projection period, the results of the measurement may be sensitive to the mortality assumption. Because of this sensitivity and the observation that life expectancies have increased significantly over the recent past, the actuary should consider reflecting future mortality improvements. Pension benefit measurements may use unisex mortality tables. Use of gender-specific mortality tables, however, may be more appropriate for retiree group benefit measurements, depending on the levels of retiree, spouse, and surviving spouse benefits as well as the demographic composition of the covered population.

3.8.3 Coverage Assumptions—In addition to covering eligible retirees, many plans also cover the spouse and dependents of retirees. Also, plans may offer some or all participants a choice of coverages such as HMOs, PPOs, and POS plans. The magnitude of the retiree group benefit obligation can vary significantly as a result of the coverage assumption. The actuary should therefore consider historical participation rates and trends in coverage rates when selecting the coverage assumptions.

a. Plan Participation—For plans that require some form of contribution to maintain coverage, some eligible individuals may not elect to be covered, particularly if they have other coverage available. Empirical data on plan participation, where available and credible, should be considered when selecting the participation assumption for future retirees. When developing the participation rates, the actuary should consider how plan eligibility rules, plan choices, or retiree contribution rates have changed over time.

Furthermore, plan participation may be different in the future due to participants' response to changes in retiree contribution levels and plan choices (for example, Medicare+Choice). For plans that anticipate changes in retiree contributions the actuary should consider the appropriateness of participation rates that vary over the projection period for both current and future retirees. The actuary should consider plan eligibility rules governing dropping coverage and subsequent reenrollment when selecting participation rates.

b. Spouse and Dependent Coverage—The actuary should consider who is eligible for coverage under the plan and make appropriate assumptions regarding the coverage of spouses and dependents. The actuary should also consider the impact of plan rules governing changes in coverage after retirement, such as remarriage, if significant. The actuary should review historical data on spouse and dependent coverage rates when selecting the assumption to be used in the projection. If the gender mix of future retirees and retired plan participants differs, the actuary should consider developing separate spouse coverage rates for males and females.

c. Spouse and Dependent Age—Wherever practical, the actuary should use actual data for the age of the spouse and dependents of retired participants. If actual data is not available for all retired participants the actuary should review the empirical data and develop an appropriate assumption for the spouse age difference and dependents' ages. The spouse and dependents of an active employee today may not be the same spouse and dependents covered at retirement, therefore the actuary should generally select an assumed spouse age difference for purposes of projecting future spouse coverage and assumed dependents' ages for projecting dependent coverage.

3.8.4 Effect of Plan Changes on Assumptions—When selecting projection assumptions, the actuary should consider the impact of relevant plan design changes during the measurement period. Whenever a plan design change is being modeled, the actuary should consider whether or not assumptions, which in combination are appropriate for measuring overall plan costs, are also appropriate for valuing the element under study. For example, if a plan sponsor adds or advises the actuary of its intent to add HMO coverage for a portion of its retiree group, the actuary should consider how that affects the cost of current coverage, future cost trends, and participation (including changes in coverage between plans).

Assumptions selected for purposes of estimating short-term cost increases or decreases arising from a plan change may not be appropriate for developing the long-term cost implications. For example, a change to the contribution level may change participation in the plan, which may, in turn, have an impact on per capita health care rates due to adverse selection after the change. A change in benefits or cost-sharing may have a similar impact for a plan requiring participant

contributions. The actuary should exercise professional judgment about the impact on long-term assumptions, but this standard does not require explicit assumptions about changing participation rates or adverse selection.

Many plan sponsors have reserved the right to unilaterally change or terminate their retiree welfare plans. When appropriate for the purpose of the measurement, the actuary may include assumptions in the measurement model that attempt to quantify the probability that the current plan will change significantly in the future, beyond the changes already included in the modeled plan. For example, the actuary might assume a probability of plan termination or assume a discount rate with an additional risk premium that implicitly reflects the participants' financial risk in receiving benefit coverage that is not guaranteed. The actuary should disclose that such an assumption has been used. Such assumptions are not appropriate for all measurement purposes. For example, SFAS No. 106 requires that the actuary assume that the substantive plan will continue indefinitely.

3.8.5 Assumptions Considered Individually and in Relation to Other Assumptions—The actuary should consider the reasonableness of each actuarial assumption independently on the basis of its own merits and its consistency with the other assumptions selected by the actuary. When selecting assumptions, the actuary should consider the degree of uncertainty, the potential for fluctuation, and the consequences of such fluctuation.

3.8.6 Reviewing Assumptions—The actuary is not required to do a complete assumption study at each measurement date. However, at each measurement date the actuary should consider whether the selected assumptions continue to be reasonable. If the actuary determines that one or more of the previously selected assumptions are no longer reasonable, the actuary should select reasonable new assumptions in accordance with this section.

3.8.7 Changes in Assumptions—Whenever a change in an assumption is considered, the actuary should review other assumptions to assess whether they remain consistent with the changed assumption. For example, if the actuary is anticipating more disabled participants due to recent experience, consideration should be given to the impact on plan costs of the health risk of this group.

3.9 Selecting a Cost Allocation Policy—When the measurement involves the allocation of an obligation to different time periods (including measurements that take into account plan assets, plan amendments, or actuarial gains and losses), the actuary should select a cost allocation policy, based on the following considerations:

3.9.1 Criteria for Acceptable Actuarial Cost Methods—The actuary should select an actuarial cost method that meets the following requirements:

a. Limits on Allocation Period—The period over which the allocation is made for an active participant should begin no earlier than the date of

employment and should not extend beyond the last assumed retirement age. This period may be determined for each participant individually or for the active participant group as a whole.

b. Reasonableness of Allocation Basis—The allocation basis should be reasonable and produce an orderly allocation of the actuarial present value of future plan benefit costs.

3.9.2 Dedicated Assets—In measuring the unfunded obligation and allocating costs to time periods, the actuary should take into account dedicated plan assets, if any.

a. The actuary should collect data regarding the amounts and types of dedicated assets held.

b. In general, the actuary should value the dedicated assets using a method that takes into account market value, unless constrained to use an asset valuation method prescribed by law or regulation. Asset valuation methods include market value; market-related methods that smooth out the effects of short-term volatility in market value; and methods that discount the future cash flow of the underlying investments. The use of book or cost value may be prescribed for some specific purposes (for example, in determining tax on trust income under Section 512 of the Internal Revenue Code).

c. The actuary should obtain sufficient details regarding insurance polices held as dedicated assets to determine an appropriate value, reflecting the nature of the contractual obligations upon early termination of the policies, as well as the costs of continued maintenance of the policies. If the cash surrender value of the policies is not readily determinable, the actuary should rely on his or her professional judgment to develop an appropriate value, depending on the purpose of the measurement.

3.9.3 Amortization Methods—Unless already reflected in the actuarial cost method, the actuary should select a reasonable and systematic amortization method to recognize changes in plan obligations arising from plan amendments (including plan initiation), actuarial gains and losses, changes in assumptions, or changes in the actuarial cost method.

3.9.4 Cash Flow Adequacy—Absent regulatory or legal restrictions, where a cost allocation policy is used to determine funding requirements, the actuary should select a policy that accumulates assets such that, absent experience losses, adequate funds are on hand to pay benefits included in the measurement when due.

Notwithstanding the above criteria, the actuary may be required to use a prescribed cost allocation policy for a particular purpose (for example, for financial reporting purposes under SFAS No. 106 the actuary is required to use the Projected Unit Credit Cost Method

and a defined approach to recognize changes in obligation arising from plan amendments and actuarial gains or losses (see section 3.11)).

3.10 Use of Roll-Forward Techniques—The actuary may determine that it is appropriate to use prior measurement results, using a roll-forward technique, rather than conduct a new measurement.

3.10.1 Full and Partial Roll-Forward—Roll-forward techniques include full roll-forwards of both claims and census data, as well as partial roll-forward techniques. For example, the actuary may use partial roll-forward techniques that use health care claim rates developed for the prior measurement trended forward to the current measurement date coupled with updated census data.

3.10.2 Limitation—The actuary may use roll-forward techniques to reduce the frequency of full measurements. In general, the actuary should not rely on prior measurement results if the measurement date is three or more years earlier than the current measurement date. For example, a January 1, 2000 measurement could be used to develop roll-forward results as of January 1, 2001 and 2002, but should not be relied upon for measurements or cost allocations after December 31 , 2002.

3.10.3 Appropriateness—Generally, the actuary should not use full roll-forward techniques when the population, plan design, or other key model component has changed significantly since the last full measurement.

3.10.4 Disclosure—Whenever the actuary uses a roll-forward technique, the actuary should disclose such use in the actuarial communication.

3.11 Prescribed Assumptions, Cost Allocation Policies, or Other Model Components—When the actuary uses assumptions, cost allocation policies, or other model components prescribed by the plan sponsor or other binding authority, the actuary's communication should state the source of the prescribed elements. Examples are the initial per capita health care rates prescribed by the plan sponsor and the discount rate basis and cost allocation policy prescribed by SFAS No. 106.

3.12 Reasonableness of Results—The actuary should review the measurement results for reasonableness. For example, the actuary could compare the overall measurement results to benchmarks such as measurement of similar plans, or could review the results for sample participants for reasonableness.

3.12.1 Modeled Cash Flows Compared to Recent Experience—The actuary should compare the expected claims produced by the model for the first year from the measurement date to actual claims over a recent period of years. If the expected and actual claims are significantly different, the actuary should consider the likely causes of such differences (for example, cost trends, large claims, a change in the demographics of the group, or the volatility of experience in small plans), and consider the impact of those differences on the reasonableness of the measurement results.

3.12.2 Results Compared to Last Measurement—The actuary should compare the overall results to the last measurement's results when available and applicable. If the results are significantly different from results the actuary expected based on the last measurement, the actuary should consider the likely causes of such differences. If another actuary performed the prior measurement, some allowance may be made for differences due to different actuarial techniques or modeling. The actuary should, if practicable, review the prior actuary's documentation and, if necessary, seek further information.

3.13 Sensitivity of Results to Chosen Assumptions—There can be a broad range of reasonable results when measuring the present value of retiree health benefit obligations because projected benefit payments are often uncertain and based on assumptions about future claims. The combination of different present value factors applied to projected future benefit payments produces wide variations in present values. For example, if a 1% change in the discount rate produces a 20% change in the present value, and a 20% change in initial per capita health care rates produces a 20% change in present value, then changing both assumptions could produce a 44% change in the present value, or a 4% change.

In light of the sensitivity of the results to key assumptions, the actuary should consider the purpose of the measurement and use professional judgment when advising the plan sponsor and presenting present values. In some instances the actuary may develop alternative results using a range of reasonable assumptions.

3.14 Reliance on a Collaborating Actuary—The various elements of a retiree group benefit measurement require expertise in the two different actuarial fields of health data analysis and long-term projections. In recognition of the complexities involved, two or more actuaries with complementary qualifications in the health and pension practice areas may collaborate on a project. While each actuary may concentrate on his or her area of expertise during the project, the actuary (or actuaries) issuing the actuarial opinion must take professional responsibility for the overall appropriateness of the analysis, assumptions, and results.

Section 4. Communications and Disclosures

4.1 Documentation—The actuary should maintain appropriate documentation regarding the analysis of the known plan provisions, covered population, and claims and expenses, as well as documenting the measurement model and the use of the model output. Documentation should demonstrate how the actuary has met the requirements of sections 3.2–3.14 above. The methodology and assumptions used in the measurement should be documented and, in some cases, made available for disclosure. In particular, ASOP No. 31 provides guidance on documenting the work of section 3.4 and 3.6–3.8 as applied to ratemaking.

4.2 Disclosure—The actuary's communication of the results of the measurement should identify the data, assumptions, and methods used in the measurement with sufficient clarity that another actuary qualified in this practice area could make an objective appraisal of the reasonableness of the actuary's work. In particular, this standard calls for disclosure of the following:

a. information about known significant plan provisions, including anticipated future changes (section 3.2.1(f)), any combining of plans (section 3.3.7) for measurement purposes, and a description of any known significant plan provisions not reflected in the model;

b. significant information about the covered population;

c. the initial per capita health care rate assumptions (including the use of normative data or premium rates), assumed future trends, and all other significant projection assumptions;

d. significant modeling techniques and methods, such as those mentioned in sections 3.4.12, 3.4.13, 3.8.4, and 3.10;

e. identification, including the source, of any assumptions, methods, or other model components prescribed by the plan sponsor or other binding authority;

f. significant and unresolved inconsistencies in data or administration, such as those mentioned in sections 3.6 and 3.7; and

g. information significant to interpreting measurement results.

To the extent the disclosures identified above have been described in a previous actuarial communication available to the intended audience, such disclosures, if appropriate for the circumstances, may be incorporated by reference.

4.3 Prescribed Statement of Actuarial Opinion—This ASOP does not require a prescribed statement of actuarial opinion (PSAO) as described in the *Qualification Standards for Prescribed Statements of Actuarial Opinion* promulgated by the American Academy of Actuaries. However, law, regulation, or accounting requirements may also apply to an actuarial communication prepared under this standard, and as a result, such actuarial communication may be a PSAO.

4.4 Deviation from Standard—An actuary must be prepared to justify the use of any procedures that depart materially from those set forth in this standard and must include, in any actuarial communication disclosing the results of the procedures, an appropriate statement with respect to the nature, rationale, and effect of such departures.

Note: The following appendixes are provided for informational purposes, but are not part of the standard of practice.

Appendix 1

Background and Current Practices

Background

Actuarial Standard of Practice (ASOP) No. 6, originally titled *Measuring and Allocating Actuarial Present Values of Retiree Health Care and Death Benefits*, was adopted by the ASB in October 1988. Because measuring retiree health and death benefits was a new and emerging field and because it would become a new practice area for many actuaries, this standard was needed to provide guidelines regarding what was acceptable actuarial practice. The original ASOP No. 6, however, purposely provided a high degree of flexibility to allow for emerging understanding in this developing practice area.

In December 1990, the Financial Accounting Standards Board issued Statement of Financial Accounting Standards (SFAS) No. 106, *Employers' Accounting for Postretirement Benefits Other Than Pensions*. SFAS No. 106 generally requires plan sponsors to recognize the cost of providing retiree group benefits over an employee's service period. Before the implementation of SFAS No. 106, most plan sponsors accounted for retiree group benefits on a pay-as-you-go basis. Therefore, at the time SFAS No. 106 was implemented, few actuaries had any experience measuring retiree group benefit obligations and practices for performing such measurements were not consistent.

Actuarial Compliance Guideline No. 3, *For Statement of Financial Accounting Standards No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions,* was adopted in October 1992. ACG No. 3 was written with a great level of detail and with a high level of educational content for the same reasons as ASOP No. 6.

Since the adoption of ASOP No. 6, ACG No. 3, and SFAS No. 106, both the design of retiree group benefits and the actuarial practices for measuring retiree group benefit obligations have evolved. Faced with the recognition of large unfunded liabilities for retiree health care benefits, many plan sponsors have taken steps to reduce their retiree group benefit obligations. Often, this has meant introducing or increasing participant contributions (including placing fixed dollar limits on the average plan sponsor obligation per person, with the balance to be paid by participant contributions). Participant contributions have not always been implemented consistent with the plan sponsor's objectives. For example, participant contributions may, in practice, have been set based on combined active and retiree claims, resulting in "hidden" plan sponsor subsidies (see "Participant Contributions" in appendix 2 for more detail).

Other types of plan design changes intended to reduce plan sponsor obligations include restricting eligibility for plan benefits (including requiring preretirement contributions), reducing

annual or lifetime benefit limits, and changing the way the plan integrates with Medicare. But here again, actual plan operation may not be fully consistent with the plan sponsor's intent. For example, the claims payer may not have the data or systems necessary to implement lifetime limits on plan benefits.

The actuary may be in the best position to identify such discrepancies between the plan sponsor's stated intent and actual plan operation. Often the plan sponsor has divided internal responsibility for administration of the retiree group benefit plan between different departments. The actuary may be the only person to have seen data elements and plan provisions as a whole. Plan sponsor policy may not have considered subsequent changes in future eligibility, cost levels, medical practice, health care delivery systems, or other plan elements that have a significant effect on financial obligations. Written provisions regarding aspects of dependent coverage, contribution levels required from participants, and integration with Medicare may be absent. As a result, data that the actuary receives may conflict significantly with information received about known plan provisions or administration.

Current Practices

Actuarial practices for measuring retiree group benefit obligations have evolved since SFAS No. 106 was implemented. As noted above, actuaries have recognized the importance of evaluating information about plan operations (including actual participant contribution levels, participation rates, and retiree claims data) as well as plan documents and plan sponsor policies to resolve any inconsistencies. As a result of the trend toward greater retiree cost-sharing, the modeling of participant contributions has become increasingly important. This includes appropriately reflecting the effect of increased participant contributions on plan participation and per capita health claims rates of those electing to participate.

Measuring retiree group benefit obligations generally requires expertise in both the development and projection of health care claims rates and the long-term projection of the covered population. Therefore, it is common for two actuaries with complementary qualifications (such as a pension actuary and a health care actuary) to collaborate on a measurement. In some cases, it may not be clear which actuary has taken professional responsibility for the overall appropriateness of the analysis, assumptions, and results.

The models used to value retiree health care benefit obligations have become increasingly sophisticated. Models commonly use age-specific initial per capita health care rates within the retired population (for example in individual age brackets). Some of these models are based on net incurred claims, while other models are based on gross expenses incurred reduced by amounts paid outside the plan or not covered by the plan. Some models project a distribution of expected claims with an associated probability distribution, while other models use separate age-specific per capita claim rates for the last year of life and for survivors.

Despite the development of these more sophisticated approaches, some actuaries continue to use highly simplified models. Examples include using pension census data as the basis for the measurement, using only two initial per capita health care rates (for Medicare eligible

participants and for participants who are not yet eligible for Medicare), and developing initial per capita health care rates based solely on premiums or normative databases. Such simplified approaches may result in significantly understated or overstated retiree group benefit obligations for the following reasons:

1. Retiree group benefit eligibility requirements are often different from pension benefit eligibility requirements, so pension census data may not appropriately reflect retiree group benefit plan participation;

2. Significant discrepancies between the plan sponsor's stated policy and actual plan operation may not be identified and "hidden" subsidies may not be valued;

3. Normative databases may be applied inappropriately, or may be outdated;

4. The effects of aging of the retired population on future per capita claim rates may not be appropriately taken into account; or

5. The impact of expected future participant contribution increases on future participation and projected per capita claim rates of participants may not be appropriately reflected.

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.