



ACTUARIAL STANDARDS BOARD

**Actuarial Standard
of Practice
No. 6**

Revised Edition

**Measuring Retiree Group Benefits Obligations and Determining
Retiree Group Benefits Program Periodic Costs or Actuarially
Determined Contributions**

**Developed by the
Retiree Group Benefits Subcommittee of the
Actuarial Standards Board**

**Adopted by the
Actuarial Standards Board
May 2014**

Doc. No. 177

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TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions

FROM: Actuarial Standards Board (ASB)

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

This document contains the final version of a revision of ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions*.

Background

The ASB provides coordinated guidance for measuring pension and retiree group benefit obligations through the series of ASOPs listed below.

1. ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*;
2. ASOP No. 6, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions*;
3. ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations*;
4. ASOP No. 35, *Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations*; and
5. ASOP No. 44, *Selection and Use of Asset Valuation Methods for Pension Valuations*.

Although the titles of ASOP Nos. 27, 35, and 44 reference Pension Obligations or Valuations, they are also applicable to Retiree Group Benefits Obligations or Valuations. Additional guidance is also provided in other standards, including ASOP No. 5, *Incurred Health and Disability Claims*, and ASOP No. 25, *Credibility Procedures*.

First Exposure Draft

The first exposure draft of this ASOP was issued in April 2012 with a comment deadline of July 15, 2012. Eighteen comment letters were received and considered in developing modifications that were reflected in the second exposure draft.

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Second Exposure Draft

The second exposure draft of this ASOP was issued in March 2013 with a comment deadline of August 30, 2013. The Retiree Group Benefits Subcommittee carefully considered the thirteen comment letters received. Key changes made to the final standard in response to comment letters received on the second exposure draft include the following:

1. Additional guidance was provided on retiree group benefits programs participating in pooled health plans, including situations when it may be appropriate to use the pooled health plan's premium without regard to adjustments for age.
2. Language in sections 4.1(s) and 4.1(t) was clarified to state that related disclosures are not required for funded status measurements performed in accordance with or prescribed by federal law or regulation.
3. Section 4.4 regarding confidential information was added to remove potential confusion regarding the interrelationship of this standard and Precept 9 of the *Code of Professional Conduct*.

In addition, a number of other changes were made to the text. Please see appendix 2 for a detailed discussion of the comments received and the reviewers' responses.

Key Changes from Current Standard

Key changes from the version of ASOP No. 6 adopted December 2001 (and updated May 2011 for standard deviation language) include the following:

Disclosure of Funded Status

Sections 4.1(s) and 4.1(t) contain new disclosure requirements related to a retiree group benefits program's funded status if the program's funded status is disclosed.

Disclosure of Information, Analysis, and Rationale for Changes in Assumptions and Methods

Sections 4.1(i) and 4.1(x) contain new disclosure requirements for changes in the assumptions and methods.

Disclosure of Rationale for Changes in Cost or Contribution Allocation Procedure

Section 4.1(y) contains new disclosure requirements for a change in the cost or contribution allocation procedure.

Assessment of Contribution Allocation Procedure or Funding Policy

Sections 4.1(o) and 4.1(p) contain new disclosure requirements related to the implications of the contribution allocation procedure or plan sponsor's funding policy on future expected plan contributions, funded status, and ability to make benefit payments when due.

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Prescribed Assumptions or Methods

The standard has been revised to address prescribed assumptions or methods set by another party or set by law (sections 2.33 and 2.34).

Pooled Health Plans (including Community Rated Plans)

Additional guidance is provided concerning retiree group benefits programs that participate in a pooled health plan.

Trend Rates

Additional guidance is provided concerning the setting of trend rates, particularly regarding the factors an actuary should consider in setting the ultimate trend rate and the select period.

Acceptance, Lapse, and Re-Enrollment Rates

More guidance is provided on the selection of acceptance, lapse, and re-enrollment rates.

Guidance on Medicare Benefits

Actuaries providing services in this area need to determine which participants are covered by Medicare and which are not. In addition, Medicare now provides prescription drug subsidies to some retiree plans. The standard was revised to provide guidance in both areas.

Dedicated Assets

The language regarding dedicated assets has been modified to clarify that, when legal or accounting requirements don't conflict, dedicated assets may include assets such as earmarked book reserves or Rabbi Trusts that are not part of an irrevocable trust.

Coordination with ASOP No. 4

The standard has been revised so that consistent guidance is provided in ASOP Nos. 4 and 6 in areas that are common to both pension and retiree group benefits.

ASOP No. 6 is intended to accommodate the concepts of financial economics as well as traditional actuarial practice.

The ASB thanks everyone who took the time to contribute comments and suggestions on the exposure drafts.

The Pension Committee thanks former committee member Gordon C. Enderle for his assistance with drafting this ASOP.

The ASB voted in May 2014 to adopt this standard.

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The ASB establishes and improves standards of actuarial practice. These ASOPs identify what the actuary should consider, document, and disclose when performing an actuarial assignment. The ASB's goal is to set standards for appropriate practice for the U.S.

ACTUARIAL STANDARD OF PRACTICE NO. 6

MEASURING RETIREE GROUP BENEFITS OBLIGATIONS AND DETERMINING
RETIREE GROUP BENEFITS PROGRAM COSTS OR ACTUARIALLY
DETERMINED CONTRIBUTIONS

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 performing actuarial services with respect to measuring obligations under a **retiree group benefits program** and determining **periodic costs** or **actuarially determined contributions** for such **retiree group benefits programs**. This standard provides guidance on assumptions that are specific to **retiree group benefits programs**. In addition, it addresses broader measurement issues, **cost allocation procedures**, and **contribution allocation procedures**. This standard provides guidance for coordinating and integrating all of the elements of an **actuarial valuation** of a **retiree group benefits program**.
- 1.2 Scope—This standard applies to actuaries when performing actuarial services with respect to the following tasks in connection with a **retiree group benefits program**:
- a. measurement of obligations. Examples include determinations of **funded status**, assessments of solvency upon **retiree group benefits program** termination, market measurements, and measurements for use in pricing benefit provisions;
 - b. assignment of the value of **retiree group benefits program** obligations to time periods. Examples include **actuarially determined contributions**, **periodic costs**, and **actuarially determined contribution** or **periodic cost** estimates for potential **retiree group benefits program** changes;
 - c. development of a **cost allocation procedure** used to determine **periodic costs** for a **retiree group benefits program**;
 - d. development of a **contribution allocation procedure** used to determine **actuarially determined contributions** for a **retiree group benefits program**;
 - e. determination as to the types and levels of benefits supportable by specified **periodic cost** or **actuarially determined contribution** levels; and
 - f. projection of **retiree group benefits** obligations, **retiree group benefits program periodic costs** or **actuarially determined contributions**, and other

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related measurements. Examples include cash flow projections and projections of a **retiree group benefits program's funded status**.

Throughout this standard, any reference to selecting actuarial assumptions, **actuarial cost methods**, asset valuation methods, and **amortization methods** also includes giving advice on selecting actuarial assumptions, **actuarial cost methods**, asset valuation methods, and **amortization methods**. In addition, any reference to developing or modifying a **cost allocation procedure** or **contribution allocation procedure** includes giving advice on developing or modifying a **cost allocation procedure** or **contribution allocation procedure**.

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

This standard does not require the actuary to evaluate the ability of the **plan sponsor** or other contributing entity to make **actuarially determined contributions** for the **retiree group benefits program** when due.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority), or for any other reason the actuary deems appropriate, the actuary should refer to section 4.

- 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 any actuarial work product with a **measurement date** on or after March 31, 2015; however, if roll-forward techniques are used in the measurement, the standard is not effective until three years after the last full measurement before March 31, 2015. Earlier adoption of this standard is permitted.

Section 2. Definitions

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

- 2.1 Actuarial Accrued Liability—The portion of the **actuarial present value of projected benefits** (and **expenses**, if applicable), as determined under a particular **actuarial cost method**, that is not provided for by future **normal costs**. Under certain **actuarial cost methods**, the **actuarial accrued liability** is dependent upon the actuarial value of assets.

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- 2.2 Actuarial Cost Method—A procedure for allocating the **actuarial present value of projected benefits** (and **expenses**, if applicable) to time periods, usually in the form of a **normal cost** and an **actuarial accrued liability**. For purposes of this standard, a pay-as-you-go method is not considered to be an **actuarial cost method**.
- 2.3 Actuarially Determined Contribution—A potential payment, other than by a retired **participant**, to prefund the **retiree group benefits program**, as determined by the actuary using a **contribution allocation procedure**. It may or may not be the amount actually paid by the **plan sponsor** or other contributing entity. This does not include the development of **premiums** or budget rates.
- 2.4 Actuarial Present Value—The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of actuarial assumptions with regard to future events, observations of market or other valuation data, or a combination of assumptions and observations.
- 2.5 Actuarial Present Value of Projected Benefits—The **actuarial present value** of benefits that are expected to be paid in the future, taking into account the effect of such items as future service, advancement in age, and expected future per capita health care costs (sometimes referred to as the “present value of future benefits”).
- 2.6 Actuarial Valuation—The measurement of relevant **retiree group benefits** obligations and, when applicable, the determination of **periodic costs** or **actuarially determined contributions**.
- 2.7 Adverse Selection—Actions taken by one party using risk characteristics or other information known to or suspected by that party that cause a financial disadvantage to the **retiree group benefits program** (sometimes referred to as antiselection).
- 2.8 Amortization Method—A method under a **contribution allocation procedure** or **cost allocation procedure** for determining the amount, timing, and pattern of recognition of the unfunded **actuarial accrued liability**.
- 2.9 Benefit Options—Choices that a **benefit plan member** may make under a **benefit plan** including basic coverages (for example, choice of medical plans) and additional coverages (for example, contributory dental coverage).
- 2.10 Benefit Plan—An arrangement providing medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) to **participants** of the **retiree group benefits program**, whether on a reimbursement, indemnity, or service benefit basis.
- 2.11 Benefit Plan Member—An individual covered by a **benefit plan**.
- 2.12 Contribution Allocation Procedure—A procedure that uses an **actuarial cost method**, and may include an asset valuation method, an **amortization method**, and an **output**

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- smoothing method**, to determine the **actuarially determined contribution** for prefunding a **retiree group benefits program**. It may produce a single value, such as **normal cost** plus an amortization payment of the unfunded **actuarial accrued liability**, or a range of values. This term does not relate to the process of determining the **participant contribution**.
- 2.13 Cost Allocation Procedure—A procedure that uses an **actuarial cost method**, and may include an asset valuation method and an **amortization method**, to determine the **periodic cost** for a **retiree group benefits program** (for example, the procedure to determine the net periodic postretirement benefit cost under some accounting standards).
- 2.14 Covered Population—Active and retired **participants**, participating **dependents**, and **surviving dependents** of **participants** who are eligible for benefit coverage under a **retiree group benefits program**. The **covered population** may also include contingent **participants**.
- 2.15 Dedicated Assets—Assets designated for the exclusive purpose of satisfying the **retiree group benefits program** obligations. Examples include the following:
- a. life insurance policies held by the **plan sponsor** to cover some of the **plan sponsor's** retired **participant** death benefits;
 - b. welfare benefit trusts (for example, voluntary employees' beneficiary associations);
 - c. Internal Revenue Code section 401(h) accounts in a qualified pension plan; and
 - d. Internal Revenue Code section 115 trusts sponsored by governmental entities for **retiree group benefits**.
- 2.16 Dependents—Individuals who are covered or may become covered under a **retiree group benefits program** by virtue of their relationship to an active or retired **participant**.
- 2.17 Expenses—Administrative or investment expenses borne or expected to be borne by the **benefit plan** or **retiree group benefits program**.
- 2.18 Funded Status—Any comparison of a particular measure of plan assets to a particular measure of plan liabilities.
- 2.19 Immediate Gain Actuarial Cost Method—An **actuarial cost method** under which actuarial gains and losses are included as part of the unfunded **actuarial accrued liability** of the **retiree group benefits program**, rather than as part of the **normal cost** of the **retiree group benefits program**.
- 2.20 Market-Consistent Present Value—An **actuarial present value** that is estimated to be consistent with the price at which benefits that are expected to be paid in the future would

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trade in an open market between a knowledgeable seller and a knowledgeable buyer. The existence of a deep and liquid market for **retiree group benefits program** cash flows or for entire **retiree group benefits programs** is not a prerequisite for this present value measurement.

- 2.21 Measurement Date—The date as of which the values of the **retiree group benefits** obligation and, if applicable, the assets are determined (sometimes referred to as the “valuation date”).
- 2.22 Measurement Period—The period subsequent to the **measurement date** during which the chosen assumptions or other model components will apply. The period often ends at the time the last **participant** is expected to receive the final benefit.
- 2.23 Medicare Integration—The approach to determining the portion of a Medicare-eligible claim that is paid by the **benefit 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 health 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 health plan applies its normal reimbursement formula to the amount remaining after Medicare reimbursements have been deducted from total eligible charges.
 - c. Carve-Out—The health plan applies its normal reimbursement formula to the total eligible charges, and then subtracts the amount of Medicare reimbursement.
- 2.24 Normal Cost—The portion of the **actuarial present value of projected benefits** (and **expenses**, if applicable) that is allocated to a period, typically twelve months, under the **actuarial cost method**. Under certain **actuarial cost methods**, the **normal cost** is dependent upon the actuarial value of assets.
- 2.25 Normative Database—Data compiled from sources that are expected to be typical of the **retiree group benefits program**, rather than from plan-specific experience. Examples of **normative databases** include published mortality and disability tables, proprietary **premium** manuals, and experience on similar **retiree group benefits programs**.
- 2.26 Output Smoothing Method—A method used by the actuary to adjust the results of a **contribution allocation procedure** to reduce volatility.
- 2.27 Participant—An individual who (a) is currently receiving benefit coverage under a **retiree group benefits program**, (b) is reasonably expected to receive benefit coverage under a **retiree group benefits program** upon satisfying its eligibility and participation requirements, or (c) is a **dependent** of an individual described in (a) or (b).

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- 2.28 Participant Contributions—Payments made by a **participant** to a **retiree group benefits program**.
- 2.29 Periodic Cost—The amount assigned to a period using a **cost allocation procedure** for purposes other than funding. This may be a function of plan obligations, **normal cost, expenses**, and assets. In many situations, **periodic cost** is determined for accounting purposes.
- 2.30 Plan Sponsor—An organization that establishes or maintains a **retiree group benefits program**. Examples of **plan sponsors** include employers and Taft-Hartley Boards of Trustees.
- 2.31 Pooled Health Plan—A health **benefit plan** in which **premiums** are based at least in part on the claims experience of groups other than the group being valued. The use of projection assumptions that are not based solely on the claims experience of the group being valued (for example, the health care cost **trend** rate assumption) would not by itself create a **pooled health plan**.
- 2.32 Premium—The price charged by a risk-bearing entity, such as an insurance or managed care company, to provide risk coverage.
- 2.33 Prescribed Assumption or Method Set by Another Party—A specific assumption or method that is selected by another party, to the extent that law, regulation, or accounting standards gives the other party responsibility for selecting such an assumption or method. For this purpose, an assumption or method set by a governmental entity for a **retiree group benefits program** that such governmental entity or a political subdivision of that entity directly or indirectly sponsors is deemed to be a **prescribed assumption or method set by another party**.
- 2.34 Prescribed Assumption or Method Set by Law—A specific assumption or method that is mandated or that is selected from a specified range or set of assumptions or methods that is deemed to be acceptable by applicable law (statutes, regulations, and other legally binding authority). For this purpose, an assumption or method set by a governmental entity for a **retiree group benefits program**, which such governmental entity or a political subdivision of that entity directly or indirectly sponsors, is not deemed to be a **prescribed assumption or method set by law**.
- 2.35 Retiree Group Benefits—Medical, prescription drug, dental, vision, legal, death, long-term care, or other benefits (excluding retirement income benefits) that are provided during retirement to a group of individuals, on account of an employment relationship.
- 2.36 Retiree Group Benefits Program—The program specifying **retiree group benefits**, including eligibility requirements, **participant contributions**, and the design of the benefits being provided.

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- 2.37 Spread Gain Actuarial Cost Method—An **actuarial cost method** under which actuarial gains and losses are included as part of the current and future **normal costs** of the **retiree group benefits program**.
- 2.38 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).
- 2.39 Surviving Dependent—A **dependent** who qualifies as a **participant** under the **retiree group benefits program** following the death of the associated **participant**.
- 2.40 Trend—A measure of the rate of change, over time, of the per capita benefit payments.

Section 3. Analysis of Issues and Recommended Practices

- 3.1 Overview—Measuring **retiree group benefits** obligations and determining **periodic costs** or **actuarially determined contributions** are processes in which the actuary may be required to make judgments or recommendations on the choice of actuarial assumptions, **actuarial cost methods**, asset valuation methods, **amortization methods**, and **output smoothing methods**.

The actuary may have the responsibility and authority to select some or all actuarial assumptions, **actuarial cost methods**, asset valuation methods, **amortization methods**, and **output smoothing methods**. In other circumstances, the actuary may be asked to advise the individuals who have that responsibility and authority. In yet other circumstances, the actuary may perform actuarial calculations using **prescribed assumptions or methods set by another party** or **prescribed assumptions or methods set by law**.

Other actuarial standards of practice provide guidance on asset valuation methods (ASOP No. 44, *Selection and Use of Asset Valuation Methods for Pension Valuations*), and actuarial assumptions and procedures not specifically addressed in this standard (for example, ASOP No. 5, *Incurred Health and Disability Claims*; ASOP No. 25, *Credibility Procedures*; ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations*; and ASOP No. 35, *Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations*).

ASOP No. 6 addresses broader measurement issues including **cost allocation procedures** and **contribution allocation procedures**, and provides guidance for coordinating and integrating all of these elements of an **actuarial valuation** of a **retiree group benefits program**. In the event of a conflict between the guidance provided in ASOP No. 6 and the guidance in any of the aforementioned ASOPs, ASOP No. 6 governs.

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- 3.2 General Procedures—When measuring **retiree group benefits** obligations and determining **retiree group benefits program periodic costs** or **actuarially determined contributions**, the actuary should perform the following general procedures:
- a. identify the purpose of the measurement (section 3.3);
 - b. identify the **measurement date** (section 3.4);
 - c. develop a model that reasonably represents the following:
 1. known provisions of the **retiree group benefits program** as they currently exist and as they are anticipated to change in the **measurement period**, as appropriate for the purpose (section 3.5);
 2. the current population covered by the benefits in question, as appropriate for the purpose (section 3.6); and
 3. current benefit costs (sections 3.7 and 3.8).
 - d. evaluate the quality and consistency of data used in construction of the model, and make appropriate adjustments (section 3.9);
 - e. identify any significant administrative inconsistencies and make appropriate adjustments in the model or disclose the unresolved inconsistency (section 3.10);
 - f. obtain from the principal other information necessary for the purpose of the measurement (section 3.11);
 - g. select actuarial assumptions (section 3.12);
 - h. evaluate **retiree group benefits** assets (section 3.13);
 - i. consider how to measure accrued or vested benefits, if applicable (section 3.14);
 - j. consider how to measure **market-consistent present values**, if applicable (section 3.15);
 - k. reflect how **retiree group benefits program** or **plan sponsor** assets as of the **measurement date** are reported, if applicable (section 3.16);
 - l. select an **actuarial cost method**, if applicable (section 3.17);
 - m. select a **cost allocation procedure** or **contribution allocation procedure**, if applicable (section 3.18);

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- n. assess the implication of the **contribution allocation procedure** or **plan sponsor's** funding policy, if applicable (section 3.18);
 - o. consider the use of approximations and estimates (section 3.19);
 - p. consider the sources of significant volatility, if applicable (section 3.20);
 - q. review and test the results of the calculations for reasonableness (section 3.21); and
 - r. evaluate **prescribed assumptions and methods set by another party**, if applicable (section. 3.22).
- 3.3 Purpose of Measurement—When measuring **retiree group benefits** obligations and determining **retiree group benefits program periodic costs** or **actuarially determined contributions**, the actuary should reflect the purpose of the measurement. Examples of measurement purposes are **periodic costs**, **actuarially determined contribution** requirements, benefit provision pricing, comparability assessments, **retiree group benefits program** settlement, **funded status** assessments, market value assessments, and **plan sponsor** mergers and acquisitions.
- 3.3.1 Projection or Point-in-Time—The actuary should consider whether assumptions or methods need to change for measurements projected into the future compared to point-in-time measurements.
 - 3.3.2 Uncertainty or Risk—In conjunction with the related guidance in ASOP No. 41, the actuary should consider the uncertainty or risk inherent in the measurement assumptions and methods and how the actuary's measurement treats such uncertainty or risk.
- 3.4 Measurement Date Considerations—When measuring **retiree group benefits** obligations and determining **retiree group benefits program periodic costs** or **actuarially determined contributions** as of a **measurement date**, the actuary should address the following:
- 3.4.1 Information as of a Different Date—The actuary may estimate asset and **participant** information at the **measurement date** on the basis of information as of a different date. In these circumstances, the actuary should make appropriate adjustments to the data. Alternatively, the actuary may calculate the obligations as of a different date and then adjust the obligations to the **measurement date** (see section 3.24 for additional guidance). In either case, the actuary should determine that any such adjustments are reasonable in the actuary's professional judgment, given the purpose of the measurement.
 - 3.4.2 Events after the Measurement Date—Events known to the actuary that occur subsequent to the **measurement date** and prior to the date of the actuarial

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communication may, but need not, be reflected in the measurement unless the purpose of the measurement requires the inclusion of such events.

3.5 Modeling Provisions of Retiree Group Benefits Programs—In modeling the known provisions of the **retiree group benefits program**, the actuary should give appropriate consideration to the written plan documents, historical practices, administrative practices, 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 3.5.1 and 3.5.2 below.

3.5.1 Components of the Modeled Retiree Group Benefits Program—The actuary should incorporate the significant elements of the known provisions of the **retiree group benefits program** into the model. Factors that the actuary should consider include:

- 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. Eligibility Conditions—All relevant eligibility conditions should be considered. These include, but are not limited to, conditions related to age, service, date of hire, employment classification, and participation in other benefit programs, such as Medicare or a pension plan.
- c. Plan Benefit Limitations, Exclusions, and Cost-Sharing Provisions—Benefit limitations and exclusions (such as an annual or 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).
- d. Participant Contributions—Many **retiree group benefits programs** require contributions from **participants** as a condition for their continued eligibility for coverage. The actuary should reflect the **participant contributions** in the model, as discussed below. In addition, **participant contributions** may affect participation rates and **adverse selection**, thus affecting per capita claim costs.
 1. Participant Postretirement Contribution Formula—In modeling the **retiree group benefits program**, the actuary should reflect the actual level of **participant contributions**. There is a wide variation in how **participant contributions** are determined (examples include flat amounts, amounts based on credited service at retirement, amounts based on claims costs for retired

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- participants**, and amounts based on combined costs for all **participants**).
2. Participant Postretirement Contribution Reasonableness—The actuary should compare for reasonableness the stated basis for **participant contributions** to what has been implemented. See section 3.10, Administrative Inconsistencies, for further guidance.
 3. Preretirement Active Employee Contributions—A **retiree group benefits program** may require active employees to make preretirement contributions in order to earn eligibility for **retiree group benefits**. The actuary should consider how this requirement may affect future benefit eligibility and **plan sponsor periodic costs** or **actuarially determined contributions**.
 4. Participant Contributions as Defined by Limits on Plan Sponsor Payments—Some **retiree group benefits programs** designate a maximum average per capita amount to be paid by the plan sponsor in a year. This limit is commonly known as a “cap.” These maximums may be based on factors such as service, employment classification, or age at retirement. The actuary should consider whether any such 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 **retiree group benefits program**.
- e. Payments from Other Sources—The cost of coverage in some **retiree group benefits programs** is partially or completely funded with payments from other sources such as retiree medical savings accounts, terminal leave balances, or non-employer funding sources. The actuary should consider payments from other sources when measuring a **retiree group benefits program’s** obligations.
 - f. Health Care Delivery System Attributes—The actuary should consider that various health care delivery system attributes can affect costs differently.
 - g. Benefit Options—The actuary should consider the effect of **benefit options**.
 - h. Anticipated Future Changes—For most measurement purposes, the actuary should reflect only changes that have been communicated to plan **participants**, changes that result from the continuation of a historical pattern, or changes that are required by law to be implemented within a

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specified period. However, depending upon the purpose of the measurement, the actuary may reflect future changes that the **plan sponsor** has requested the actuary to evaluate. The actuary should disclose that such an approach has been used (see section 4.1(d)).

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

- a. Claims Payment Practices—If the actuary becomes aware of a significant inconsistency between administrative practice and plan documents, stated **plan sponsor** policies, **participant** communications, or applicable law (statutes, regulations, and other legally binding authority), the actuary should follow the guidance in section 3.10.
- b. Patterns of Plan Changes—The actuary should consider the **plan sponsor's** historical practices or patterns of regular changes in the **retiree group benefits program** (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. The actuary should consider whether a maximum average per capita amount to be paid by the **plan sponsor** in a year would be effective in light of historical practices such as past increases in the maximum.
- c. Governmental Programs—The actuary should consider any patterns in the historically enacted legislative and administrative policy changes in Medicare and other governmental programs to the extent that the **retiree group benefits program** integrates with them.

3.5.3 Reviewing the Modeled Retiree Group Benefits Program—The actuary should consider whether the model continues to reflect actual known provisions and practices of the **retiree group benefits program**. If its administration has significantly deviated from the **retiree group benefits program** as modeled, the actuary should consider whether this deviation is temporary or should be treated as a permanent change in the **retiree group benefits program**. If the actuary becomes aware of a significant inconsistency between administrative practice and plan documents, stated **plan sponsor** policies, **participant** communications, or applicable law (statutes, regulations, and other legally binding authority), the actuary should follow the guidance in section 3.10.

3.5.4 Measurement Results by Category—The actuary should consider whether the measurement results need to be examined by category (for example, medical vs. dental; union vs. nonunion; retiree vs. **dependent**; **retiree group benefits program** paid vs. **participant** paid; and payments before Medicare eligibility age vs. payments after Medicare eligibility age). This examination may be necessary as a result of the nature of the assignment or to assess the reasonableness of the measurement model.

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- 3.6 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). Open group measurements should be used when appropriate for the purpose of the measurement. These issues are discussed below.
- 3.6.1 Census Data—The actuary should collect sufficient census data to make a reasonable estimate of the obligation. The actuary may use individual census data or grouped data, as appropriate for the measurement. Data for retirees or other former employees who decline and terminate coverage may be needed to establish participation assumptions, including election of coverage at retirement, lapse, and re-enrollment rates.
- 3.6.2 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 benefits** eligibility may accrue service in the future and whether some or all of the employees currently not making required preretirement **participant contributions** may contribute in the future, and make appropriate allowance for them in the modeled population.
- 3.6.3 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 re-enrollment assumption in situations where retirees or other former employees have opted out of medical coverage at retirement or termination, but may later elect to resume or begin coverage.
- 3.6.4 Dependents and Surviving Dependents of Participants—The actuary should include in the modeled population **dependents** and **surviving dependents** who are eligible for coverage and participating. In doing so, the actuary should take into account that the **retiree group benefits program's** eligibility conditions and benefit levels for **dependents** and **surviving dependents** may differ from the plan's eligibility conditions and benefit levels for retired **participants**. Benefit coverage for the **dependent** of a retired **participant** may continue subject to that **dependent** contributing to the plan, may continue for a limited period (for example, until Medicare eligibility, one year after the death of the retired **participant**, or a limiting age), or may cease when the retired **participant** dies.

The actuary should generally model **dependents** (other than dependent children) separately from retired **participants** because of differences in the timing of Medicare eligibility and in mortality between the retired **participant** and the **dependent**. For dependent children (including disabled adult dependent children), the actuary should consider whether the obligation related to dependent children is significant and model them appropriately. For example, for **retiree group**

benefits programs that have liberal early retirement eligibility conditions, dependent children coverage can significantly increase the overall number of **participants** and, therefore, have a significant effect on the size of the **covered population**.

- 3.6.5 Appropriateness of Pension Plan Data—**Plan sponsors** that do not maintain separate **retiree group benefits program** databases may furnish pension plan data to represent the **covered population** of the **retiree group benefits program**. In such cases, the actuary should make appropriate adjustments. Examples of the types of adjustments that may be required are discussed below.
- a. Retirees Covered by the Retiree Group Benefits Program but Not Receiving Pension Benefits—Former employees may be **participants** in the **retiree group benefits program**, but may no longer be participants in the pension plan (such as employees who received lump-sum pension payments). **Dependents** and **surviving dependents** of retired **participants** may be eligible for the **retiree group benefits program**, but may not be in the pension plan census data.
 - b. Retirees Receiving Pension Benefits but Not Covered by the Retiree Group Benefits Program—Retirees may be participants in the pension plan, but may not be covered by the **retiree group benefits program** (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 of the **retiree group benefits program** or may have waived coverage for certain or all of the underlying **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 the **retiree group benefits program**.
- 3.6.6 Use of Grouping—The actuary may use grouping techniques for modeling the population when, in the actuary’s judgment, grouping is not expected to significantly 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 health plans with similar expected costs and features. A **retiree group benefits program** with multiple health plan designs (for example, through various collective bargaining agreements) may not require separate measurement for each individual health plan. Under such circumstances, the actuary, after evaluating the eligibility conditions and range of benefits provided, may decide it is appropriate to combine health plans that have similar

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expected costs and group the **covered populations** of those health plans. The actuary should disclose such combining of health plans and grouping of populations (see section 4.1(i)).

3.6.7 Hypothetical Data—When appropriate, the actuary may prepare measurements based on assumed demographic characteristics of current or future plan **participants**.

3.7 Modeling Initial Per Capita Health Care Costs—The actuary should develop assumed per capita health care costs to be the basis of the initial annual benefit costs for estimating the future health care obligations. In the actuarial development of health care costs, health plan experience is generally considered the best predictor of future claims experience, preferable to sole reliance on **normative databases** or other measures. Therefore, preferred methods involve development of annual per capita health care costs from the claims experience of the health plan when that experience is sufficiently credible. In the absence of credible health plan experience data, the actuary may use other methods (such as methods that use **premiums** and **normative databases**) to develop the per capita costs.

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

Multiple initial per capita health care costs may be appropriate due to the modeling of known health plan and **participant contribution** provisions (section 3.5), demographic factors influencing claims, and claims experience (for example, different rates by gender, healthy vs. disabled, retired **participants** vs. **dependents**).

The actuary should document the methods and procedures followed in developing the initial per capita health care costs, such that another actuary qualified in this practice area could assess the reasonableness of the initial per capita health care costs. The actuary should also document any significant actuarial judgments applied during the modeling process.

The sections that follow address aspects of setting the per capita health care costs that are particularly important when projecting benefit costs for a long period. The actuary should consider the following elements.

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

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- 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 consider analyzing 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.
 - 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.
- 3.7.2 **Exposure Data**—In developing an initial per capita health care cost, the actuary should obtain exposure data for the same time periods and population 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 3.9).

Segmenting the exposure data by age and gender or by retired **participant** vs. **dependent** may be appropriate. The actuary should either obtain information to segment the population or employ reasonable assumptions as appropriate.

- 3.7.3 **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 3.7.8, 3.7.9, 3.7.10, and 3.7.11. 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.

- 3.7.4 **Credibility**—When data are not available or fully credible, 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*, provides guidance to the actuary when assigning credibility to sets of experience data.

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- 3.7.5 Use of Premiums—Although an analysis of the actual claims experience is preferable when reasonably possible, the actuary may use **premiums** as the basis for initial per capita costs, with appropriate analysis and adjustment for the **premium** basis. The actuary who uses **premiums** for this purpose should adjust them for changes in benefit levels, **covered population**, or **retiree group benefits program** administration. The actuary should also make the appropriate adjustments to determine the age-specific costs (see section 3.7.7).

If **premiums**, adjusted or unadjusted, are used as the basis for initial per capita costs in the measurement, the actuary should make an appropriate disclosure and consider the factors described in other paragraphs of section 3.7.

- 3.7.6 Impact of Medicare and Other Offsets—When Medicare is the primary payer and has a significant impact on the per capita health care costs, the actuary should develop separate costs for Medicare-eligible participants. Such costs should reflect the **Medicare integration** approach for the **benefit plan** or how the **benefit plan** supplements Medicare. The actuary should consider using separate per capita health care costs for **benefit plan** members who are not or will not become eligible for Medicare due to exemptions, such as for certain governmental entities. The actuary should consider the proportions of retired **participants** and their **dependents** that may be eligible for Part A and not for Part B due to non-payment of the Part B premium.

The actuary should consider whether there is a significant inconsistency between the **Medicare integration** approach being applied by the claims administrator and representations to the actuary of the terms of the health plan. See section 3.10 for further guidance.

Depending on the purpose of the measurement, the actuary should consider whether it is appropriate to reflect reimbursements or other payments from the Medicare system (for example, the retiree drug subsidies for **plan sponsors** and direct subsidies for Part D plans).

The actuary should consider changes to Medicare and other governmental programs that may have affected historical data being used in the measurement and, if the impact is significant, make appropriate adjustments.

The actuary should also adjust for other offsets, such as workers' compensation and auto insurance, if their impact is considered to be significant.

- 3.7.7 Age-Specific Costs—Various factors influence the magnitude of costs for the group being valued, often including the ages, gender, and other characteristics of the **benefit plan** members. Considerations for reflecting these factors in modeling initial per capita health care costs are discussed below.

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- a. General Principles—In general, for health coverage, benefit costs vary by age. Therefore, except as noted in (c) below, the actuary should use age-specific costs in the development of the initial per capita costs and in the projection of future **benefit plan** costs. In general, the development of the age-specific costs should be based on the demographics of the group being valued and the group's total expected claims or premiums. Any age ranges used should not be overly broad. The relationship between the costs at various ages is an actuarial assumption that may be based on **normative databases**.

Additional analysis may be needed in some circumstances. For example, if the **benefit plan** comingles the experience of active and retired individuals, and the **benefit plan's premium** for non-Medicare retirees does not reflect their full age-specific cost, the **benefit plan's** active rates include an implicit subsidy for the non-Medicare retirees. The actuary should reflect the full age-specific costs, including the implicit subsidy.

- b. Pooled Health Plans (including Community Rated Plans)—If the group being valued participates in a **pooled health plan**, additional analysis relating to age-specific costs may be needed. Except as noted in (c), the actuary should reflect the full age-specific cost, including the implicit subsidy, regardless of the size of the group being valued.

A **pooled health plan** may base its **premiums** for participating groups, in whole or in part, on the claims, demographics, or other risk factors of the total population of the **pooled health plan**. To the extent the **premiums** are based on the demographics of the total population of the **pooled health plan**, and not adjusted by the demographics of the group under consideration, the actuary performing a **retiree group benefits actuarial valuation** for a group should use age-specific costs based upon the **pooled health plan's** total age distribution and the **pooled health plan's** total expected claims costs or **premiums** rather than based on the group's own age distribution and its own expected claims costs or **premiums**. If, however, the **premiums** are explicitly based, in part, on the composition of the group under consideration, the actuary should take into account the distribution of the considered group's members by age, or by age and gender, to the extent appropriate.

The actuary should base the age-specific costs for the group being valued on a distribution table for the total number of covered health plan members by age, or by age and gender, provided by the **pooled health plan**. If the information is not available from the **pooled health plan**, then the actuary may make a reasonable assumption regarding the distribution table for the **pooled health plan** to determine the age-specific cost. Alternatively, the actuary may base the age-specific cost on manual rates or other sources relevant to the plan of benefits covering the members of the group being valued.

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- c. Possible Exceptions—In some very limited cases, the use of the **pooled health plan's premium** may be appropriate without regard to adjustments for age. The factors that an actuary should evaluate in determining whether the **premium** may be appropriate without regard to adjustments for age include:
1. the purpose of the measurement (for example, for a projection of short-term cash flow needs the use of the **premium** may be appropriate);
 2. whether for the type of **benefit plan** being valued (for example, certain dental plans) the impact of using age-specific costs would not be material;
 3. the extent to which there are no age-related implicit subsidies between actives and retirees that occur within the **pooled health plan**; and
 4. whether the **pooled health plan** and its **premium** structure are sustainable over the **measurement period**, even if other groups or active **participants** cease to participate. The use of a **premium** without regard to adjustment for age is generally inappropriate if the **pooled health plan** and its **premium** structure are not sustainable over the **measurement period** if other groups or active **participants** cease to participate.
- 3.7.8 Adjustment for Benefit Plan Design Changes—The actuary should adjust the claims costs 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**. Where significant, the impact of changes in other provisions of the **retiree group benefits program** (for example, **participant contributions**) should be reflected.
- 3.7.9 Adjustment for Administrative Practices—Changes in administrative practices affect how costs emerge. The actuary should make appropriate provisions in the model for changes in administrative practices 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).
 - b. Enrollment Practices—The actuary should consider the effect enrollment practices (for example, the ability of **participants** to drop in and out of a health plan) have had on health care costs.

- 3.7.10 Adjustment for Large Individual Claims—The actuary should recognize the significance that large claims may have with respect to claims experience and consider whether adjustments are appropriate. When data are relevant and available, the actuary should review the frequency and size of large claims 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 consider whether adjustments should be made to reflect annual or lifetime maximums. 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.
- 3.7.11 Adjustment for Trend—When adjusting the claims experience during earlier periods to the initial year of the measurement, the actuary should reflect the effect of **trend** that has occurred between those earlier claim periods and the initial year of the measurement. These adjustments of the initial per capita health care cost may reflect experience from outside the health plan.
- The actuary should consider using separate **trend** rates for major cost components (for example, medical, drugs, and health plan administration).
- 3.7.12 Adjustment When Plan Sponsor is Also a Provider—The **plan sponsor** may also be a provider under the plan, as 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 such **plan sponsor**, and make appropriate adjustments in the measurement model to properly reflect the underlying transactions.
- 3.7.13 Use of Other Modeling Techniques—Health care costs may be modeled and projected using techniques other than those mentioned above. When using an alternative approach, the actuary should disclose the method used and comment on its applicability (see section 4.1(1)). 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.
- 3.7.14 Administrative and Other Expenses—In addition to the cost of claims, the **plan sponsor** is usually responsible for the cost of administering the **retiree group benefits program** and other related **expenses**. The actuary should consider these

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expenses when performing the measurement. The actuary may model **expenses** in various ways. For example, **expenses** may be included in claims costs or expressed on a per capita basis, as a percentage of claims, or as fixed amounts.

- 3.8 Modeling the Cost of Death Benefits—Death benefits may be provided directly by the **plan sponsor** upon the death of a retired **participant** 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 actuary should appropriately reflect the financial arrangement through which the benefits are provided, including dividends, **participant 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.

- 3.9 Model Consistency and Data Quality—The actuary should review the modeled plan provisions of the **retiree group benefits program, covered population**, per capita health care costs, and death benefit costs as a whole to evaluate their consistency. ASOP No. 23, *Data Quality*, provides guidance on selecting and reviewing data and making appropriate disclosures regarding the data. The actuary should also take the following steps when reviewing the data:

3.9.1 Coverage and Classification Data—The actuary should consider the importance of coverage distinctions (such as HMO vs. PPO) and classification distinctions (such as hourly vs. salaried, or benefits that vary among different groups of retired **participants**) 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.

3.9.2 Consistency—If the actuary finds data elements that appear to be significantly inconsistent with known plan provisions of the **retiree group benefits program**, other data elements, or data used for prior measurements, the actuary should take appropriate steps to address such apparent inconsistencies as discussed below. To the extent that significant inconsistencies cannot be reconciled, the actuary should disclose them (see section 4.1(v)).

- a. Retiree Group Benefits Program Operations—If the actuary becomes aware of a significant inconsistency between administrative practice and plan documents, stated **plan sponsor** policies, **participant** communications, or applicable law (statutes, regulations, and other legally binding authority), the actuary should follow the guidance in section 3.10.

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- b. Medicare-Related Data—The actuary should make and document appropriate adjustments if data concerning Medicare eligibility and age are determined to be inaccurately or inconsistently coded for either claims or **covered population**.
 - 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.
- 3.9.3 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 actuary will be supplied with eligibility and demographic information about **participants** in the **retiree group benefits program**. 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 **retiree group benefits program** participation with sufficient accuracy (see sections 3.6.5 and 3.7.2) and, if not, seek more accurate census information. The actuary should review coverage and classification information for **dependents** and **surviving dependents** because of the impact they may have on the results of the measurement.
 - b. Claims Payment Data—Various sources of data are available for establishing per capita costs, including **normative databases** and experience data specific to the **benefit plan**. The actuary should review plan experience relative to normative ranges of value but also recognize the legitimacy of the **benefit plan** 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 for the purpose. For example, data from a **benefit plan** may be sufficient for setting an aggregate per capita health care cost but not be of sufficient size to set per capita health care costs by location.
- 3.10 Administrative Inconsistencies—In general, the actuary may rely on the **plan sponsor’s** representations. However, in the course of performing the measurement, the actuary may become aware of a significant inconsistency between administrative practice and plan documents, stated **plan sponsor** policies, **participant** communications, or applicable law

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(statutes, regulations, and other legally binding authority). Examples of areas of possible inconsistencies include: **participant contribution** determinations that combine claims for active and retired **participants** resulting in “hidden” subsidies (see section 3.5.1(d)(2)); claims payment practices including ignoring lifetime limits (see section 3.5.2(a)); **Medicare integration** (see section 3.7.6); and **retiree group benefits program** operations (see section 3.9.2(a)). The actuary should do the following upon becoming aware of such an inconsistency:

- a. discuss the inconsistency with the **plan sponsor**, the administrator, or any other appropriate parties;
 - b. adjust the model appropriately, consistent with the purposes of the measurement;
 - c. document the resulting steps taken by the actuary in developing the model; and
 - d. disclose any significant unresolved inconsistency (see section 4.1(v)).
- 3.11 Other Information from the Principal—The actuary should obtain from the principal other information, such as accounting policies or funding elections, necessary for the purpose of the measurement.
- 3.12 Projection Assumptions—In selecting projection assumptions, the actuary should consider the following:
- 3.12.1 Economic Assumptions—The actuary should comply with the guidance contained in ASOP No. 27 when selecting economic assumptions not covered by this ASOP to be used in measuring **retiree group benefits** obligations. In applying ASOP No. 27, the actuary should take into account the purpose of the measurement, and the differences between the characteristics of **retiree group benefits** obligations and the characteristics of pension benefit obligations. For example, the discount rate selected for measuring pension benefit obligations for purposes of ASC 715-30 Defined Benefit Plans – Pension may not be appropriate for measuring **retiree group benefits** obligations for the purposes of ASC 715-60, because the payment patterns may be different.

The actuary should determine what other economic assumptions are needed, including the following when relevant to the calculation:

- a. **Health Care Cost Trend Rates**—Health care cost **trend** rates reflect the change in per capita health costs over time due to factors such as inflation, medical inflation, utilization, technology improvements, definition of covered charges, leveraging caused by health plan design features not explicitly modeled, and health plan participation. The actuary should not reflect aging of the **covered population** when selecting the **trend** assumption for projecting future costs (see section 3.7.7 for a discussion of

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“age-specific costs”). 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 set of **trend** rates, the actuary should consider these cost components when developing the aggregate set of **trend** rates.

When developing an initial **trend** assumption, the actuary should consider known or expected changes in per capita health costs in the year(s) following the **measurement date**. The actuary should consider the sustainability of current **trends** over an extended period, and the possible need for a long-term **trend** assumption that is different from the initial **trend** assumption. If these two **trend** assumptions are different, the actuary should choose an appropriate select period and transition pattern between the initial **trend** assumption and the long-term **trend** assumption.

When developing a long-term **trend** assumption and the select period for transitioning, the actuary should consider relevant long-term economic factors such as projected growth in per capita gross domestic product (GDP), projected long-term wage inflation, and projected health care expenditures as a percentage of GDP. The actuary should select a transition pattern and select period that reasonably reflects anticipated experience.

- 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 **retiree group benefits program**, the measurement may require an assumption for the rate of change in **participant contributions**. For some **retiree group benefits programs**, this may be a function of health care **trend** rates or other economic assumptions. For some other **retiree group benefits programs**, there may be no **participant contributions** currently but caps on other funding sources and assumed **trend** rates may make it likely that **participant contributions** will be required in future years. In those cases, and depending upon the purpose of the measurement, the actuary should determine when **participant contributions** are expected to be required during the **measurement period** and model subsequent increases accordingly.
- d. Adverse Selection—When a **retiree group benefits program** requires **participant contributions**, those choosing to participate may have a higher average benefit cost than those not participating would have had. Also when a **retiree group benefits program** offers **benefit options**, **adverse selection** may have an impact on plan costs.

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The actuary should consider whether **adverse selection** will result from such items as decreasing participation and, if **adverse selection** is projected to have a significant impact on the measurement, then the actuary should appropriately reflect that **adverse selection** in the measurement, either implicitly or explicitly. The actuary should document how that **adverse selection** is reflected in the measurement.

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

- a. **Assumptions Based on Related Pension Plan Valuation**—The actuary should determine whether the assumptions used in a related pension plan valuation are appropriate for **retiree group benefits programs** 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 **retiree group benefits program**. 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- or service-related retirement rates. A single average retirement age is generally not appropriate.
- d. **Mortality**—When the per capita health care costs are expected to increase during the projection period or when death benefits are being valued, the results of the measurement may be sensitive to the mortality assumption. The actuary should take this sensitivity into account when selecting a mortality improvement assumption under ASOP No. 35.

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- 3.12.3 Participation and Dependent Coverage Assumptions—In addition to covering eligible retired **participants**, many **retiree group benefits programs** also cover **dependents** of retired **participants**. Also, **retiree group benefits programs** may offer some or all **participants benefit options**, such as HMOs, PPOs, and POS plans. The magnitude of the **retiree group benefits program** obligation can vary significantly as a result of the participation assumption and also the **dependent coverage** assumption. The actuary should therefore consider historical participation rates and trends in coverage rates when selecting these assumptions.
- a. **Retiree Group Benefits Program Participation**—For **retiree group benefits programs** that require some form of **participant contribution** to maintain coverage, some eligible individuals may not elect to be covered, particularly if they have other coverage available. Plan participation in this context is the result of acceptance, lapse, and re-enrollment elections. The actuary should take into account empirical data and future expectations regarding these elections when selecting participation assumptions. When developing the participation rates, the actuary should consider how changes in **retiree group benefits program** eligibility rules, **benefit options**, and **participant contribution** rates have influenced experience over time. Furthermore, plan participation may be different in the future due to **participants'** responses to changes in **participant contribution** levels and **benefit options**. For **retiree group benefits programs** that anticipate changes in these factors, the actuary should consider the appropriateness of participation rates that vary over the projection period for both current and future retired **participants**. The actuary should also consider eligibility rules governing dropping coverage and subsequent re-enrollment when selecting participation rates.
 - b. **Dependent Coverage**—The actuary should consider who is eligible for coverage under the **retiree group benefits program** and make appropriate assumptions regarding the coverage of **dependents**. The actuary should consider the impact of the **retiree group benefits program's** rules governing changes in coverage after retirement, such as remarriage, if significant. The actuary should review historical data on **dependent** coverage rates and should consider **participant contribution** rates for **dependent** coverage. If the gender mix of future retired **participants** and currently retired **participants** differs, the actuary should consider developing separate **dependent** coverage rates for males and females.
 - c. **Dependent Ages**—Whenever practical, the actuary should use actual data for the age of **dependents** of retired **participants**. If actual data is not available for all retired **participants**, the actuary should review the empirical data and consider developing an assumption to account for the difference in age between the **participant** and the **dependent** for the missing data. The **dependents** of an active employee today may not be the

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same **dependents** covered at retirement. Therefore, the actuary should generally select an assumed age difference between retired **participants** and **dependents** for purposes of projecting future **dependent** coverage.

3.12.4 Effect of Retiree Group Benefits Program Design Changes on Assumptions—

When selecting assumptions, the actuary should consider the impact of relevant **retiree group benefits program** design changes during the **measurement period**. Whenever changes in provisions are being modeled, the actuary should consider whether assumptions that in combination are appropriate for measuring overall 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 options that may be selected by a portion of its group of retired **participants**, the actuary should consider how that affects the cost of current coverage, future cost **trends**, and participation. Both short-term and long-term implications of the change should be considered.

For most measurement purposes, the actuary should assume that the **retiree group benefits program** will continue indefinitely even though many **plan sponsors** have reserved the right to change unilaterally or terminate their **retiree group benefits programs**. The actuary should only include assumptions in the measurement model that attempt to quantify the probability that the current plan provisions will change significantly in the future when appropriate for the purpose of the measurement. In that event, the actuary should disclose that such an assumption has been used (see section 4.1(d)).

3.12.5 Assumptions Considered Individually and in Relation to Other Assumptions—

The actuary should select reasonable actuarial 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.

3.12.6 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 **benefit plan** costs of the health risk of this group.

- 3.13 Retiree Group Benefits Program Assets—In measuring the unfunded obligation and allocating **periodic costs** to time periods, the actuary should take into account **dedicated assets** of the **retiree group benefits program**, if any. The actuary should consider any additional requirements or restrictions on what assets can be taken into account that are imposed by the purpose of the measurement, such as requirements imposed by accounting standards. Depending on the purpose of the measurement, such as for

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management planning purposes, taking non-dedicated assets into account may be appropriate.

The actuary should obtain sufficient details regarding insurance policies 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.

The actuary should refer to ASOP No. 44 for guidance on the selection and use of an asset valuation method.

3.14 Measuring the Value of Accrued or Vested Benefits— Although in many situations retiree group benefits are neither accrued nor vested, some assignments do call for the actuary to measure accrued or vested benefits. The actuary should determine the following when making such measurements:

- a. the extent to which the **retiree group benefits** are accrued or vested;
- b. relevant plan provisions and applicable law (statutes, regulations, and other legally binding authority);
- c. the status of the plan (for example, whether the plan is assumed to continue to exist or be terminated);
- d. the contingencies upon which benefits become payable, which may differ for ongoing- and termination-basis measurements;
- e. the extent to which **participants** have satisfied relevant eligibility requirements for accrued or vested benefits and the extent to which future service or advancement in age may satisfy those requirements;
- f. whether the plan provisions regarding accrued benefits provide an appropriate attribution pattern for the purpose of the measurement (for example, following the attribution pattern of the plan provisions may not be appropriate if the plan's benefit accruals are significantly backloaded); and
- g. if the measurement reflects the effect of a special event (such as a plant shutdown or plan termination), factors such as the following:
 1. the likely effect of the special event on continued employment;
 2. the likely effect of the special event on employee behavior;
 3. the **expenses** associated with a potential plan termination, including transaction costs to liquidate plan assets; and

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4. any likely changes in investment policy.

3.15 Market-Consistent Present Values—If the actuary calculates a **market-consistent present value**, the actuary should do the following:

- a. select assumptions based on the actuary’s observation of the estimates inherent in market data (as applied to assumptions for which guidance is provided in this standard as well as assumptions for which relevant guidance is provided in ASOP Nos. 27 and 35), depending on the purpose of the measurement; and
- b. reflect benefits earned as of the **measurement date**.

In addition, the actuary may consider how benefit payment default risk or the financial health of the **plan sponsor** affects the calculation.

3.16 Relationship Between Asset and Obligation Measurement—The actuary should reflect how **retiree group benefits program** or **plan sponsor** assets as of the **measurement date** are reported. For example, if the **retiree group benefits program** or **plan sponsor** assets have been reduced to reflect a lump sum paid, the lump sum or the value of the related projected benefit payments should be excluded from the obligation.

3.17 Actuarial Cost Method—When assigning **periodic costs** or **actuarially determined contributions** to time periods before the time benefit payments are due, the actuary should select an **actuarial cost method** that meets the following criteria:

- a. The period over which **normal costs** are allocated for an employee should begin no earlier than the date of employment and should not extend beyond the last assumed retirement age. The period may be applied to each individual employee or to groups of employees on an aggregate basis.

When a plan has no active **participants** and no **participants** are accruing benefits, a reasonable **actuarial cost method** will not produce a **normal cost** for benefits. For purposes of this standard, an employee does not cease to be an active **participant** merely because he or she is no longer accruing benefits under the plan.

- b. The attribution of **normal costs** should bear a reasonable relationship to some element of the **retiree group benefit program’s** benefit formula or the employee’s compensation or service. The attribution basis may be applied on an individual or group basis. For example, the **actuarial present value of projected benefits** for each employee may be allocated by that employee’s own compensation or may be allocated by the aggregated compensation for a group of employees.
- c. **Expenses** should be considered when assigning **periodic costs** or **actuarially determined contributions** to time periods. For example, administrative **expenses**

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may be included in the per capita costs as discussed in section 3.7.15. Alternatively, the **expenses** for a period may be added to the **normal cost** for benefits or **expenses** may be reflected as an adjustment to the investment return assumption or the discount rate. As another example, **expenses** may be reflected as a percentage of **retiree group benefits** obligations or **normal cost**.

- d. The sum of the **actuarial accrued liability** and the **actuarial present value** of future **normal costs** should equal the **actuarial present value of projected benefits and expenses**, to the extent **expenses** are included in the liability and **normal cost**. For purposes of this criterion, under a **spread gain actuarial cost method**, the sum of the actuarial value of assets and the unfunded **actuarial accrued liability**, if any, should be considered to be the **actuarial accrued liability**.

3.18 Allocation Procedure—When selecting a **cost allocation procedure** or **contribution allocation procedure**, the actuary should consider factors such as the timing and duration of expected benefit payments and the nature and frequency of plan amendments. In addition, the actuary should consider relevant input received from the principal, such as a desire for stable or predictable **periodic costs** or **actuarially determined contributions**, or a desire to achieve a target funding level within a specified time frame.

3.18.1 Consistency Between Contribution Allocation Procedure and the Payment of Benefits—In some circumstances, a **contribution allocation procedure** may not be expected to produce adequate assets to make benefit payments when they are due even if the actuary uses a combination of assumptions selected in accordance with this standard and ASOP Nos. 27 and 35, an **actuarial cost method** selected in accordance with section 3.16 of this standard, and an asset valuation method selected in accordance with ASOP No. 44.

Examples of such circumstances include the following:

- a. a plan covering a sole proprietor with funding that continues past an expected retirement date with payment due in a lump sum;
- b. using the aggregate **actuarial cost method** for a plan covering three employees, in which the principal is near retirement and the other employees are relatively young; and
- c. a plan amendment with an amortization period so long that overall plan **actuarially determined contributions** would be scheduled to occur too late to make plan benefit payments when due.

When selecting a **contribution allocation procedure**, the actuary should select a **contribution allocation procedure** that, in the actuary's professional judgment, is consistent with the plan being able to make benefit payments when due, assuming that all actuarial assumptions will be realized and that the **plan sponsor**

or other contributing entity will make **actuarially determined contributions** when due.

In some circumstances, the actuary's role is to determine the **actuarially determined contribution**, or range of **actuarially determined contributions**, using a **contribution allocation procedure** that the actuary did not select. If, in the actuary's professional judgment, such a **contribution allocation procedure** is significantly inconsistent with the plan being able to make benefit payments when due, assuming that all actuarial assumptions will be realized and that the **plan sponsor** or other contributing entity will make **actuarially determined contributions** when due, the actuary should disclose this in accordance with section 4.1(o).

3.18.2 Implications of Contribution Allocation Procedure—The actuary should qualitatively assess the implications of the **contribution allocation procedure** or **plan sponsor's** funding policy on the plan's expected future **actuarially determined contributions** and **funded status**. For purposes of this section, contributions set by law or by a contract, such as a collective bargaining agreement, constitute a funding policy. In making this assessment, the actuary may presume that all actuarial assumptions will be realized and the **plan sponsor** (or other contributing entity) will make **actuarially determined contributions** anticipated by the **contribution allocation procedure** or funding policy. The actuary's assessment required by this section should be disclosed in accordance with section 4.1(p).

3.19 Approximations and Estimates—The actuary should use professional judgment to establish a balance between the degree of refinement of methodology and materiality. The actuary may use approximations and estimates where circumstances warrant. Following are some examples of such circumstances:

- a. situations in which the actuary reasonably expects the results to be substantially the same as the results of detailed calculations;
- b. situations in which the actuary's assignment requires informal or rough estimates; and
- c. situations in which the actuary reasonably expects the amounts being approximated or estimated to represent only a minor part of the overall **retiree group benefits** obligation, **periodic cost**, or **actuarially determined contribution**.

3.20 Volatility—If the scope of the actuary's assignment includes an analysis of the potential range of future **retiree group benefits** obligations, **periodic costs**, **actuarially determined contributions**, or **funded status**, the actuary should consider sources of

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volatility that, in the actuary's professional judgment, are significant. Examples of potential sources of volatility include the following:

- a. plan experience differing from that anticipated by the economic or demographic assumptions, as well as the effect of new entrants;
- b. changes in economic or demographic assumptions, such as medical **trend**, initial per capita health care costs, acceptance rates, or lapse rates;
- c. the effect of discontinuities in applicable law (statutes, regulations, and other legally binding authority) or accounting standards, such as welfare benefit fund limits or the end of amortization periods;
- d. the delayed effect of smoothing techniques, such as the pending recognition of prior experience losses; and
- e. patterns of rising or falling **periodic cost** expected when using a particular **actuarial cost method** for the **covered population**.

When analyzing potential variations in economic and demographic experience or assumptions, the actuary should exercise professional judgment in selecting a range of variation in these assumptions (while maintaining internal consistency among these assumptions, as appropriate) and in selecting a methodology by which to analyze them, consistent with the scope of the assignment.

3.21 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 **retiree group benefits programs**, or could review the results for sample **participants** for reasonableness.

3.21.1 Modeled Cash Flows Compared to Recent Experience—The actuary should compare the expected costs produced by the model for the first year from the **measurement date** to actual costs available over a recent period of years. If the expected and actual costs are significantly different, the actuary should determine, and should consider documenting, if appropriate, 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 **benefit plans** with limited credible experience), and should determine the impact of those differences on the reasonableness of the measurement results.

3.21.2 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 determine, and should consider documenting, if appropriate, 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 practical, review the prior actuary's documentation and, if necessary, seek further information.

- 3.22 Evaluation of Assumptions and Methods—An actuarial communication should identify the party responsible for each material assumption and method. Where the communication is silent about such responsibility, the actuary who issued the communication will be assumed to have taken responsibility for that assumption or method.
- 3.22.1 Prescribed Assumption or Method Set by Another Party—The actuary should evaluate whether a **prescribed assumption or method set by another party** is reasonable for the purpose of the measurement, except as provided in section 3.22.3. The actuary should be guided by Precept 8 of the Code of Professional Conduct, which states, “An Actuary who performs Actuarial Services shall take reasonable steps to ensure that such services are not used to mislead other parties.” For purposes of this evaluation, reasonable assumptions or methods are not necessarily limited to those the actuary would have selected for the measurement.
- 3.22.2 Evaluating Prescribed Assumption or Method—When evaluating a **prescribed assumption or method set by another party**, the actuary should determine whether the prescribed assumption or method significantly conflicts with what, in the actuary's professional judgment, would be reasonable for the purpose of the measurement. If, in the actuary's professional judgment, there is a significant conflict, the actuary should disclose this conflict in accordance with section 4.2(a).
- 3.22.3 Inability to Evaluate Prescribed Assumption or Method—If the actuary is unable to evaluate a **prescribed assumption or method set by another party** without performing a substantial amount of additional work beyond the scope of the assignment, the actuary should disclose this in accordance with section 4.2(b).
- 3.23 Reliance on a Collaborating Actuary—The various elements of a **retiree group benefits** 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.
- 3.24 Use of Roll-Forward Techniques—The actuary may determine that it is appropriate for the purpose of the measurement to use prior measurement results and a roll-forward technique rather than conduct a new full measurement. The actuary should not use roll-forward techniques unless, in the actuary's professional judgment at the time of the roll-

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forward calculation, the resulting measurement is not expected to differ significantly from the results of a new full measurement.

- 3.24.1 Full and Partial Roll-Forward—Roll-forward techniques include full roll-forwards of claims data 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 costs developed for the prior measurement trended forward to the current **measurement date** coupled with updated census data.
- 3.24.2 Limitation—The actuary may use roll-forward techniques to reduce the frequency of full measurements. The actuary should not roll-forward prior measurement results if the **measurement date** of those results is three or more years earlier than the current **measurement date**. For example, a January 1, 2016 measurement could be used to develop roll-forward results as of January 1, 2017 and 2018, but should not be used for measurements or **periodic cost** allocations after December 31, 2018.
- 3.24.3 Appropriateness—The actuary should not use full roll-forward techniques when the **covered population, retiree group benefits program** design, or other key model components have changed significantly since the last full measurement.

Section 4. Communications and Disclosures

- 4.1 Communication Requirements—Any actuarial communication prepared to communicate the results of work subject to this standard should comply with the requirements of ASOP Nos. 23, 27, 35, 41, and 44. In addition, such communication should contain the following disclosures, when relevant and material. An actuarial communication can comply with some or all of the specific requirements of this section by making reference to information contained in other actuarial communications available to the intended users (as defined in ASOP No. 41, *Actuarial Communications*), such as an annual **actuarial valuation** report.
- a. a statement of the intended purpose of the measurement and a statement to the effect that the measurement may not be applicable for other purposes;
 - b. the **measurement date**;
 - c. a description of adjustments made for events after the **measurement date** under section 3.4.2;
 - d. information about known significant **retiree group benefits program** provisions (such as types of **benefit plans** provided, benefit eligibility conditions, retired **participant** and **dependent** coverage options, and **participant contribution** requirements), a description of known changes in significant plan provisions included in the **actuarial valuation** from those used in the immediately preceding

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measurement prepared for a similar purpose, a description of any known significant **retiree group benefits program** provisions not reflected in the model along with the rationale for not including such significant plan provisions, and any anticipated future changes (see sections 3.5.1(h) and 3.12.4);

- e. the date(s) as of which the **participant** and financial information were compiled;
- f. summary information about the **covered population**;
- g. if hypothetical data are used, a description of the data;
- h. a description of any accounting policies or funding elections made by the principal that are pertinent to the measurement;
- i. a brief description of the information and analysis used in selecting each significant assumption that was not prescribed. Items to disclose could include any specific approaches used, sources of external advice, and how past experience and future expectations were considered. For example, for the initial per capita health care costs and Medicare-related assumptions, a brief description of the methodology used to develop these assumptions as well as any combining of **benefits plans** (section 3.6.6) for measurement purposes and a description of the extent to which they are based on **premium** (or self-funded equivalent) rates and any adjustments to those rates (see section 3.7.5) should be included. If age-specific costs were not used, the actuary should disclose the rationale for not doing so;
- j. a description of the future health care cost **trend** rates used (see section 3.12.1(a));
- k. a description of all other significant assumptions (including, but not limited to, participation and dependent coverage assumptions);
- l. if using modeling or projection techniques other than those mentioned in section 3.7, a description of the method used and a discussion on its applicability;
- m. a description of the **actuarial cost method** and the manner in which **normal costs** are allocated, in sufficient detail to permit another actuary qualified in the same practice area to assess the significant characteristics of the method (for example, how the **actuarial cost method** is applied to multiple benefit formulas, compound benefit formulas, or benefit formula changes, where such plan provisions are significant);
- n. a description of the **cost allocation procedure** or **contribution allocation procedure** including a description of **amortization methods** and a description of any pay-as-you-go funding (i.e., the intended payment by the **plan sponsor** of some or all benefits when due). The actuary should disclose the outstanding

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amortization balance, the amortization payment included in the periodic cost or actuarially determined contribution, and the remaining amortization period for each amortization base along with a disclosure if the unfunded **actuarial accrued liability** is not expected to be fully amortized. For purposes of this section, the actuary should assume that all actuarial assumptions will be realized and **actuarially determined contributions** will be made when due;

- o. a statement indicating that the **contribution allocation procedure**, if any, is significantly inconsistent with the plan accumulating adequate assets to make benefit payments when due, if applicable in accordance with section 3.18;
- p. a qualitative description of the implications of the **contribution allocation procedure** or **plan sponsor's** funding policy on future expected plan **actuarially determined contributions** and **funded status** in accordance with section 3.18.2. The actuary should disclose the significant characteristics of the **contribution allocation procedure** or **plan sponsor's** funding policy, and assumptions used in the assessment;
- q. a description of the types of benefits regarded as accrued or vested if the actuary measured the value of accrued or vested benefits, and, to the extent the attribution pattern of accrued benefits differs from or is not described by the plan provisions, a description of the attribution pattern;
- r. a description of how benefit payment default risk or the financial health of the **plan sponsor** was included if a **market-consistent present value** measurement was performed;
- s. **funded status** based on an **immediate gain actuarial cost method** if the actuary discloses a **funded status** based on a **spread gain actuarial cost method**, unless the sole purpose of the calculation was contribution determination in accordance with federal law or regulation. The **immediate gain actuarial cost method** used for this purpose should be disclosed in accordance with section 4.1(m);
- t. if applicable, a description of the particular measures of plan assets and plan obligations that are included in the actuary's disclosure of the plan's **funded status**. For funded status measurements that are not prescribed by federal law or regulation, the actuary should accompany this description with each of the following additional disclosures:
 - 1. whether the **funded status** measure is appropriate for assessing the sufficiency of plan assets to cover the estimated cost of settling the plan's benefit obligations;
 - 2. whether the **funded status** measure is appropriate for assessing the need for or the amount of future **actuarially determined contributions**; and

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3. if applicable, a statement that the **funded status** measure would be different if the measure reflected the market value of assets rather than the actuarial value of assets.
- u. a brief description of the roll-forward method, if any, used in the calculations (see section 3.24);
- v. a description of any significant and unresolved inconsistencies in data or administration, such as those mentioned in sections 3.9 and 3.10;
- w. a statement, appropriate for the intended users, indicating that future measurements (for example, of **retiree group benefit program** obligations, **periodic costs**, **actuarially determined contributions** or **funded status** as applicable) may differ significantly from the current measurement. For example, a statement such as the following could be applicable: “Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: retiree group benefits program experience differing from that anticipated by the assumptions; changes in assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and changes in retiree group benefits program provisions or applicable law. Retiree group benefits models necessarily rely on the use of approximations and estimates, and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements.”

In addition, the actuarial communication should include one of the following:

1. if the scope of the actuary’s assignment included an analysis of the range of such future measurements, disclosure of the results of such analysis together with a description of the factors considered in determining such range; or
 2. a statement indicating that, due to the limited scope of the actuary’s assignment, the actuary did not perform an analysis of the potential range of such future measurements.
- x. a description of known changes in assumptions and methods from those used in the immediately preceding measurement prepared for a similar purpose. For assumption and method changes that are not the result of a **prescribed assumption or method set by another party** or a **prescribed assumption or method set by law**, the actuary should include an explanation of the information and analysis that led to those changes. The explanation may be brief but should be pertinent to the **retiree group benefit program’s** circumstances;

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- y. a description of all changes in **cost allocation procedures** or **contribution allocation procedures** that are not a result of a **prescribed assumption or method set by law**, including the resetting of an actuarial asset value. The actuary should disclose the reason for the change, and the general effect of the change on relevant **periodic cost, actuarially determined contribution, funded status**, or other measures, by words or numerical data, as appropriate. The disclosure of the reason for the change and the general effects of the change may be brief but should be pertinent to the **retiree group benefit program's** circumstances; and
- z. if, in the actuary's professional judgment, the actuary's use of approximations and estimates could produce results that differ materially from results based on a detailed calculation, a statement to this effect.

4.2 Disclosure about Prescribed Assumptions or Methods—The actuary's communication should state the source of any prescribed assumptions or methods.

With respect to **prescribed assumptions or methods set by another party**, the actuary's communication should identify the following, if applicable:

- a. any **prescribed assumption or method set by another party** that significantly conflicts with what, in the actuary's professional judgment, would be reasonable for the purpose of the measurement (section 3.22.2); or
- b. any **prescribed assumption or method set by another party** that the actuary is unable to evaluate for reasonableness for the purpose of the measurement (section 3.22.3).

4.3 Additional Disclosures—The actuary should also include the following, as applicable, in an actuarial communication:

- a. the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and
- b. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

4.4 Confidential Information—Nothing in the standard is intended to require the actuary to disclose confidential information.

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

Appendix 1

Background, Current Practices, and Supplementary Information

Background

The original ASOP No. 6 was effective October 17, 1988. In addition, actuaries were provided guidance by Actuarial Compliance Guideline (ACG) No. 3, *For Statement of Financial Accounting Standards No. 106, Employers' Accounting for Postretirement Benefits Other Than Pensions (AGC No. 3)*, which 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*. (Note that effective in July 2009, FASB reorganized all U.S. GAAP into one codification. Accounting Standards Codification (ASC) 715-60—Compensation—Retirement Benefits—Defined Benefit Plans—Other Postretirement replaces SFAS No. 106.) Prior to the issuance of the accounting guidance currently included in ASC 715-60, 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 benefits obligations was an emerging practice area that would be new to many actuaries.

The measurement of retiree group benefits obligations continued to develop as an actuarial field within the profession. In 1999, the ASB determined that practice in this field had developed sufficiently to permit revision of ASOP No. 6. It 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 appropriate 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. A revised version of ASOP No. 6 was adopted by the ASB in December 2001.

The process of measuring retiree group benefits obligations is similar to the process of measuring pension obligations. Since the prior ASOP No. 6 was adopted, the ASB has adopted or revised the following standards that provide more detailed guidance regarding specific elements of the process of measuring retiree group benefits obligations:

1. ASOP No. 5, *Incurred Health and Disability Claims*;
2. ASOP No. 23, *Data Quality*;

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3. ASOP No. 25, *Credibility Procedures*;
4. ASOP No. 27, *Selection of Economic Assumptions for Measuring Pension Obligations*;
5. ASOP No. 35, *Selection of Demographic and Other Noneconomic Assumptions for Measuring Pension Obligations*;
6. ASOP No. 41, *Actuarial Communications*; and
7. ASOP No. 44, *Selection and Use of Asset Valuation Methods for Pension Valuations*.

In addition, ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*, was revised to create an “umbrella” standard to tie together the applicable standards for pension plans and address overall considerations for the actuary when measuring pension obligations.

Current Practices

This standard and the related standards listed in the Background section of this appendix 1 cover actuarial practices that are central to the work regularly performed by actuaries measuring retiree group benefits obligations. The actuarial tasks covered by the standards are performed for a number of purposes, examples of which are discussed below:

1. Periodic Cost, Plan Sponsor Actuarially Determined Contribution, and Benefit Recommendations—Calculations may be performed for purposes of determining actuarial periodic cost, plan sponsor actuarially determined contribution, and benefit recommendations and related information. Examples are calculations related to the following:
 - a. recommendations for the assignment of periodic costs or actuarially determined contributions to time periods for retiree group benefits programs;
 - b. recommendations for the type and levels of benefits for specified periodic cost or plan sponsor actuarially determined contribution levels;
 - c. plan sponsor actuarially determined contributions required under standards imposed by statute, regulations, or other third-party requirements;
 - d. maximum actuarially determined contributions deductible for tax purposes;
 - e. information required to evaluate alternative plan designs, assumptions, cost management programs, and provider networks; and
 - f. determination of progress toward a defined financial goal, such as funding of projected benefits or limiting annual plan cash expense.

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2. Evaluations of Current Funding Status—Calculations may be performed for purposes of comparing available assets to the actuarial present value of benefits (or a subset of those benefits) specified by the plan. Examples are calculations related to the following:
 - a. actuarial present value of current or future benefit accruals (to the extent retiree group benefits are accrued);
 - b. actuarial present value of benefits payable to currently retired participants or active participants eligible to retire; and
 - c. information required with respect to plan mergers, acquisitions, spin-offs, and business discontinuances.
3. Projection of Cash Flow—Calculations may be done for the sole purpose of projecting the annual cash flow of retiree group benefits obligations. Examples are calculations related to the following:
 - a. Time horizon to exhaust trust assets; and
 - b. Projections of participant contributions or changes in participant contributions.
4. Evaluations of the Impact of Government or Third-Party Funding—Calculations may be performed to estimate the effect on funding of government or third-party funding. Some examples of such funding are:
 - a. Retiree Drug Subsidy (RDS) program providing partial reimbursements to plan sponsors of drug benefits for Medicare-eligible retired participants;
 - b. Federal direct subsidy of Part D plans; and
 - c. Pharmaceutical manufacturer discounts on brand name drugs during the coverage gap.

Supplementary Information

Modeling of Retiree Group Benefits Obligations

The models used to value retiree group benefit obligations have become increasingly sophisticated. Models commonly use age-specific initial per capita health care costs 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 costs for the last year of life and for survivors.

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

1. Retiree group benefits eligibility requirements are often different from pension benefit eligibility requirements, so pension census data may not appropriately reflect retiree group benefits program 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 costs may not be appropriately taken into account;
5. A trend assumption that reaches the ultimate rate too quickly may not adequately reflect the structural upward pressures on medical costs;
6. Expected future participation rates may not reflect recent experience; or
7. The impact of expected future participant contribution increases on future participation and projected per capita claim costs of participants may not be appropriately reflected.

Possible Data Inconsistencies

As part of the development of the model, the eligibility and payment data received may conflict significantly with information received about known retiree group benefits program provisions or administration. 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 plan sponsor's indication of that method, or that the classification of the covered dependent is based on the retired participant's age.
2. Participant contributions before Medicare eligibility are so low that it is unlikely that plan sponsor subsidies are as limited as the plan sponsor may indicate.
3. The ratio of dependents to retired participants 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 dependent coverage is as stated, that coding of dependent ages is inaccurate, or that surviving dependents were coded as "retired participants."

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

Measurements Using Premiums

As defined in this standard, 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 retired participants is unlikely to be the same as for a group consisting of active participants and the same retired participants. Examples of this are shown in the "Participant Contributions" section below.

The term "premium" is commonly used for insured group plans and self-insured group plans. In the case of self-insured plans, the "premium" 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. Further comments about common types of retiree group benefits program premiums follow:

1. **Self-Insured Premiums**—Some self-insured plans have expenditures that the plan sponsor refers to as "premiums" or "premium rates." These premiums may reflect the experience of retired participants, active employees, or both. Also, the premiums may reflect only expected claims experience, or may include other adjustments (such as administrative expenses and stop-loss claims and premiums). Furthermore, the premiums may reflect the effect of the plan sponsor's contribution or managed care strategy. The premiums also may not reflect supplemental funding contributions not considered in the ratemaking process.
2. **Community-Rated Premiums**—In some regulatory jurisdictions, community-rated premiums are required by statute for some fully insured plans. There is variation in the structure of community-rated premiums. For example, retired participants not eligible for Medicare may be included with active employees in a community-rated premium category, while retired participants 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 retirees not eligible for Medicare and active employees probably understates the expected claim cost for the retirees alone.

There are many pooled health fund entities that provide contribution rates that are a blend of active employee and pre-Medicare retiree claim experience (and may also include

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Medicare retiree claim experience). Historically, similar types of funding arrangements have failed because their premium rating structure did not adequately reflect the risks of the enterprise. Since geography and demographics are key indicators of health care risk (and recognized by most of the new marketplace exchanges under the Patient Protection and Affordable Care Act, discussed in further detail below), many of today's pooled health funds may move to recognizing some variation of those risk characteristics.

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 comments above on self-insured premiums also apply here.

Interaction Between Trend and Plan Provisions

Plan provisions and health care trend rates in combination impact the projected net per capita health care costs. 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 program may cover a different mix of services than Medicare. Trend rates may differ between Medicare-covered services and the retiree group benefits.
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 group benefits programs work. Plan sponsors must advise participants and plan administrators of 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

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monthly contribution used in the measurements of retiree group benefits obligations. Here are two examples:

1. The plan sponsor's stated policy is that retired participants 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 \$200 per month (\$2,400 per year) based on average annual per capita health care claims of \$4,800 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 retired participant is \$8,000. So the plan sponsor subsidy is really \$5,600 or 70%, not the stated 50%.
2. A plan sponsor will pay a fixed subsidy of \$4,000 annually toward retiree health care coverage for retired participants who are not Medicare eligible. The plan sponsor determines an annual retiree contribution of \$1,000 based on average per capita claims of \$5,000 for active employees and pre-Medicare retired participants combined. However, when the actuary evaluates the claims experience for pre-Medicare retired participants, the average annual claims per retired participant is determined to be \$9,000. The actual plan sponsor subsidy is \$8,000 (\$9,000 average claims per retired participant less \$1,000 retiree contribution)—double the fixed subsidy of \$4,000.

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 costs, 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.

Health Care Reform Considerations

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The Patient Protection and Affordable Care Act (PPACA) was passed in the U.S. in March 2010 and includes many provisions that actuaries will need to consider in selecting assumptions in future valuations. Because the legislation was so comprehensive, it may be years before the impact of the new provisions result in a stable set of assumptions.

Key provisions of the PPACA that may affect retiree group benefits assumptions are:

Market Reforms. Several different requirements are imposed by the PPACA with varying effective dates. Whether these requirements apply will depend on if a plan is a retiree-only plan. These effective dates also may depend on whether a plan is grandfathered. Because these market reforms do not apply to retiree-only medical plans, whether plans being valued meet the definition of such a plan (basically, a separate legal plan, unique plan identification, and coverage for fewer than two active employees) is key.

Some plans are grandfathered from certain aspects of these market reforms if they do not significantly change the plan design from the date of PPACA enactment. The most common reason a retiree plan may lose its grandfathered status is if the employer's percentage subsidy for the plan is materially reduced. All plans with a cap on the subsidy provided by the plan sponsor or other entity will eventually fail grandfathered status.

Examples of PPACA changes required for all plans (except for retiree-only plans) include the following: having no lifetime limits; having no pre-existing condition exclusions; establishing out-of-pocket limits that include all benefits and do not exceed the limits on out-of-pocket costs for High Deductible Health Plans; and providing coverage for dependent children until age 26 (can have a greater relative impact on pre-65 retiree plans than on active employee plans).

Examples of additional market reforms required for non-grandfathered plans include the following: providing coverage of preventive health care with no cost sharing; satisfying non-discrimination requirements for all medical plans; and providing the same coverage for emergency services regardless of network status.

The above reforms may significantly impact the appropriate level of starting health care claims costs as well as cost trends.

Medicare Advantage. Government payments to Medicare Advantage plans are generally reduced from those payable under prior law. These plans also must meet the same minimum loss ratio requirements that apply to other plans (greater than 85 percent). In addition, payments will be tied to quality measures and beneficiary satisfaction ratings. These changes may affect health care claims costs, trend rates, and plan participation.

Retiree Drug Subsidy. Prior law allowed the plan sponsor to receive retiree drug subsidies (RDS) from the government tax-free and not reduce its actual pharmacy costs by the amount of the retiree drug subsidy received in determining its tax-deductible benefit cost. PPACA requires the employer to reduce its actual tax deduction for pharmacy costs by the amount of the retiree drug subsidy received, effectively eliminating the tax advantage of the RDS program for many

for-profit employers. FASB required this part of the legislation be reflected in financial statements for private employers as soon as the impact could be determined.

The elimination of the tax-favored RDS has led many plan sponsors to reevaluate alternative pharmacy designs and funding to yield financially better results. Any changes the plan sponsor makes may impact the valuation assumptions and methods, including eliminating the tax asset adjustments made for current RDS payments, adjusting future trends, and adjusting claim costs for anticipated design changes.

Part D Employer Group Waiver Plans (EGWPs). PPACA improved the Medicare Part D standard benefit by closing the coverage gap (also known as the “donut hole”) by 2020. This change should result in larger direct subsidy payments to Part D plans than under the previous law. However, because of the complexity of the calculation of the payments to the Part D plans, the actuary will need to work closely with the Part D plan to estimate the size and growth pattern of these Part D payments.

High Cost Plan Excise Tax. The PPACA imposes a non-deductible excise tax beginning in 2018 on plans that exceed specified dollar thresholds. For 2018, the threshold for single coverage is \$10,200 (may be adjusted depending on cost trends from 2014). For individuals aged 55 to 64, an additional \$1,650 is added to the threshold. Retirees with family coverage have thresholds of \$27,500 and an additional \$3,450. The thresholds are indexed to general inflation after 2018. Many health plans will eventually exceed these thresholds over typical projection periods and, therefore, the liabilities could include payment of the tax plus any gross-up of the tax that might be charged by the insurer.

Health Exchanges. Health exchanges (or Public Marketplaces) became available beginning in 2014. These new exchanges made available health insurance coverage for individuals who are not eligible for Medicare. Some plan sponsors may terminate current coverage or utilize the new options in their retiree benefit offerings. This may require changes to costs or the anticipation of selection of different plan options. Considerations may be similar to those involved in the current treatment of private exchanges for Medicare beneficiaries.

Appendix 2

Comments on the Second Exposure Draft and Responses

The second exposure draft of this revision of ASOP No. 6 now titled, *Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions*, was issued in March 2013 with a comment deadline of August 30, 2013. Thirteen comment letters were received, some of which were submitted on behalf of multiple commentators, such as by firms or committees. For purposes of this appendix, the term “commentator” may refer to more than one person associated with a particular comment letter.

The Retiree Group Benefits Subcommittee carefully considered all comments received and the subcommittee, Pension Committee, and ASB reviewed (and modified, where appropriate) the proposed changes.

In addition, comments were received on the second exposure draft of the revision of ASOP No. 4, *Measuring Pension Obligations and Determining Pension Plan Costs or Contributions*. In areas where parallel language is included in ASOP Nos. 4 and 6, changes made to ASOP No. 4 in response to those comments are reflected in this revised standard.

Summarized below are the significant issues and questions contained in the comment letters and the responses.

The term “reviewers” in appendix 2 includes the subcommittee, the Pension Committee, and the ASB. Also, unless otherwise noted, the section numbers and titles used in appendix 2 refer to those in the second exposure draft.

| GENERAL COMMENTS | |
|-------------------------|---|
| Comment | One commentator suggested that the word “cost” in connection with per capita health costs could be confused with the other uses of the word “cost.” |
| Response | The reviewers note that this usage is common in connection with retiree group benefits programs and that the standard specifically defines “periodic cost,” which is in bold letters wherever it is used, to reduce confusion. The reviewers, therefore, made no change. |
| Comment | A few commentators opined that retiree group benefit actuaries serve clients and not the public at large. In this view: <ul style="list-style-type: none">• Actuaries serve clients and prepare work for the client’s benefit and at the client’s behest;• No party other than the client should expect to benefit or draw any inference from the actuary’s work;• Other entities in society provide regulations that serve the public interest;• As a result of the prior bullets, the standards should not require any work or disclosure that is intended to benefit interested parties in the public at large. |
| Response | The reviewers considered this viewpoint but concluded the current paradigm for self-governance established by the <i>Code of Professional Conduct</i> requires the ASOPs to reflect the profession’s responsibility to the public and made no change. |

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| SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE | |
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| Section 1.1, Purpose | |
| Comment | One commentator suggested that benefit payment projections should be mentioned in this section. |
| Response | The reviewers note that cash flow projections are included in the scope of the standard in section 1.2 and made no change. |
| Comment | One commentator suggested that “defined dollar programs or programs containing health retirement accounts” as well as “executive health and/or fringe benefits for retired executives” should be included. |
| Response | The reviewers note that these are examples of retiree group benefits programs and do not need to be explicitly mentioned, and made no change. |
| Section 1.2, Scope | |
| Comment | One commentator suggested that the standard say that it does not apply to individual benefit calculations or nondiscrimination testing. |
| Response | The reviewers believe that the description of the scope of the standard was sufficiently clear and made no change. |
| Section 1.4, Effective Date | |
| Comment | One commentator expressed the opinion that using roll-forward techniques would not be appropriate for measurements performed in actuarial work covered by this standard. |
| Response | The reviewers considered this comment, noted that using roll-forward techniques was a common and appropriate practice in this area, and did not change the language. |
| SECTION 2. DEFINITIONS | |
| Comment | One commentator suggested that the word “group” be defined or be replaced by “population” or “covered population.” |
| Response | The reviewers note that the use of the word “group” in the context of “group being valued” is expected to be understood by the users of the standard and that it might not be the same as the “covered population,” and made no change. |
| Comment | One commentator suggested that the term “obligations” should be defined as this term is used in the title of the standard and throughout the standard. |
| Response | The reviewers believe that the common understanding of this term is sufficient for the purposes of the standard and made no change. |
| Comment | One commentator suggested that the phrase “implicit subsidy” be defined. |
| Response | The reviewers believe that the concept of “implicit subsidy” is commonly understood and made no change. |
| Section 2.9, Benefit Plan | |
| Comment | One commentator suggested changing “Benefit Plan” to “Retiree Benefit Plan,” “Benefit Plan Member” to “Retiree Benefit Plan Member,” and “Benefit Option” to “Retiree Benefit Option.” |
| Response | The reviewers note that while the ASOP covers only retiree group benefits, benefit plans might cover both actives and retirees, and made no change. |

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|---|--|
| Section 2.11, Contingent Participant | |
| Comment | One commentator suggested that this definition is not needed as the defined word “participant” includes “contingent participant.” |
| Response | The reviewers agree with this suggestion and made the proposed change. |
| Section 2.13, Cost Allocation Procedure | |
| Comment | One commentator suggested changes to the definition. |
| Response | The reviewers agree with most of the suggestions and also made other minor modifications to improve clarity. |
| Section 2.14, Covered Population | |
| Comment | One commentator suggested that the phrase “participating dependents” was redundant and confusing. This commentator also asked whether the term “participant” includes “dependents.” |
| Response | The reviewers note that “participants” was intended to include all individuals who are receiving or are reasonably expected to receive benefits coverage and therefore would include “dependents.” In the standard the word “participant” is occasionally modified by the word “active” or “retired” to distinguish a specific type of “participant” from a “dependent.” The reviewers modified the definition of “participant” to explicitly include a “dependent.” |
| Section 2.16, Dependents | |
| Comment | One commentator indicated that it wasn’t clear if yet-to-be-identified dependents were included and proposed language to make it clear that they were included in the definition. |
| Response | The reviewers agree and made the proposed change. |
| Section 2.19, Immediate Gain Actuarial Cost Method | |
| Comment | One commentator questioned the need to define this term. |
| Response | The reviewers note that it was included because of the disclosure requirements concerning “funded status” and to be consistent with ASOP No. 4, <i>Measuring Pension Obligations and Determining Pension Plan Costs or Contributions</i> , and made no change. |
| Section 2.20, Market-Consistent Present Values | |
| Comment | One commentator suggested deleting the phrase “that are expected.” Another commentator asked if it was possible to reflect risk loading or adjustments due to uncertainty in the benefit payments. |
| Response | The reviewers revised the definition to be consistent with the definition in ASOP No. 4. The reviewers made no further change. |
| Section 2.23, Medicare Integration | |
| Comment | One commentator suggested changing “health plan” to “retiree group benefits program” or to “benefit plan.” |
| Response | The reviewers agree and changed “health plan” to “benefit plan.” |
| Section 2.27, Participant Contributions | |
| Comment | One commentator suggested changes to the definition to clarify the intent. |
| Response | The reviewers agree that the definition could have been clearer and made changes to the language to clarify the meaning of the phrase “participant contributions.” |

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| Section 2.30, Pooled Health Plan | |
| Comment | One commentator suggested several changes to improve the clarity of the definition. |
| Response | The reviewers agree with some of the proposed changes, disagree with others, and made further changes to improve clarity. |
| Comment | One commentator suggested replacing “health care cost trend rate assumption” with “health care trend assumption.” |
| Response | The reviewers disagree, noting that including the words “cost” and “rate” help improve the clarity, and made no change. |
| Section 2.32, Premium | |
| Comment | One commentator noted that the “definition of premium as a price incorporates the idea of premium as a rate” and so suggested that throughout the standard the word “premium” be used instead of “premium rate.” |
| Response | The reviewers agree with the suggestion and made the proposed change throughout the standard. |
| Section 2.37, Spread Gain Actuarial Cost Method | |
| Comment | One commentator questioned the need to define this term. |
| Response | The reviewers note that it was included because of the disclosure requirements concerning “funded status” and to be consistent with ASOP No. 4, and made no change. |
| Section 2.40, Trend | |
| Comment | One commentator suggested that the definition not include the word “expected” because trend can also refer to a past change in payment levels. The commentator suggested other related changes. |
| Response | The reviewers agree with the suggestion of deleting the word “expected” but made no other changes. |
| Comment | One commentator suggested that based on the definition of “trend,” in the phrase “trend rate,” the word “rate” was redundant and should be deleted throughout the standard. |
| Response | The reviewers believe that including the word “rate” after “trend” improves the clarity of the guidance and made no change. |
| SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES | |
| Section 3.3, Purpose of Measurement | |
| Comment | One commentator suggested that projections of benefit payments be included in the list of examples. |
| Response | The reviewers note that the list of examples is not intended to be exhaustive and is similar to the list included in ASOP No. 4. The reviewers, therefore, made no change. |
| Section 3.3.3, Risk or Uncertainty | |
| Comment | One commentator noted that ASOP No. 41, <i>Actuarial Communications</i> , refers to “Uncertainty or Risk” and suggested that the heading of this section be changed accordingly. The commentator also questioned this section’s inclusion given the guidance in ASOP No. 41. |
| Response | The reviewers agree with the proposed change in the heading of the section. They note that considering the uncertainty or risk inherent in a measurement for retiree group benefit purposes is important and the reinforcement of the guidance provided in ASOP No. 41 would be useful to the actuary and retained this section. |

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| Section 3.4.1, Information as of a Different Date | |
| Comment | One commentator felt that this guidance is redundant since the actuary was required in other parts of the standard to make appropriate adjustments. The commentator also felt that this section could be moved to section 3.24 on Roll-Forward Techniques. |
| Response | The reviewers considered the comments and concluded that the placement of the guidance in this section was appropriate in the sequence of items that an actuary should consider in measuring obligations, periodic costs, or actuarially determined contributions, since data may be as of different dates within a valuation year. Also, section 3.24 provides guidance on adjusting results to future valuation dates. Therefore, no change was made. |
| Section 3.5.1(d), Participant Contributions | |
| Comment | One commentator questioned whether a “participating dependent” was included or not. |
| Response | The reviewers note that the definition of “participants” has been modified to make it clear that it includes “participating dependents,” and, therefore, made no change to the definition of “participant contributions.” |
| Section 3.5.1(d)(2), Participant Postretirement Contribution Reasonableness | |
| Comment | One commentator suggested that the concept of “implicit subsidy” could be introduced here. |
| Response | The reviewers believe that the concept of “implicit subsidy” is commonly understood and applies in other parts of the standard as well, and made no change. |
| Section 3.5.1(d)(3), Preretirement Active Employee Contributions | |
| Comment | One commentator opined that the distinction among the different types of contributions could be clarified. |
| Response | The reviewers believe that the difference between pre-retirement active employee contributions and other types of contributions is sufficiently clear, and made no change. |
| Section 3.5.1(d)(4), Participant Contributions as Defined by Limits on Plan Sponsor Costs | |
| Comment | Several commentators suggested changes in this section to make it clearer. |
| Response | The reviewers agree and revised this section to make the guidance clearer. |
| Section 3.5.1(e), Payments from Other Sources | |
| Comment | One commentator asked for clarification on the guidance provided in this section. |
| Response | The reviewers modified the language to make the guidance clearer. |
| Section 3.5.1(f), Health Care Delivery System Attributes | |
| Comment | One commentator suggested that the considerations implied by the example might place an unrealistic burden on the actuary and asked for clarification. |
| Response | The reviewers agree that the example might mislead users of the standard and, therefore, deleted it. |

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| Section 3.5.1(g), Benefit Options | |
| Comment | One commentator noted that the language might be unduly restrictive for several reasons, including a) new benefit options might reduce participant contributions or periodic costs as well as increase them, and b) the actuary may want to consider the effect of benefit options on participants' behavior and adverse selection. |
| Response | The reviewers agree and deleted the relevant language to address the concerns raised by the commentator. |
| Section 3.5.1(h), Anticipated Future Changes | |
| Comment | One commentator suggested changing the phrasing "the actuary should consider only changes..." The commentator also thought that the last sentence cross-referencing the disclosure requirement was redundant. |
| Response | The reviewers agree that "should consider" is not the appropriate language to use in this situation and revised it to "should reflect." To be consistent, later in the section the language "may take into account" was revised to "may reflect." The reviewers believe that reinforcing the disclosure requirement in this section is particularly important in this circumstance and left the cross-reference to the disclosure requirements in the standard. |
| Section 3.5.2(b), Patterns of Plan Changes | |
| Comment | One commentator suggested that changes similar to those recommended in section 3.5.1(d)(4) be made in this section. |
| Response | The reviewers agree and made those changes. |
| Section 3.5.2(c), Governmental Programs | |
| Comment | One commentator thought that the use of "historically enacted" in this section seems to suggest that the actuary has to anticipate more legislative or administrative policy changes based on history and recommended that the section be deleted or clarified. |
| Response | The reviewers added language to clarify the intent that this section applies to patterns of changes consistent with section 3.5.2(b). |
| Section 3.5.3, Reviewing the Modeled Retiree Group Benefits Program | |
| Comment | One commentator felt that it was inappropriate for the responsibility to determine whether the deviation was temporary or permanent to be with the actuary. The commentator recommended that the standard should require the actuary to discuss the actuary's finding of deviation with the plan sponsor to seek guidance concerning the deviation. |
| Response | The reviewers note that nothing in the standard precludes the actuary from talking to the plan sponsor and gathering more information to make this determination and that guidance regarding administrative inconsistencies is provided in section 3.10. The reviewers, therefore, made no change. |

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| Section 3.6, Modeling the Covered Population | |
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| Comment | One commentator felt that the “access only” situation should be mentioned in the standard and that guidance is needed on whether there is a responsibility to determine whether the participant is in fact paying for the entire value of the benefits received. |
| Response | The reviewers believe that there is sufficient guidance in the standard to cover an “access-only” situation and made no change. |
| Section 3.6.1, Census Data | |
| Comment | One commentator suggested that the language in this section be revised to be more consistent with the language in section 3.12.3(a) and other places in the standard. |
| Response | The reviewers agree and modified the language to be more consistent. |
| Section 3.6.4, Dependents and Surviving Dependents of Participants | |
| Comment | Several commentators suggested changes in the language in this section regarding “dependents.” |
| Response | The reviewers revised the language in this section to clarify the intent and make it more consistent with the use in other parts of the standard. |
| Comment | One commentator thought that the first sentence of the second paragraph was redundant because the first paragraph refers to spouses and surviving spouses. |
| Response | The reviewers note that the first paragraph provides general guidance on the treatment of all dependents, both spouses and dependent children while the first sentence of the second paragraph provides specific guidance on the treatment of spouses and the second sentence of that paragraph provides specific guidance on the treatment of dependent children. The reviewers, therefore, made no change. |
| Section 3.6.6, Use of Grouping | |
| Comment | One commentator suggested revising the disclosure requirement to “...should consider disclosing, if significant....” |
| Response | The reviewers believe it is important to disclose the specifics regarding the combining of health plans and grouping of populations so that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the combining and grouping. They also note that, as provided for in ASOP No. 1, <i>Introductory Actuarial Standard of Practice</i> , the standards do not apply to items that are immaterial. Therefore, no change was made. |
| Section 3.6.7, Hypothetical Data | |
| Comment | One commentator suggested that several examples could be added to this section. |
| Response | The reviewers believe that examples are not needed and made no change. |

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| Section 3.7, Modeling Initial Per Capita Health Care Costs | |
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| Comment | One commentator thought there was the potential of confusion with the use of the word “cost” and suggested changing the phrase to “per capita health care rates.” |
| Response | The reviewers note that “per capita health care costs” is a well-understood term among actuaries in this area and that “costs” is used consistently throughout the standard and understood in that context. They further note that “periodic cost” is now a defined term in both ASOP Nos. 4 and 6, and usually refers to accounting expense. As a result, the reviewers made no change. |
| Section 3.7.1(a), Paid Claims | |
| Comment | One commentator suggested changing “should analyze” to “should consider analyzing” for several reasons including the fact that the data available may not be sufficient for analysis. |
| Response | The reviewers agree and made the change. |
| Section 3.7.4, Credibility | |
| Comment | One commentator noted that this section does not provide a threshold definition other than “fully credible” and expressed concern that references to ASOP No. 25, <i>Credibility Procedures</i> , may need to change depending on the final version of that standard. |
| Response | The reviewers note that “full credibility” is defined in ASOP No. 25, and made no change. |
| Section 3.7.6, Impact of Medicare and Other Offsets | |
| Comment | One commentator suggested replacing the phrase “health plan” by “retiree group benefits program” or “benefit plan.” |
| Response | The reviewers agree and replaced the phrase “health plan” by “benefit plan.” |
| Comment | One commentator noted that the guidance regarding other offsets doesn’t pertain to Medicare and might be better if located differently. |
| Response | The reviewers agree and included the guidance regarding other offsets in a separate paragraph at the end of the section. |
| Comment | One commentator suggested changing the phrase “should be aware” to “should consider” in the paragraph concerning changes in Medicare. In addition, the commentator noted that it was not the magnitude of the changes in Medicare programs but the impact that those changes had on the retiree group benefits program that was important for purposes of the standard. |
| Response | The reviewers agree and made changes to reflect these considerations. |
| Section 3.7.7, Age-Specific Costs | |
| Comment | One commentator suggested moving some of the guidance included in section 3.7.8, Pooled Health Plans (Including Community-Rated Plans), into this section as it applied in general and not just to those types of plans. |
| Response | The reviewers agree and combined sections 3.7.7 and 3.7.8 into one section. The general guidance that had been included in sections 3.7.7 and 3.7.8 is now in the new section 3.7.7(a). |

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| Section 3.7.8, Pooled Health Plans (including Community Rated Plans) | |
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| Comment | Several commentators suggested that individual circumstances needed to be taken into account in determining whether the pooled health plan’s premium would be appropriate for use without adjustment for age. |
| Response | The reviewers agree that it would be appropriate to provide more guidance regarding the limited circumstances for using unadjusted premium rates. As noted earlier, sections 3.7.7 and 3.7.8 were combined into one section. The new section 3.7.7(c) clarifies the guidance regarding the limited circumstances for using unadjusted premium rates. |
| Comment | Several commentators suggested that in cases where the cost of coverage is borne by a large independent community, the use of an unadjusted premium should be allowed if the aging or demographic distribution of the individual employer’s population would not affect the program’s premiums, such as for many small public sector plans. |
| Response | The reviewers believe that implicit subsidies do exist within pooled health plans and that such subsidies should be recognized in valuations of retiree group benefits by incorporating age-specific costs in the measurement, except in some very limited cases. Thus the reviewers believe that the use of age-specific costs will generally result in a more appropriate representation of the employer’s long term liabilities for retirees than the use of unadjusted premiums. They point out that there is no guarantee that the current premium structure or the pooled health plan will continue over the long term nor that the employer will continue or be allowed to continue in the pool and that the value of employer’s benefit commitment independent of the method used to provide that benefit is the most appropriate basis for valuing the liability, except in some very limited cases. Accordingly, the reviewers added more guidance throughout section 3.7.7, which now also includes the guidance contained in section 3.7.8 of the second exposure draft. |
| Comment | Several commentators were concerned that by using age-specific costs for groups participating in a pooled health plan: <ul style="list-style-type: none"> • accounting liabilities could be too large considering the cash flows; and • the liability might not be defeased by contributions/expenses when all assumptions were met. |
| Response | The reviewers agree that year-to-year differences between cash flows/contributions based on premium and age-specific costs may occur, but believe that it is appropriate to measure the employer’s long term benefit obligation based on a projection of age-specific costs. As noted previously, the reviewers clarified the guidance, including a description of factors that the actuary should consider in determining whether the use of the premium may be appropriate without regard to adjustments for age. |
| Comment | Several commentators agreed with the use of age-specific costs, but suggested that the standard should state explicitly that an adjustment be made to recognize in the liability calculation the age-specific subsidies (both positive and negative) from other employers, and that if this were not done the liability would be either too large or too small depending on the average age of the group relative to that of the pool. |
| Response | The reviewers note that all employers participating in a pooled health plan share in the collective risks and costs (some positive and some negative). As such, the reviewers believe developing a set of age-specific costs based on the total pooled health plan to measure retiree health benefits for any and all participating employers is appropriate, except in very limited circumstances as set forth in the standard. In other words, absent evidence to the contrary, the reviewers do not believe that non-guaranteed subsidies should be assumed to persist indefinitely. The reviewers, therefore, made no change. |

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| Comment | Several commentators suggested that information would not be available to make an accurate determination of a pooled health plan’s age-specific costs. |
| Response | The reviewers believe that either sufficient information will be available or reasonable assumptions and approximations can be developed for the actuary to make a reasonable determination of the pooled health plan’s age-specific costs. The reviewers, therefore, made no change. |
| Comment | One commentator suggested several clarifications in the guidance regarding what the actuary should do if a distribution table for the pooled health plan is not available. |
| Response | The reviewers agree that the intent of the guidance was not clear and revised this language to clarify that the actuary may either make a reasonable assumption regarding the distribution or base the age-specific costs on manual rates or other sources. |
| Comment | One commentator suggested the standard be more explicit in encouraging the use of the individual group’s own demographic distribution in developing the age-specific costs for those groups taking part in a pooled health plan. |
| Response | The reviewers note that pooled plans develop premiums in a wide variety of ways. The reviewers recognize that some pooled health plans charge participating groups premiums that are explicitly based in part on the composition of the given employer (whether influenced by claims or age distribution or another factor). The guidance provides that, to the extent appropriate, the composition of the group being valued should be taken into account when developing and applying age-specific costs. The reviewers, therefore, made no change. |
| Comment | One commentator suggested that several areas of guidance included in section 3.7.8 are more general in nature than indicated by the title of that section and might be more appropriate in section 3.7.7. |
| Response | The reviewers agree and, as noted earlier, combined sections 3.7.7 and 3.7.8, expanded the guidance in section 3.7.7(a) to cover certain points raised by the commentator, and removed the corresponding guidance from section 3.7.7(b). |
| Comment | One commentator suggested that, in the second paragraph of section 3.7.8, the term “premium equivalent” be replaced with “premium” and questioned why there was no reference to self-insured plans in that context. |
| Response | The reviewers agree and replaced the phrase “premium equivalent” with “premiums.” The reviewers note that the phrase “claims costs” covers the situation of a self-insured plan and, therefore, no reference is needed. |
| Comment | One commentator suggested that, in the third paragraph of section 3.7.8, the phrase “distribution table for” be replaced with “age distribution of.” |
| Response | The reviewers made no changes to the references to distribution tables because they believe the actuary should have the option of using distribution tables by both age and gender. |
| Comment | One commentator felt that the example in section 3.7.8 regarding Medicare Advantage Plans was confusing. The commentator noted that although for a Medicare Advantage plan itself the use of the premium without regard to adjustments for age could be appropriate, for a Medicare Advantage-Prescription Drug (“MA-PD”) program the prescription drug portion of the benefits should be adjusted for age. |
| Response | The reviewers agree the example could be confusing and deleted it. |

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| Comment | One commentator suggested that comments regarding this section made after the first exposure draft were not carefully reviewed. |
| Response | The Retiree Group Benefits Subcommittee, the Pension Committee, and the ASB carefully considered the comments made after the first exposure draft and took the comments into consideration when preparing the second exposure draft. |
| Comment | One commentator suggested that the reviewers' rationale for decisions regarding section 3.7.8 comments be more fully explained. |
| Response | Responses to commentators' exposure draft comments are meant to be brief in nature but to capture the essence of the issue and the decisions made. The reviewers have included more detailed responses in this section of the appendix to provide more context for the guidance in the final ASOP. |
| Comment | One commentator suggested that the guidance was not in any way reflective of the environment in which actuaries work. |
| Response | The members of the subcommittee regularly practice in, and drafted the guidance to reflect, all areas of retiree group benefits, including: public sector plans; private sector plans; funded and unfunded plans; small and large plans; and small employers and large employers. The guidance reflects the fact that there can be a number of different purposes of the measurement, including, but not limited to, funding and accounting requirements. |
| Section 3.7.10(b), Enrollment Practices | |
| Comment | One commentator suggested that instead of the general word "effect" in the phrase "effect... have had on health care practices," the standard should specify what types of effects the actuary should consider, such as adverse selection. |
| Response | The reviewers believe that the items that the actuary should consider should not be limited to adverse selection, as there could be other effects depending on the circumstances of the retiree group benefits program, and made no change. |
| Section 3.7.12, Adjustment for Trend | |
| Comment | One commentator recommended that the language regarding the basis for the adjustments for trend should require the actuary to take into account experience from outside the health plan. |
| Response | The reviewers note that in some situations it may be appropriate to consider only the experience of the health plan and made no change. |
| Section 3.7.15, Administrative Expenses | |
| Comment | One commentator noted that there are other expenses such as PPO access fees and stop-loss premiums and suggested that this section should also make reference to other non-administrative expenses. |
| Response | The reviewers agree, and made changes to the section heading and throughout the section. |

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| Section 3.11, Other Information from the Principal | |
| Comment | One commentator questioned the inclusion of this section and indicated that “accounting election” is unclear. |
| Response | The reviewers believe the guidance in this section has relevance to several other sections and therefore included it in its own section. The reviewers made edits to clarify the language. |
| Section 3.12.1, Economic Assumptions | |
| Comment | One commentator noted that part of the reference to an accounting standard was missing. |
| Response | The reviewers agree and corrected the reference. |
| Section 3.12.1(a), Health Care Cost Trend Rate | |
| Comment | One commentator recommended that the paragraph be revised to account for the common usage of the SOA-Getzen model. |
| Response | The reviewers believe that the guidance is consistent with the use of the SOA-Getzen model but believe that the standard should not mandate a specific model and, therefore, did not include a reference to it in the guidance. |
| Comment | One commentator suggested revising the guidance regarding the select period, noting that there may be times when health care cost trend rates could reasonably be expected to increase for a short period of time before declining. |
| Response | The reviewers agree and revised the language to make it clearer that the trend rates could increase during the select period. |
| Comment | One commentator suggested moving the sentence regarding the development of an initial trend assumption from the third paragraph to the beginning of the second paragraph so that it would be before the guidance on selecting the long-term trend assumption. |
| Response | The reviewers agree and made the proposed change. |
| Comment | One commentator suggested deleting the words “cost” and “rate” in this section. |
| Response | The reviewers believe that including those words provide clarity and left them in the standard. The reviewers did change the word “rate” to “rates” to reflect the fact that there generally is not one trend rate. |
| Comment | One commentator suggested changing “the appropriate length of a select period” to “an appropriate length...” to avoid implying that there is one and only one length that the actuary could use. |
| Response | The reviewers agree and revised the section. |
| Comment | One commentator felt that “relevant long-term economic factors” may not clarify whether the projections are those of the actuary, of those who are responsible for the retiree group benefit program, or of other sources such as national agencies and suggested that additional guidance be provided. |
| Response | The reviewers believe the guidance provided is sufficiently clear and made no change. |

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| Comment | One commentator felt that the sentence, “The actuary should select a transition pattern and select period that reasonably reflects anticipated experience,” was redundant and should be deleted. The commentator also felt that asking an actuary to choose a select period that reasonably reflects anticipated experience goes beyond what should be expected from a trend assumption that may exceed 50 years. |
| Response | The reviewers disagree and made no change, believing that the sentence is not redundant and it is reasonable to require the actuary to consider what is likely to happen to trend over the long term. |
| Comment | One commentator suggested moving the entire economic section of ASOP No. 6 to ASOP No. 27, <i>Selection of Economic Assumptions for Measuring Pension Obligations</i> . |
| Response | The reviewers feel that including this guidance in the standard is useful and more convenient to the actuary working in this practice area as the economic assumptions applied can have consequences for the demographic assumptions used (for example, enrollment assumption) and made no changes. |
| Comment | One commentator suggested that the sentence regarding annual or lifetime maximums might be more appropriate in the section dealing with the modeling of plan provisions and suggested moving to section 3.5.1(c). |
| Response | The reviewers agree that guidance regarding annual or lifetime maximums would be more appropriate in section 3.5.1(c) and expanded the guidance in that section to cover annual and lifetime maximums. |
| Section 3.12.1(b), Other Cost Change Rates | |
| Comment | One commentator noted that section 2.9 references “long-term care” but not “long-term care insurance” and suggested deleting the word “insurance.” |
| Response | The reviewers note that these are examples of types of benefits that may be affected by other economic factors and made no change. |
| Section 3.12.1(c), Participant Contribution Changes | |
| Comment | One commentator felt that this language may be construed as applying only to situations in which a cap on benefits has not yet been placed and suggested adding: “In cases in which a plan has a cap on benefits already in place, the actuary should consider modeling participant contributions based on the provisions of the Retiree Group Benefits Program and on communications to participants which describe application of the cap.” |
| Response | The reviewers believe that the situation described by the commentator is covered by the first sentence of this section and made no change. |
| Section 3.12.1(d), Adverse Selection | |
| Comment | One commentator noted that “adverse selection” is not a “process” and that the word can be deleted, particularly since adverse selection is a defined term. |
| Response | The reviewers agree and made the change. |
| Section 3.12.2(d), Mortality | |
| Comment | One commentator made suggestions on revising the language in this section to discuss the interaction with trend rates. |
| Response | The reviewers believe that the language is sufficiently clear and made no change to reference the effect of trend rates. They did clarify the language to reference death benefits in addition to health care costs. |

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| Section 3.12.3(b), Dependent Coverage | |
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| Comment | One commentator suggested adding the word “materially” in connection with the guidance concerning the gender mix of participants. |
| Response | The reviewers note that ASOP No. 1 states that the guidance in ASOPs need not be applied to immaterial items and made no change. |
| Section 3.12.4, Effect of Retiree Group Benefits Program Design Changes on Assumptions | |
| Comment | One commentator suggested several changes to and a reordering of the language in the second paragraph of this section. |
| Response | The reviewers believe that the language is sufficiently clear as written and made no change. |
| Sections 3.14, Measuring the Value of Accrued or Vested Benefits | |
| Comment | One commentator suggested deleting this section as this type of calculation is not common for these types of valuations. |
| Response | The reviewers agree that the measurement of accrued or vested benefits is less common for these valuations than for pensions but note that the guidance is useful for those situations in which such a calculation is required and did not delete the section. |
| Comment | One commentator suggested that more guidance be provided and proposed several text edits, including moving 3.14(e), “whether or the extent to which any retiree group benefits are accrued or vested” to the introductory paragraph of 3.14. |
| Response | The reviewers believe that the level of guidance is appropriate and did not add more guidance. The reviewers did reorder the list of items that the actuary should consider. The reviewers added language to the section that indicates that in many situations these benefits are neither vested nor accrued. The reviewers did not make any other of the proposed changes. |
| Comment | Several commentators suggested deleting references in the section to “accrued or vested” as many retiree group benefit programs do not define these terms. One commentator suggested adding a paragraph describing how “the meaning of accrued or vested as defined by plan sponsors and their legal counsel” might “differ from the meanings used by the actuarial community.” |
| Response | The reviewers note that the guidance in this situation applies only where the scope of the assignment requires an actuary to do this type of calculation and that many factors might determine whether benefits are considered accrued or vested, including the purpose of the measurement. They believe that the language provides the appropriate balance between guidance and flexibility for the actuary to deal with specific situations and, therefore, made no change. |
| Comment | One commentator suggested adding “employment contracts” after the reference to plan provisions. |
| Response | The reviewers note that the guidance in section 3.5 discusses the identification of the relevant plan provisions and feel that the language in that section is broad enough to include employment contracts. Therefore, the reviewers made no change. |
| Section 3.14(g), Measuring the Value of Accrued or Vested Benefits | |
| Comment | One commentator suggested adding “changes in retiree group benefits eligibility” to the list in this section. |
| Response | The reviewers note that the list in this section gives examples of factors for the actuary to consider and is not intended to be exhaustive, and made no change. |

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| Section 3.15, Market-Consistent Present Values | |
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| Comment | One commentator suggested that the phrase “benefits earned” be changed to something else as “benefits earned” is not defined. |
| Response | The reviewers note that depending on the purpose of the measurement the definition of “benefits earned” could vary, and made no change. |
| Section 3.17, Actuarial Cost Method | |
| Comment | In response to the question asked in the transmittal letter to the second exposure draft, several commentators indicated that the description of an actuarial cost method in the second exposure draft of ASOP No. 4 was preferable to that included in the second exposure draft of ASOP No. 6, while one commentator preferred the version in the second exposure draft of ASOP No. 6. |
| Response | The reviewers concluded that ASOP Nos. 4 and 6 should use the same definition of a reasonable actuarial cost method and revised the guidance to be consistent with that included in the revised version of ASOP No. 4. |
| Section 3.18, Allocation Procedure | |
| Comment | One commentator expressed the opinion that the requirement to consider relevant input received from the principal was inconsistent with the paragraph in section 1.2 indicating that the standard “does not require the actuary to evaluate the ability of the plan sponsor to make prefunding contributions to the plan when due.” |
| Response | The reviewers disagree and made no change. |
| Comment | One commentator suggested that the term “principal” be replaced by “plan sponsor.” |
| Response | The reviewers note that “principal” is defined in ASOP No. 1 and is more appropriate in this context than “plan sponsor.” Therefore, no change was made. |
| Comment | One commentator said that section 3.18.1 and 3.18.2 appear to presuppose that the objective of prefunding contributions is to accumulate assets sufficient to pay future benefits. The commentator noted that that may not be the plan sponsor’s objective and expressed the opinion that it would not be necessary for the actuary to perform the analysis described. The commentator suggested alternative language to the section and the disclosure requirements. |
| Response | The reviewers believe that the analysis required of a contribution allocation procedure and the related disclosure requirements concerning the funding of the retiree group benefits program are appropriate and made no change. |
| Sections 3.20, Volatility | |
| Comment | One commentator suggested adding a reference to the initial per capita health care costs as a source of possible volatility, noting that there can be significant changes from one year to the next. |
| Response | The reviewers agree and expanded the example of changes in assumptions to include initial per capita health care costs. |
| Comment | One commentator suggested adding a disclosure of the rationale for the range selected in assumptions for the purpose of analyzing the potential volatility of the results. |
| Purpose | The reviewers believe that the disclosure requirements are sufficient and made no change. |

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| Sections 3.21, Reasonableness of Results | |
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| Comment | One commentator noted that a similar section is not included in ASOP No. 4 and questioned its inclusion in ASOP No. 6. |
| Response | In light of the varied and complex assumptions unique to retiree group benefit valuations, the reviewers believe that requiring this analysis for reasonableness is appropriate and made no change. |
| Comment | One commentator suggested that the actuary should document the likely causes of the differences identified in this analysis. |
| Response | The reviewers revised the language in this section, including adding that the actuary “should consider documenting, if appropriate, the likely causes of such differences.” |
| Section 3.22.3, Inability to Evaluate Prescribed Assumption or Method | |
| Comment | One commentator asked if this section would allow an actuary to avoid calculating age-adjusted claims costs for a pooled plan because to do such analysis would require “performing a substantial amount of additional work beyond the scope of the assignment?” |
| Response | The reviewers do not believe that age-adjusted claims costs for pooled plans are prescribed assumptions or methods set by another party and, therefore, made no change |
| Sections 3.23, Reliance on a Collaborating Actuary | |
| Comment | One commentator asked if all signing actuaries are responsible for the entire report, including areas in which the actuary may have limited expertise or if the intended meaning is that one principal signing actuary is responsible for the entire report and, if the latter, if language can be added to that effect. |
| Response | The reviewers note that this section is consistent with section 2.4, Statements of Actuarial Opinion Issued by More than One Actuary, of the “Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States” and made no change. |
| Comment | One commentator suggested deleting the word “analysis” in the phrase “overall appropriateness of the analysis, assumptions, and results” because some of that analysis may never be communicated in the statement of actuarial opinion. |
| Response | The reviewers believe that even though the analysis may not be communicated in the statement of actuarial opinion, the actuary is still responsible for it and, therefore, made no change. |

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| Section 3.24, Use of Roll-Forward Techniques | |
| Comment | One commentator expressed the opinion that roll-forward valuations should not be encouraged in actuarial standards and that the requirements regarding the use of these techniques should be revised. |
| Response | The reviewers believe that the guidance included in this section is appropriate for measurements regarding retiree group benefits programs. They note that the guidance provides that “the actuary should not use roll-forward techniques unless, in the actuary’s professional judgment at the time of the roll-forward calculation, the resulting measurement is not expected to differ significantly from the results of a new full measurement.” The reviewers made no change. |
| SECTION 4. COMMUNICATIONS AND DISCLOSURES | |
| Section 4.1(g), Communication Requirements | |
| Comment | One commentator suggested that a requirement be added that the actuary comment about the source of any hypothetical data and whether the use of such data is expected to have a significant impact. The commentator discussed the differences between, for example, assuming dates of hire for a small percentage of the population versus assuming the demographics of the population making up a pooled plan. |
| Response | The reviewers believe that the issue of missing dates of hire is adequately covered by the existing section 4.1(g) and that section 4.1(i) requires disclosure of the information and analysis used in developing the age-related costs for a pooled plan. The reviewers, therefore, made no change. |
| Section 4.1(i), Communication Requirements | |
| Comment | One commentator suggested changes in the text in this disclosure requirement regarding the information and analysis used in selecting each significant assumption that was not prescribed. |
| Response | The reviewers note that the language in this section parallels the language in the similar disclosure requirement in ASOP No. 27. The reviewers modified the language to clarify that when age-specific costs are not used, a description of the reasons why they are not used is a part of this disclosure. |
| Section 4.1(k), Communication Requirements | |
| Comment | One commentator suggested adding references to adverse selection and plan selection/migration to the list of other significant assumptions. |
| Response | The reviewers note that the parenthetical list is not intended to be exhaustive and made no change. |
| Section 4.1(s), Communication Requirements | |
| Comment | One commentator asked whether this disclosure requirement applied to a calculation of the maximum deductible contribution to a voluntary employees’ beneficiary association using the aggregate cost method. |
| Response | The reviewers note that this disclosure requirement does not apply to intermediate steps of a calculation but added language to clarify that it does not apply if the purpose of the calculation was contribution determination in accordance with federal law or regulation. |
| Comment | Several commentators expressed concern about the added disclosure requirements regarding “fully funded” and “funded status.” |
| Response | The reviewers agree with concerns regarding “fully funded” and removed the proposed disclosures regarding such statements. However, the reviewers retained and modified the language of this section regarding measurements of funded status. The modified language makes it clearer that the standard does not require the disclosure of “funded status,” only what is required if an actuary does |

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| | disclose a plan's "funded status." |
| APPENDIX 1 | |
| Comment | Several commentators suggested changes in the text. |
| Response | The reviewers made some changes to the text, taking into account the comments received, the changes in the defined terms used in the standard, and updated cost levels. |