

Comments on the November 2025 Exposure Draft of ASOP No. 6

Disclosure regarding use of artificial intelligence: A large language model was used to assist with drafting and refining the language in this document. The substantive analysis, judgments, and recommendations are my own. I have reviewed the final language and stand behind the document as submitted.

Overview

These comments focus on a small number of substantive issues. The most significant relate to the breadth of the new defined term "funding valuation" (Section 2.19) and the cascade of consequences that flow from that classification – particularly the requirement to calculate a reasonable actuarially determined contribution (Section 3.27), the LDRM disclosure (Section 3.29.2), and the additional funding-report disclosures (Section 4.1.1). The proposed scope of risk assessment (Sections 3.28 and 3.29) and several technical points are also addressed.

A common thread is the treatment of OPEB programs whose economic structure is *inverted* relative to a typical employer-funded retiree health plan – that is, programs whose benefits are explicitly contingent on the funding available. Contributions are set by collective bargaining agreement, memorandum of understanding, or similar binding instrument, and trustees adjust benefit levels to what the contribution stream can support. The actuary's role is to advise on supportable benefit levels rather than on contribution levels. These programs are not rare in California and elsewhere; they include union-trusted Retiree Medical Trusts (RMTs) and certain Taft-Hartley-style postretirement health and welfare arrangements. The exposure draft, as written, sweeps these programs into the "funding valuation" category and then imposes disclosure requirements that, in several cases, do not map onto the underlying economics of the plan.

A useful framing for several of the substantive concerns below is the structural difference between pension and OPEB programs. ASOP No. 4 reflects a model in which the benefit obligation is established by the plan's terms and the actuary's role is to determine an appropriate contribution. The accrued benefit is treated as a fixed input; the contribution is the variable. That model fits most pension plans, where accrued benefits, once earned, are protected by statute or contract from sponsor modification. It does not fit several common OPEB designs. Union-trusted Retiree Medical Trusts (RMTs) and certain other collectively-bargained postretirement health and welfare arrangements are structured the opposite way: contributions are fixed by external agreement, and benefit levels are set by trustees in light of those contributions and the trust's funded status. The alignment of ASOP No. 6 with ASOP No. 4, while procedurally desirable, has imported the pension model's premise about which side of the equation is fixed and which is variable into a setting where that premise does not hold. Several of the issues below reflect this mismatch.

Responses to the ASB's Questions

Question 1 – Age-specific costs (Sections 3.7.7[a] and 3.7.7[b])

The new guidance on pooled health plans in Section 3.7.7(a) is, on balance, an improvement. Many California public agency OPEB programs purchase coverage through the CalPERS PEMHCA pool, and current practice for developing age-specific costs in that setting has been inconsistent. The expectation that age-specific costs reflect the pool's demographics where the pool's premiums are not adjusted for the employer's own claims or demographics is reasonable.

We are, however, concerned with the removal of the exception for the purpose of the measurement. Take, for example, a pooled health plan where the pool charges a uniform rate regardless of age, gender, retirement status, or Medicare status. For accounting disclosures, the entity discloses liabilities using age-based curves. However, the same entity also wants to prefund its retiree premiums. For that purpose, using non-age-based curves is more relevant, though a risk analysis showing the impact of the pooled plan going away or changing its rating structure would likely be a valuable thing to include as additional information.

A practical concern relates to defined-dollar programs. For programs in which the plan sponsor's obligation is a defined dollar amount per retiree (whether expressed as a stipend, an HRA-type credit, or a unit-based benefit funded through a trust), the per-capita cost from the program's perspective is the dollar benefit itself. That cost does not vary with the retiree's age in the way that a self-insured medical claim does; the age-cost gradient is borne by the retiree (and any insurance carrier). The (b)(2) exception ("costs do not vary significantly by age for the type of benefit plan being valued") arguably covers this, but the examples given in (b)(2) – Medicare Advantage plans and plans with sufficiently low annual benefit limits – do not match the defined-dollar fact pattern, and a practitioner could reasonably read the exception as not extending to defined-dollar programs. We suggest adding a defined-dollar benefit example to (b)(2) or otherwise clarifying that age-specific costs are not required where the program's obligation is a fixed dollar amount that does not vary by age of the retiree.

Question 2 – Should risk assessment (Sections 3.28 and 3.29) apply to all valuations or only funding valuations?

It should apply only to funding valuations, parallel to ASOP No. 51 for pensions.

The policy rationale that led the ASB to confine ASOP No. 51's risk assessment requirements to funding-related pension valuations applies with equal force to OPEB:

- *Existing accounting frameworks already address risk and sensitivity.* ASC 715-60 requires sensitivity disclosures on health care cost trend rates for postretirement benefits. GASB 74 and 75 require disclosures of net OPEB liability sensitivity to the discount rate and to the health care cost trend assumption. International accounting standards likewise impose sensitivity disclosures. Layering ASOP-driven risk disclosures onto accounting reports adds cost and length without adding insight for the intended user (typically the auditor and the financial-statement preparer), and in some cases creates apparent conflict with the issuer's accounting disclosures.

- *Different intended users.* Accounting valuations are prepared for financial reporting; their intended users are typically auditors and preparers operating within a defined disclosure framework. Funding valuations are prepared for boards and sponsors making contribution and benefit-level decisions. The two audiences have different informational needs, and ASOP 51's structure recognizes that for pensions.
- *Marginal cost.* For small or fully-insured OPEB programs, particularly accounting-only engagements, the marginal cost of formal risk identification, assessment, and disclosure is significant relative to the size of the engagement and the size of the obligation. The benefit to intended users for accounting-only purposes is limited.
- *Non-vested benefit.* In many cases, the OPEB benefit is not vested and can be changed or terminated at any time by the plan sponsor. The value of the risk assessment is limited if the plan sponsor can simply modify the benefits in response to adverse situations.

We recommend that Sections 3.28 and 3.29 be confined to funding valuations. If the ASB nonetheless believes some risk discussion is appropriate in accounting reports, a more limited disclosure – perhaps drawing attention to the existing accounting-required sensitivities – would be a reasonable middle path that avoids duplication.

Additional Comments

Section 2.19 – Definition of "Funding Valuation"

The proposed definition is:

"A measurement of retiree group benefits program obligations or projection of cash flows performed by the actuary intended to be used by the principal to determine program contributions for prefunding or to evaluate the adequacy of specified contribution levels to support benefit provisions."

The first prong ("to determine program contributions for prefunding") is intuitive and tracks the conventional meaning of a funding valuation. The second prong ("to evaluate the adequacy of specified contribution levels to support benefit provisions") is much broader, and we believe broader than the task force may have intended.

By its terms, the second prong captures any analysis whose purpose is to test whether contributions are sufficient. That could include:

- Benefit-level adequacy studies for RMT and similar union-trusted plans, where the contribution stream is fixed by an MOU or CBA and the actuary advises on whether a proposed benefit level can be supported;
- Cash flow runout studies for unfunded or partially-funded employer plans, where the principal asks how long current pay-as-you-go arrangements remain workable;
- Sustainability or "stress" studies for collectively bargained postretirement health and welfare arrangements;

- Some advisory work performed in connection with collective bargaining, where the actuary models contribution and benefit alternatives for negotiation;
- Maximum tax-deductible contribution and similar upper-bound calculations, where the actuary determines a regulatory or tax ceiling rather than recommends a contribution;
- 401(h) subordination limit calculations, where the actuary tests compliance with Internal Revenue Code limits on funding retiree group benefits through a subordinate account in a qualified pension trust; and,
- GASB 74/75 reports that include crossover analysis. The crossover test – projecting whether plan assets will be sufficient to cover projected benefit payments under the assumed contribution stream – is, by its nature, an evaluation of contribution adequacy, and could be read as bringing the GASB report into the funding-valuation framework. This is a particularly material category, since GASB reports are the principal OPEB deliverable for many California public-agency plans, and they have not historically been treated as funding valuations. Whether GASB reports with crossover analysis should be classified as funding valuations under the proposed definition is itself a subject of practitioner disagreement, which underscores the value of explicit clarification.

For many such engagements, the actuary does not produce – and the principal does not expect – a traditional funding valuation report. The natural output is a supportable benefit measure, an open-group cash flow projection, or a sensitivity analysis, not an actuarial accrued liability and an ADC.

The cascade of consequences flowing from "funding valuation" classification compounds the issue:

- Section 3.25 (implications of contribution allocation procedure) asks the actuary to estimate a date by which contributions exceed normal cost plus interest, the period over which the UAAL is expected to be amortized, and time to depletion. For an inverted-design plan where benefits adjust to contributions, several of these metrics are not natural outputs of the analysis.
- Section 3.27 requires a reasonable ADC. Discussed separately below.
- Section 3.29.2 requires an LDRM. Discussed separately below.
- Section 4.1.1 then layers additional disclosure requirements on top.

We suggest one of the following revisions, in order of preference:

- *Narrow the definition.* The second prong should turn on the engagement's primary purpose. Suggested wording: "A measurement of retiree group benefits program obligations or projection of cash flows whose primary purpose is to inform the principal's setting, modification, or assessment of contributions for prefunding the retiree group benefits program. The following may not be funding valuations, even where the analysis incidentally evaluates contribution adequacy: (a) advice on supportable benefit levels for a plan whose benefits are explicitly contingent on the funding available; (b) determination of an input for accounting or financial reporting, including a discount rate based on

crossover analysis; (c) computation of a regulatory ceiling or test of compliance with applicable law; and (d) projection of plan cash flows or asset depletion." This framing reaches union-trusteed Retiree Medical Trusts (RMTs) and similar Taft-Hartley-style postretirement health and welfare arrangements through carve-out (a) – contributions are set by collective bargaining agreement and trustees adjust benefit levels to whatever the contribution stream can support, with the actuary advising on the supportable benefit rather than on the contribution. It reaches GASB 74/75 reports incorporating crossover analysis through carve-out (b) – the analysis is performed to determine a discount rate, not to inform a contribution decision. Maximum tax-deductible contribution calculations, 401(h) subordination tests, runout studies, and sustainability studies fall under carve-outs (b)–(d) for analogous reasons.

- *Add explicit guidance.* Retain the current definition but add language (in Section 1.2 or Section 3.3) recognizing that for plans whose benefits are explicitly contingent on the funding available, the actuary's analysis may produce a "supportable benefit measure" or analogous output instead of an ADC, with appropriate disclosure of why.
- *Allow the actuary to disclaim ADC applicability.* Permit the actuary, with appropriate explanation, to disclose that an ADC is not a meaningful measure given the plan's design and to provide alternative measures consistent with the purpose of the engagement.

We would prefer option (1) or (2). Option (3) is a workable fallback but pushes the burden onto every individual report.

Section 3.27 – Reasonable Actuarially Determined Contribution

The economic premise of Section 3.27 is that contributions can be calibrated to support benefits – i.e., that contribution is the dependent variable and the benefit promise is fixed. For most pension plans and most employer-funded OPEB plans, this is correct.

For RMT and similar inverted-design plans, the relationship is reversed. Contributions are fixed by collective bargaining agreement, MOU, or trust agreement and are not subject to actuarial adjustment. The benefit level – typically a defined dollar amount funded through a trust and used by the retiree to purchase insurance or pay qualifying expenses – is the variable that adjusts (within trustee discretion) to maintain the actuarial balance of the program. The trustees' fiduciary question is "given the contribution stream we receive, what benefit level is sustainable?" not "given a fixed benefit, what contribution would amortize the obligation?"

In this setting:

- An ADC calculated under Section 3.27 risks being misleading. It implies the existence of a contribution amount that can be adjusted to fund a particular benefit, when in fact the contribution is constrained by an external contract and the benefit level is what is actually being recommended.
- The Section 3.27(f) condition – that the contribution allocation procedure "be consistent with the program accumulating assets adequate to make benefit payments when due" – is satisfied by construction in a well-managed RMT, because trustees adjust the benefit

downward (or upward) precisely to maintain that consistency. Stating this in ADC terms obscures rather than clarifies the analysis.

- The information actually useful to the principal is the maximum supportable benefit level, the projected cash-flow trajectory under current benefits, and sensitivity to demographic and economic assumptions. Several of these are already required or recommended elsewhere in the standard.

Recommendation: Add a Section 3.27(g) permitting the actuary to omit the ADC and substitute a supportable benefit measure where the plan's benefits are structurally contingent on funding.

Suggested wording:

(g) When the retiree group benefits program is structured such that benefit levels are explicitly contingent on the funding available – including where contributions are determined by a collective bargaining agreement, memorandum of understanding, trust agreement, or similar binding instrument that the plan sponsor cannot unilaterally modify – the actuary may, in lieu of an actuarially determined contribution, calculate and disclose a supportable benefit measure or analogous measure consistent with the purpose of the engagement. The actuary should describe the alternative measure and explain why an actuarially determined contribution is not a meaningful indicator for the program.

A related drafting suggestion: even setting aside inverted-design plans, requiring a "reasonable" ADC for engagements that are not, in their nature, contribution-setting decisions – including max-tax calculations, 401(h) tests, runout studies, and GASB 74/75 reports incorporating crossover analyses – imposes a calculation that does not correspond to a decision the principal is making. If the Section 2.19 narrowing recommended above is adopted, this concern is largely addressed; if not, suggested wording for the opening of Section 3.27 would clarify the scope:

When performing a funding valuation for the purpose of determining, recommending, or evaluating a contribution for prefunding the retiree group benefits program, except where the actuarially determined contribution is based on a prescribed assumption or method set by law, the actuary should also calculate a reasonable actuarially determined contribution.

Section 3.27 – Plans Whose OPEB is Primarily an Implicit Subsidy

A related but distinct question concerns plans whose OPEB obligation consists primarily of an implicit subsidy arising from age-blended premiums, with at most a relatively small fixed-dollar benefit on top. A common example is participating agencies of the CalPERS PEMHCA medical program, where the program's age-blended premium charged to active employees and pre-Medicare retirees produces an expected difference between retiree premiums and the underlying age-related claims. Many PEMHCA participating agencies provide a benefit substantially larger than the statutory minimum employer contribution, but some provide only the minimum; for those agencies, the OPEB consists, in substance, of that implicit subsidy and a relatively small fixed-dollar payment.

Our understanding of current practice for PEMHCA participating agencies is that the implicit subsidy is disclosed in the GASB 75 actuarial valuation, but where the agency is not prefunding, an ADC tied to the expected cost of the subsidy is not disclosed. The economic rationale is straightforward: the implicit subsidy is paid as it is incurred – it does not exist as a separately payable cash obligation that can be funded apart from the underlying premium structure. When the agency is not making contributions to a dedicated trust, an ADC-style measure does not correspond to any decision the principal is making, and computing one risks suggesting that a contribution amount is being considered when in fact the obligation is being managed pay-as-you-go.

The exposure draft does not appear to address this fact pattern explicitly, and it is not clear from the current text whether such a plan, when not prefunded, would now be drawn into the funding-valuation framework with an attendant ADC requirement under Section 3.27 (and, by extension, the LDRM under Section 3.29.2 and the additional disclosures under Section 4.1.1). The "evaluate the adequacy of specified contribution levels to support benefit provisions" prong of Section 2.19 could plausibly be read either way.

We recommend that the ASB clarify this point. Specifically:

- If the intent is that ADC and related funding-valuation disclosures are *not* required for plans whose OPEB obligation consists primarily of an implicit subsidy (with at most a small fixed-dollar benefit) and the principal is not prefunding, this should be stated explicitly – either in Section 2.19, in Section 3.27, or in commentary accompanying the standard.
- If the intent is that ADC and related disclosures *are* required in those engagements, the standard should explain why such disclosure is informative for the intended user. For the reasons noted in the Section 3.27 discussion above and in our response to Question 2, we have difficulty seeing what an ADC would contribute in the case of such a non-prefunded plan: it would not reflect a contribution decision the agency is making, it would not measure a separately-payable obligation, and the principal's decision-relevant information – the magnitude of the implicit subsidy, its trajectory, and its sensitivity to assumptions – is already captured elsewhere in the valuation and in existing accounting disclosures.

Our preference is the first approach. It is consistent with the broader theme of these comments – that several of the new funding-valuation requirements are well-suited to plans the principal is actively prefunding but produce limited useful information, and risk being affirmatively misleading, when applied to plans where contribution decisions are constrained or absent.

Section 3.29.2 – Low-Default-Risk Obligation Measure

We recommend removing the LDRM requirement for OPEB. The LDRM's premise is that a portfolio of low-default-risk fixed-income securities provides a meaningful economic benchmark because such a portfolio could approximate defeasance of the obligation with limited residual risk. For OPEB obligations subject to medical trend, that premise does not hold. Medical trend is typically the largest source of obligation uncertainty for an OPEB program, and an LDR-matched fixed-income portfolio leaves the holder fully exposed to it. The LDRM as drafted does not, on its own terms, meaningfully reduce the asset-liability mismatch it is intended to surface.

Sections 3.28 and 3.29 – Risk Assessment

Addressed in the response to Question 2. Briefly, our recommendation is that these sections be confined to funding valuations, parallel to ASOP No. 51.

If the ASB declines to confine the requirements to funding valuations, the actuary should be permitted to satisfy the risk assessment requirement, in an accounting-only engagement, by reference to the sensitivity disclosures already required by the applicable accounting standard, supplemented by any additional commentary the actuary considers significant.

Section 3.5.2(d)(2) – Limits on Plan Sponsor Payment (Cap Analysis)

The list of items the actuary must take into account when a plan designates a maximum per-capita amount paid by the plan sponsor is appropriate. We note, however, that for RMT-style plans the relevant "cap" is structural rather than contingent: the contribution stream itself is fixed, and the benefit is set by trustees in light of that stream. The cap-analysis framework – historical pattern, expected timing of cap activation, expected future modifications – does not naturally describe such plans. A more useful approach would be to add brief language within 3.5.2(d)(2) – or a parallel sub-provision – that addresses this fact pattern directly. For plans whose contribution is fixed by a collective bargaining agreement, MOU, trust agreement, or similar binding instrument, the actuary should take into account the terms and expected duration of the governing instrument, historical patterns of renegotiation, any trustee or other party's authority to adjust benefits in response to the fixed contribution stream, and the historical pattern of benefit adjustments under that authority. The relevant "pattern of plan changes" to be analyzed is, in substance, the trustees' history of benefit adjustments rather than the sponsor's history of cap modifications.

Section 3.7.1 – Claims Data

The new requirement that the actuary "request claims data, if credible, regardless of whether the underlying plan is insured or not" is well-intentioned. However, we are concerned with a new requirement to "request" certain data but not others. For example, 3.7.2 states "the actuary should obtain exposure data..." Several questions come to mind – is this a requirement for every valuation, or if the actuary requested it in prior years and nothing has changed, does the actuary need to request it again? What if the actuary is aware that the insurer won't release claims experience for a plan of that size or of that type? What if exposure data is not available and, therefore, the claims data is of limited use? Is the requirement limited to fully credible data? Or if that claims data is only, say, 10% credible, should the actuary still have to request it?

In addition, there are programs where claims data is not relevant to measurement, our preference is to remove the requirement to request data. However, if it is retained, the standard should clarify that the requirement is to request claims data where it exists at a level that could be credible and relevant to the measurement, and that programs whose obligation is a defined dollar payment rather than reimbursement of medical claims are not within the scope of the requirement.

For programs where the plan sponsor or trust is not a payer of claims – for example, an RMT that pays a defined dollar benefit which retirees use to purchase coverage through a third party (CalPERS PEMHCA, an insurance carrier, etc.) – claims data is not generated at the program level. The standard should clarify that the requirement is to request claims data where it exists at a level that could be credible to the measurement, and that programs whose obligation is a defined dollar payment rather than reimbursement of medical claims are not within the scope of the requirement.

Closing Observation

The ASB's effort to align ASOP No. 6 with the recently revised ASOP No. 4 is welcome, and many of the changes – the joint-opinion guidance, the assessment of assumptions and methods not selected by the actuary, the treatment of pooled health plan age-specific costs – are constructive. The principal substantive concern is that the alignment has imported into ASOP No. 6 assumptions about which side of the equation is fixed and which is variable that hold for pension accrued benefits but not for OPEB programs whose contributions are externally fixed and whose benefits adjust to maintain actuarial balance. The result is a "funding valuation" definition broader than the term as practitioners use it, and a set of attached requirements (ADC, LDRM, implications analysis, expanded disclosures) several of which do not map onto the economic structure of these plans. Some of those requirements are inappropriate for OPEB more generally – most clearly the LDRM, where a low-default-risk fixed-income portfolio does not hedge the obligation given exposure to medical trend. Narrowing the funding-valuation definition, removing the LDRM for OPEB, adding flexibility for inverted-design plans, and confining risk assessment to funding valuations (parallel to ASOP No. 51), and adjusting the language around requesting claims data would address the principal concerns.

Title of Exposure Draft: Proposed Revision of Actuarial Standard of Practice (ASOP) No. 6 – Measuring Retiree Group Benefits Obligations and Determining Retiree Group Benefits Program Periodic Costs or Actuarially Determined Contributions

Comment Deadline: May 15, 2026

Instructions: Please review the exposure draft and give the ASB the benefit of your recommendations by completing this comment template. Please fill out the tables within the section below, adding rows as necessary. Each completed comment template received by the comment deadline will receive consideration by the drafting committee and the ASB. The ASB accepts comments by email. Please send to comments@actuary.org and include the phrase “ASOP No. 6 COMMENTS” in the subject line.

I. Identification:

<p>Name of Commentator / Company</p>	<p>Submitted by Graham Schmidt (FSA, EA, MAAA, FCA), John Colberg (FSA, EA, MAAA), and Kathleen Weaver (FSA, EA, MAAA, FCA). These comments represent our own views, and not necessarily those of our employer.</p>
<p>Use of artificial intelligence</p>	<p>A large language model was used to assist with drafting and refining the language in this comment template. The substantive analysis, judgments, and recommendations are our own. We have reviewed the final language and stand behind the document as submitted.</p>

II. ASB Questions. Responses to the transmittal memorandum questions are entered below.

<p>Question No.</p>	<p>Commentator Response</p>
<p>1</p>	<p>The new guidance on pooled health plans in Section 3.7.7(a) is, on balance, an improvement. The expectation that age-specific costs reflect the pool’s demographics where the pool’s premiums are not adjusted for the employer’s own claims or demographics is reasonable and matches current practice for many California public-agency OPEB programs purchasing coverage through the CalPERS PEMHCA pool.</p> <p>We are, however, concerned with the removal of the exception for the purpose of the measurement. Take, for example, a pooled health plan where the pool charges a uniform rate regardless of age, gender, retirement status, or Medicare status. For accounting disclosures, the entity discloses liabilities using age-based curves. However, the same entity also wants to prefund its retiree premiums; for</p>

Question No.	Commentator Response
	<p>that purpose, using non-age-based curves is more relevant, though a risk analysis showing the impact of the pooled plan going away or changing its rating structure would likely be a valuable thing to include as additional information.</p> <p>A practical concern relates to defined-dollar programs. For programs in which the plan sponsor's obligation is a defined dollar amount per retiree (a stipend, an HRA-type credit, or a unit-based benefit funded through a trust), the per-capita cost from the program's perspective is the dollar benefit itself; the age-cost gradient is borne by the retiree. The Section 3.7.7(b)(2) exception arguably covers this, but the examples given (Medicare Advantage plans, plans with sufficiently low annual benefit limits) do not match the defined-dollar fact pattern, and a practitioner could reasonably read the exception as not extending to defined-dollar programs. A defined-dollar example should be added to (b)(2), or the exception should otherwise clarify that age-specific costs are not required where the program's obligation is a fixed dollar amount that does not vary by age.</p>
2	<p>Sections 3.28 and 3.29 should apply only to funding valuations, parallel to ASOP No. 51 for pensions. The policy rationale that led the ASB to confine ASOP No. 51's risk assessment requirements to funding-related pension valuations applies with equal force to OPEB:</p> <ul style="list-style-type: none"> • <i>Existing accounting frameworks already address risk and sensitivity.</i> ASC 715-60 requires sensitivity disclosures on health care cost trend rates. GASB 74 and 75 require disclosures of net OPEB liability sensitivity to the discount rate and to the health care cost trend assumption. International standards likewise impose sensitivity disclosures. Layering ASOP-driven risk disclosures onto accounting reports adds cost and length without adding insight for the intended user. • <i>Different intended users.</i> Accounting valuations are prepared for financial reporting; their intended users are typically auditors and preparers operating within a defined disclosure framework. Funding valuations are prepared for boards and sponsors making contribution and benefit-level decisions. ASOP 51 recognizes this distinction for pensions. • <i>Marginal cost.</i> For small or fully-insured OPEB programs, particularly accounting-only engagements, the marginal cost of formal risk identification, assessment, and disclosure is significant relative to the size of the engagement and the size of the obligation. The benefit to intended users for accounting-only purposes is limited. • <i>Non-vested benefit.</i> In many cases, the OPEB benefit is not vested and can be changed or terminated at any time by the plan sponsor. The value of the

Question No.	Commentator Response
	<p>risk assessment is limited if the plan sponsor can simply modify the benefits in response to adverse situations.</p> <p>If the ASB nonetheless believes some risk discussion is appropriate in accounting reports, a more limited disclosure – perhaps drawing attention to the existing accounting-required sensitivities – would be a reasonable middle path that avoids duplication.</p>
3	Section 3.2 is helpful as a roadmap of the steps the actuary undertakes. We have no specific suggested changes to that section.

III. Specific Recommendations:

A useful framing for the recommendations below is the structural difference between pension and OPEB programs. ASOP No. 4 reflects a model in which the benefit obligation is established by the plan’s terms and the actuary’s role is to determine an appropriate contribution – the accrued benefit is treated as a fixed input and the contribution is the variable. That model fits most pension plans, where accrued benefits, once earned, are protected by statute or contract from sponsor modification. It does not fit several common OPEB designs. Union-trusted Retiree Medical Trusts (RMTs) and certain other collectively-bargained postretirement health and welfare arrangements are structured the opposite way: contributions are fixed by external agreement, and benefit levels are set by trustees in light of those contributions and the trust’s funded status. The alignment of ASOP No. 6 with ASOP No. 4 has imported the pension model’s premise about which side of the equation is fixed and which is variable into a setting where that premise does not hold. Several of the recommendations below reflect this mismatch.

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
2.19	<p>Narrow the definition of “Funding Valuation,” in order of preference:</p> <ul style="list-style-type: none"> • <i>Preferred:</i> the second prong should turn on the engagement’s primary purpose. Suggested wording: “A measurement of retiree group benefits program obligations or projection of cash flows whose primary purpose is to inform the principal’s setting, modification, or assessment of contributions for prefunding the retiree 	<p>The first prong of the proposed definition (prefunding) tracks the conventional meaning of a funding valuation. The second prong (“evaluate the adequacy of specified contribution levels to support benefit provisions”) is much broader. By its terms, it captures benefit-level adequacy studies for union-trusted Retiree Medical Trusts (RMTs) and similar inverted-design plans, cash flow</p>

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
	<p><i>group benefits program. The following may not be funding valuations, even where the analysis incidentally evaluates contribution adequacy: (a) advice on supportable benefit levels for a plan whose benefits are explicitly contingent on the funding available; (b) determination of an input for accounting or financial reporting, including a discount rate based on crossover analysis; (c) computation of a regulatory ceiling or test of compliance with applicable law; and (d) projection of plan cash flows or asset depletion.”</i></p> <ul style="list-style-type: none"> • <i>Alternative:</i> retain the current definition but add language (in Section 1.2 or Section 3.3) recognizing that for plans whose benefits are explicitly contingent on the funding available, the actuary’s analysis may produce a “supportable benefit measure” or analogous output instead of an ADC, with appropriate disclosure of why. • <i>Fallback:</i> permit the actuary, with appropriate explanation, to disclose that an ADC is not a meaningful measure given the plan’s design and to provide alternative measures consistent with the purpose of the engagement. 	<p>runout studies for unfunded employer plans, sustainability studies for collectively bargained postretirement health and welfare arrangements, CBA-related advisory work, maximum tax-deductible contribution and similar upper-bound calculations, 401(h) subordination limit calculations, and GASB 74/75 reports that include crossover analysis. The crossover test – projecting whether plan assets will be sufficient to cover projected benefit payments under the assumed contribution stream – is, by its nature, an evaluation of contribution adequacy and could be read as bringing GASB reports into the funding-valuation framework. This is a particularly material category, since GASB reports are the principal OPEB deliverable for many California public-agency plans, and they have not historically been treated as funding valuations. Whether GASB reports with crossover analysis should be classified as funding valuations under the proposed definition is itself a subject of practitioner disagreement, which underscores the value of explicit clarification.</p> <p>The proposed narrowing turns on the engagement’s primary purpose. A funding valuation is one whose intended output is to inform a contribution decision; the carve-outs identify common fact patterns where the actuary’s mathematical</p>

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
		<p>analysis resembles a funding valuation but the principal's actual question is different. Carve-out (a) reaches RMTs and similar Taft-Hartley-style arrangements, in which contributions are set by collective bargaining agreement and trustees adjust benefit levels to whatever the contribution stream can support – the actuary's role is to advise on the supportable benefit, not on the contribution. Carve-out (b) reaches accounting, compliance, and projection engagements, most notably GASB 74/75 reports incorporating crossover analysis, where the analysis is performed to determine a discount rate rather than to inform a contribution decision.</p> <p>The cascade of consequences flowing from “funding valuation” classification (Sections 3.25, 3.27, 3.29.2, and 4.1.1) compounds the issue: several of these requirements do not map onto the underlying economics of these engagements.</p>
3.27	<p>Add a Section 3.27(g) (or comparable provision) permitting the actuary to omit the ADC and substitute a supportable benefit measure where the plan's benefits are structurally contingent on funding. Suggested wording:</p> <p><i>(g) When the retiree group benefits program is structured such that benefit levels are explicitly contingent on the funding available – including where</i></p>	<p>Section 3.27 assumes that contribution is the dependent variable and the benefit promise is fixed. For RMTs and similar inverted-design plans the relationship is reversed: contributions are fixed by binding external agreement, and the benefit level (typically a defined dollar amount) is the variable that</p>

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
	<p><i>contributions are determined by a collective bargaining agreement, memorandum of understanding, trust agreement, or similar binding instrument that the plan sponsor cannot unilaterally modify – the actuary may, in lieu of an actuarially determined contribution, calculate and disclose a supportable benefit measure or analogous measure consistent with the purpose of the engagement. The actuary should describe the alternative measure and explain why an actuarially determined contribution is not a meaningful indicator for the program.</i></p> <p>Independent of (g): if the Section 2.19 narrowing is not adopted, clarify the scope of Section 3.27. Suggested wording for the opening of Section 3.27:</p> <p><i>When performing a funding valuation for the purpose of determining, recommending, or evaluating a contribution for prefunding the retiree group benefits program, except where the actuarially determined contribution is based on a prescribed assumption or method set by law, the actuary should also calculate a reasonable actuarially determined contribution.</i></p>	<p>adjusts within trustee discretion to maintain the actuarial balance of the program.</p> <p>In this setting, an ADC calculated under Section 3.27 risks being misleading; it implies that a contribution amount can be adjusted to fund a particular benefit, when in fact the contribution is constrained by external contract and the benefit level is what is actually being recommended. The Section 3.27(f) condition is satisfied by construction in a well-managed RMT because trustees adjust the benefit precisely to maintain the consistency 3.27(f) requires.</p> <p>The information actually useful to the principal is the maximum supportable benefit level, the projected cash-flow trajectory under current benefits, and sensitivity to demographic and economic assumptions – several of which are already required or recommended elsewhere in the standard.</p> <p>The scope clarification, separately, addresses engagements where the actuary’s analysis is not for the purpose of contribution-setting – including max-tax calculations, 401(h) tests, runout studies, and GASB 74/75 reports incorporating crossover analyses. Requiring a “reasonable” ADC in those cases imposes a calculation that does not</p>

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
		correspond to a decision the principal is making.
3.27	<p>Clarify that ADC and related funding-valuation disclosures are NOT required for plans whose OPEB obligation consists primarily of an implicit subsidy (with at most a small fixed-dollar benefit) and the principal is not prefunding. The clarification should be made explicit – either in Section 2.19, in Section 3.27, or in commentary accompanying the standard.</p> <p>If, alternatively, the ASB intends that ADC and related disclosures ARE required in such engagements, the standard should explain why such disclosure is informative for the intended user.</p>	<p>A common example is participating agencies of the CalPERS PEMHCA medical program. The program’s age-blended premium produces an expected difference between retiree premiums and the underlying age-related claims. Many PEMHCA participating agencies provide a benefit substantially larger than the statutory minimum employer contribution, but some provide only the minimum; for those agencies, the OPEB consists, in substance, of that implicit subsidy and a relatively small fixed-dollar payment.</p> <p>Current practice is that the implicit subsidy is disclosed in the GASB 75 valuation, but where the agency is not prefunding, an ADC tied to the expected cost of the subsidy is not disclosed. The economic rationale: the implicit subsidy is paid as it is incurred – it does not exist as a separately payable cash obligation that can be funded apart from the underlying premium structure. An ADC-style measure does not correspond to any decision the principal is making, and computing one risks suggesting that a contribution amount is being considered when in fact the obligation is being managed pay-as-you-go.</p>

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
		<p>The exposure draft does not address this fact pattern explicitly, and the second prong of the Section 2.19 definition could be read either way.</p>
3.29.2	<p>Remove the LDROM requirement for OPEB.</p>	<p>The LDROM's premise is that a portfolio of low-default-risk fixed-income securities provides a meaningful economic benchmark because such a portfolio could approximate defeasance of the obligation with limited residual risk.</p> <p>For OPEB obligations subject to medical trend, that premise does not hold. Medical trend is typically the largest source of obligation uncertainty for an OPEB program, and an LDR-matched fixed-income portfolio leaves the holder fully exposed to it. The LDROM as drafted does not, on its own terms, meaningfully reduce the asset-liability mismatch it is intended to surface.</p>
3.28 / 3.29	<p>Confine these sections to funding valuations, parallel to ASOP No. 51 (see response to Question 2).</p> <p>If the ASB declines to confine the requirements to funding valuations, the actuary should be permitted to satisfy the risk assessment requirement, in an accounting-only engagement, by reference to the sensitivity disclosures already required by the applicable accounting standard, supplemented by</p>	<p>Existing accounting frameworks already require sensitivity disclosures for OPEB. Different intended users have different informational needs, which is why ASOP 51 is confined to pension funding valuations. For small, fully-insured, or accounting-only engagements, the marginal cost of a separate ASOP-driven risk assessment is significant relative to the size of the obligation, with</p>

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
	any additional commentary the actuary considers significant.	limited additional benefit to the intended user.
3.5.2(d)(2)	<p>Add brief language within 3.5.2(d)(2) – or a parallel sub-provision – addressing plans whose contribution is fixed by a collective bargaining agreement, MOU, trust agreement, or similar binding instrument. For such plans, the actuary should take into account:</p> <ul style="list-style-type: none"> • the terms and expected duration of the governing instrument; • historical patterns of renegotiation; • any trustee or other party’s authority to adjust benefits in response to the fixed contribution stream; and • the historical pattern of benefit adjustments under that authority. 	<p>The current 3.5.2(d)(2) list is appropriate for the conventional employer-cap fact pattern. For RMT-style plans, however, the relevant “cap” is structural rather than contingent: the contribution stream itself is fixed, and the benefit is set by trustees in light of that stream. The cap-analysis framework (historical pattern, expected timing of cap activation, expected future modifications) does not naturally describe such plans. The relevant “pattern of plan changes” to be analyzed is, in substance, the trustees’ history of benefit adjustments rather than the sponsor’s history of cap modifications.</p>
3.7.1	<p>Revise the requirement in Section 3.7.1 from “should” to “should consider.” Within ASOP usage, “should consider” directs the actuary to weigh whether the action is appropriate but does not require the actuary to undertake it, which better fits the range of fact patterns in which a claims-data request may or may not be informative or feasible. Suggested wording:</p> <p><i>The actuary should consider requesting claims data, if credible, regardless of whether the underlying plan is insured or not.</i></p> <p>Whether the requirement is recast as “should consider” or retained as “should,”</p>	<p>The new requirement that the actuary “request claims data, if credible, regardless of whether the underlying plan is insured or not” is well-intentioned, but the “should” formulation imposes an obligation in fact patterns where requesting claims data would add no value or be impractical. Section 3.7.2 uses “should obtain” for exposure data while 3.7.1 uses “should request” for claims data – the difference in verbs is presumably deliberate, but the standard does not explain when “request” is required and when discretion applies.</p>

Section #	Commentator Recommendation (please provide recommended wording for any suggested changes)	Commentator Rationale (support for the recommendation)
	<p>the standard should also clarify that programs whose obligation is a defined dollar payment rather than reimbursement of medical claims are not within the scope of the requirement.</p>	<p>Open questions include: whether the request is required for every valuation or only on material change; what the actuary should do where the insurer is known not to release claims experience for plans of the relevant size or type; whether the requirement applies where exposure data is unavailable (limiting the usefulness of any claims data obtained); and the credibility threshold (e.g., whether the actuary must request data that would be only marginally credible). Recasting the provision as “should consider” allows the actuary to exercise professional judgment over these factors while preserving the underlying intent.</p> <p>Separately, for programs where the plan sponsor or trust is not a payer of claims – for example, an RMT that pays a defined dollar benefit which retirees use to purchase coverage through a third party (CalPERS PEMHCA, an insurance carrier, etc.) – claims data is not generated at the program level, and the requirement as drafted has no natural object.</p>