

Title of Exposure Draft: ASOP No. 6 (November 2025 Exposure Draft)

Comment Deadline: May 15, 2026

I. Identification:

Deloitte (Tim Geddes / Bill Byrd)

II. ASB Questions (If Any). Responses to any transmittal memorandum questions should be entered below.

Question No.	Commentator Response
1	Not fully. The current guidance does not adequately address fully insured employer group Medicare arrangements, where age-specific cost development may not reflect the actual pricing basis or sponsor obligation. We recommend consideration of including broader exceptions that permit reasonable approximations or non-age-specific approaches where age-specific decomposition is unavailable, not credible, and/or not relevant.
3	Yes, generally. It would be more helpful if the revised ASOP more explicitly recognized that retiree group benefit valuations can involve fundamentally varied economic obligations depending on whether the arrangement is self-funded or fully insured, particularly in Medicare Part D contexts.

III. Specific Recommendations:

Section # (e.g. 3.2.a)	Commentator Recommendation (Please provide recommended wording for any suggested changes)	Commentator Rationale (Support for the recommendation)
3.7.1 and 3.7.5	<p>Clarify that, for fully insured employer group Medicare arrangements, premiums or carrier pricing information may be the primary basis for measurement when these metrics better reflect the sponsor's obligation.</p> <p>Suggested wording: "For insured arrangements, including fully insured employer group Medicare arrangements, the actuary may use premiums, carrier-provided pricing information, or other reasonable methods as the primary basis for developing initial per capita health care costs when such information, in the actuary's judgement, best reflects the plan sponsor's expected obligation."</p>	<p>The draft requires the actuary to request credible claims data and permits use of premiums or other methods in certain circumstances. That framework is reasonable in many scenarios, but it is too claims-centric for fully insured employer group Medicare arrangements. In these arrangements, premiums often better reflect the sponsor's obligation than underlying claims because sponsor cost is shaped by carrier pricing, CMS bid mechanics, subsidies, rebates, manufacturer discounts, and risk adjustments.</p>
3.7.6	<p>Expand the section to address the treatment of Medicare and Medicare Part D subsidies, rebates, discounts, and similar offsets in fully insured group arrangements.</p> <p>Suggested wording: "The actuary should determine whether Medicare-related subsidies, rebates, discounts, or other offsets are reflected directly in the plan sponsor's cash flows, embedded in premiums, or retained by another party, and should reflect such items consistently for the purpose of the valuation so as to avoid double counting or omission."</p>	<p>Section 3.7.6 appropriately requires the actuary to reflect Medicare reimbursements, direct subsidies for Part D plans, and other offsets. However, the guidance should more directly address whether these items are reflected in sponsor cash flows, embedded in premiums, or retained by the carrier. Without that clarification, there is risk of double-counting or omission in fully insured Part D valuations.</p>
3.7.7(a) and 3.7.7(b)	<p>Broaden the exceptions to expressly include fully insured employer group Medicare arrangements when age-specific development is not credible, not material, or not representative of the pricing basis.</p>	<p>The draft generally requires age-specific initial and projected per capita costs, with limited exceptions including where costs do not vary significantly by age, such as Medicare Advantage plans. For fully insured employer group Medicare</p>



	Suggested wording: "The actuary may use reasonable approximations or non-age-specific cost assumptions when age-specific costs are unavailable, not credible, not impactful, or not representative of the pricing structure of the arrangement."	arrangements, age-specific decomposition may be unavailable, unreliable, or inappropriate because pricing may be driven more by pooled carrier methodology, CMS benchmarks, and/or risk adjustment than by employer-specific age curves.
3.7.11 and 3.7.14	Clarify that Medicare arrangement projections may require explicit consideration of premium-development factors and program design mechanics, not only claims trend. Suggested wording: "For Medicare arrangements, the actuary may need to reflect not only expected claim trend but also expected changes in governmental program provisions, premium-development mechanics, administrative expenses, and insurer risk charges, to the extent relevant to the purpose of the measurement(s)."	The draft appropriately notes that separate trend rates may be appropriate for medical, drugs, and health plan administration, and that administrative expenses should be included as appropriate. For Medicare arrangement valuations, however, sponsor cost projections often depend on more than trend. They may also depend on governmental program mechanics, insurer risk charges, premium development assumptions, and administrative loads.
3.32 and 4.1	Add more explicit disclosure guidance for premium-based valuations of fully insured Medicare arrangements. Suggested wording: "The actuary should disclose whether the measurement is primarily premium-based rather than claim-based, the extent of reliance on carrier-provided pricing information, whether Medicare-related offsets are embedded in premiums or modeled separately, and any material limitations resulting from unavailable claim-level information."	The added guidance on reliance and required disclosures is helpful. For fully insured Medicare valuations, actuaries may appropriately rely on carrier-provided premium development, summarized pricing exhibits, or bid-related information that cannot be independently replicated from raw claims. The revised ASOP should call for clear disclosure of such reliance(s) when material.
3.7.1	Use more flexible language so the actuary can use professional judgment in these scenarios. Suggested wording: "The actuary should consider requesting claims data when the underlying plan is insured and when the claims data is credible."	For small and mid-size contracts, the use of claims data instead of premiums may create a disconnect between the valuation and actual financial obligation of the company, and could therefore ignore pricing strategies, pooling charges, reinsurance, and premium stabilization efforts on the part of the insurer. Premiums also have retention loads that are outside of the company's control which may vary throughout a contract period, and the use of claims alone would ignore any negotiated rate or trend guarantees. In addition, obtaining claims costs from the insurer is not always feasible, timely, nor practical. From the company's perspective, adding a full underwriting exercise may not be financially feasible. The ASOP should allow for professional judgment in PCCC development if claims experience would not be representative of the actual costs to the plan, or if a claims-based underwriting exercise would be material to the liability.

IV. General Recommendations (If Any):

Commentator Recommendation (Identify relevant sections when possible)	Commentator Rationale (Support for the recommendation)
Sections 3.7, 3.32, 4.1	Deloitte Consulting LLP ("Deloitte") supports the Actuarial Standards Board's ("ASB") effort

<p>The revised ASOP should more explicitly recognize the distinct valuation issues faced by fully insured employer group Medicare arrangements and fully insured commercial plans. For fully insured arrangements, premiums may better reflect the sponsor's economic obligation than underlying claims, and the standard should allow professional judgment in PCCC development accordingly. See specific recommendations above for detailed suggested wording on each section.</p>	<p>to modernize Actuarial Standard of Practice (ASOP) No. 6. Our primary concern is that the exposure draft does not yet clearly distinguish between self-funded retiree health arrangements and fully insured employer group Medicare arrangements, including Employer Group Waiver Plans ("EGWPs"), Medicare Supplemental, Medicare Advantage ("MA"), and Medicare Advantage Part D ("MA-PD") plans, collectively referred to as "Medicare arrangements" for purposes of this comment letter. In the latter, the sponsor's economic obligation is often a premium obligation, not a claim-adjudicated obligation. The final ASOP should recognize that distinction more explicitly so that practice is not influenced toward claim-based methods that may be less representative of the sponsor's actual cost.</p> <p>In the commercial market, those in a fully insured plan are generally small, albeit large enough to be credible over multiple experience periods, and have limited control of the relation of their claims to premiums charged. These entities may not have as much negotiating power as larger entities, and while they can consider alternate carriers, disruption to members is also a consideration. Collective bargaining groups are prevalent in these group sizes, which is a limiting factor in a plan sponsor's ability to switch carriers. The revised ASOP should allow, in our opinion, for professional judgment in Per Capital Claims Cost ("PCCC") development if claims experience would not be representative of the actual costs to the plan, or if a claims-based underwriting exercise would be material to the liability.</p>
<p>Closing Comment</p>	<p>We believe the revised standard would be improved by more explicitly recognizing the distinct valuation issues faced by fully insured employer group Medicare arrangements and fully insured commercial plans. That clarification would better align the standard with the sponsor's actual economic obligation and improve consistency in practice. Thank you for considering these comments.</p>

V. Signature:

Commentator Signature	Date
	<p>May 15, 2026</p>
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