

**Title of Exposure Draft: Proposed Revision of Actuarial Standard of Practice No. 6**

**Comment Deadline: May 15, 2026**

Instructions: Please review the exposure draft, and give the ASB the benefit or your recommendations by completing this comment template. Please fill out the tables within the section below, adding rows as necessary. Sample for completing the template provided at the following link:

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**I. Identification:**

Name of Commentator or Company
Annette V James, FSA, MAAA, FCA Vice President, Health, American Academy of Actuaries, on behalf of the Retiree Benefits Committee

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

Question No.	Commentator Response
1	<p>Is the guidance on age-specific costs, specifically related to pooled health plans (section 3.7.7[a]) and exceptions to use of age-specific costs (section 3.7.7[b]), clear and appropriate? If not, please explain</p> <p>The exceptions in 3.7.7(b) are neither clear nor appropriate because they do not clearly explain which plans do not vary significantly by age and do not leave room for actuarial judgement.</p>
2	<p>This proposed standard requires the actuary to identify and assess pertinent risks when performing all valuations related to retiree group benefits. In contrast, ASOP No. 51, Assessment and Disclosure of Risk Associated with Measuring Pension Obligations and Determining Pension Plan Contributions, only applies when performing funding-related valuations for pension plans. Is it appropriate to apply the guidance in sections 3.28 and 3.29 to all valuations related to retiree group benefits, including valuations for accounting measurements, rather than only funding-related valuations?</p> <p>It is unclear to us why ASOP No. 51 is referenced here. ASOP No. 51 does not apply to OPEBs and presumably that exclusion was intended by the ASB. To apply the guidance of sections 3.28 and 3.29 to OPEB accounting valuations may be reasonable if a priority of the ASB is establishing a basis for funding adequacy comparisons. Otherwise, we see little reason for adding another valuation responsibility for OPEB plans funded on a pay-as-you-go basis.</p>
3	<p>Is section 3.2, General Procedures, helpful?</p> <p>Yes, Section 3.2 is helpful. It provides a clear, principles-based framework that reinforces the exercise of professional judgment and the use of reasonable procedures across a wide range of retiree group benefit measurements.</p> <p>The section could be strengthened by explicitly cross-referencing relevant ASOPs, such as ASOP Nos. 23 and 56.</p>

**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)
History of the Standard (in introductory remarks)	Change title or provide actual history	Current language does not provide any history of ASOP No. 6.  Similar language is in the current standard, but it is titled as "Background." If the intent is to provide history rather than background, complete revision is needed.
Notable changes from the existing standard (in introductory remarks)	In list of notable changes, distinguish those made to align with guidance for pensions from those made for other reasons	To more easily allow a practitioner familiar with the current standard to understand the reason for specific changes listed. With current ED language it is possible to think every listed change was due to pension standard change.

1.4	Effective Date Consider single trigger date and/or explicitly permit early adoption with appropriate disclosure to provide flexibility.	Requiring both the report issuance date and measurement date to be 12 months post adoption could delay implementation more than intended, especially for plans with biennial or lagged measurement cycles.
2.15	Dedicated Assets: Suggest adding Insurance Company Continuance Fund to the list.	A. Such a fund is not an insurance policy nor is it a Trust. B. This entity still shows up in OPEB valuations. It has been recognized as a dedicated asset in the past and should be the same today.
2.20(Current ASOP 6)	Market Consistent Present Value: Suggest retaining the definition in its current form.	When determining the price of a Company that has a retiree group benefits program, would the concept of Market Consistent Present value come into play, When such companies are involved in a purchase/sale or merger, consideration of the retiree benefit obligation is usually considered when determining the sale or purchase price of said Company.
2.23	Include a new section after 2.23 that defines more current Medicare designs such as Medicare Supplemental, Medicare Advantage, Medicare Prescription Drug, and Employer Group Waiver Plans.	Section 2.23 defines the three types of Medicare Integration – Full COB, Exclusion, and Carve-Out. Medicare Integration was much more relevant 25 years ago when ASOP No. 6 was first adopted.  Today Medicare Supplemental plans, Medicare Advantage plans and EGWP are much more relevant. It would be useful if Section 2 also included definitions for:  Medicare Supplemental Plans Medicare Advantage Plans Part D Prescription Drug Plans EGWP
3.3	We suggest clarifying that the actuary may document and consider <b>multiple stated purposes</b> , provided the actuary evaluates whether the assumptions and methods are reasonable and appropriate for each such purpose. Additional clarification would help avoid the unintended interpretation that a valuation must always be prepared for a single, exclusive purpose and would more accurately reflect common practice.	We agree that clearly identifying the purpose of the measurement is fundamental and appreciate the emphasis placed on this concept in Section 3.3. In practice, however, valuation results are frequently prepared with the expectation that they will be used for <b>more than one purpose</b> (e.g., funding, budgeting, and sustainability analysis)
3.4.2	We recommend clarifying the distinction between circumstances that warrant <b>recognition in the measurement results</b> versus those that warrant <b>disclosure only</b> . Additional guidance would help support consistent application and reduce the risk of retrospective judgment based on information that becomes available after the measurement date.  In addition, we suggest clarifying the coordination between this subsection and <b>Section 3.5.2(h) (Anticipated Future Changes)</b> . In practice, it may be unclear whether certain known or anticipated changes should be reflected as post-measurement-date events or as anticipated future changes incorporated into the modeled provisions. Clarification on how these sections are intended to interact would be helpful.	Section 3.4.2 appropriately requires consideration of post-measurement-date events, but it does not clearly distinguish between: <ul style="list-style-type: none"><li>● events that should be <b>recognized in the measurement</b>, and</li><li>● events that should be <b>disclosed qualitatively only</b>.</li></ul> Ambiguity between these sections creates uncertainty about <i>when</i> and <i>how</i> future changes should be reflected.
3.4.3	We support the objective of discouraging the indefinite use of roll-forward measurements and encouraging periodic full valuations. We recommend clarifying, however, that the three-year time horizon for roll-forwards is intended as <b>general guidance rather than a strict prohibition</b> , and that professional judgment may support longer roll-forward periods in limited circumstances.	Circumstances may include smaller or highly stable plans, or situations where the roll-forward is used for internal planning or budgeting purposes and material changes have been appropriately considered. Explicit recognition of this flexibility would help ensure the guidance is applied consistently and pragmatically.
3.5.2 d	Don't remove from current 3.5.1d: In addition, participant contributions may affect participation rates and adverse selection, thus affecting per capita claim costs.	It is a valuable comment
3.5.2.d.1	Don't remove: from current 3.5.1.d.1 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 participants, and amounts based on combined costs for all participants).	It is a valuable comment

3.5.2 e	Clarify as: Payments from Other Sources—Where appropriate, the actuary may take into account payments from other sources that may partially or completely fund benefits, including retiree medical savings accounts, terminal leave balances, or non-employer funding sources.	It recognizes that some payments from other sources or offsets are appropriate to be considered for some purposes but not others.
3.5.2 f	Replace 3.5.2 (f) with  The actuary should take into account that various health care delivery system attributes can affect costs differently.	Sentence in 3.5.2 (f) is very long and difficult to follow. Three different concepts are forced into one sentence. Difficult to link “projections methods for Medicare Advantage versus Medicare integration.”  The suggested language is meant to clarify and simplify.
3.5.4 c	Clarify as: Governmental Programs—The actuary should take into account any patterns in the historically enacted legislative and administrative policy changes in Medicare (for example, payments under Original Medicare and Medicare Advantage plans) and other governmental programs to the extent that the retiree group benefits program integrates with them. However, the actuary should use this information in junction with any known forward looking legislative and administrative policy changes that would render historical information no longer applicable.	When government programs such as Medicare make changes, prior experience is no longer relevant for models projecting the future.
3.5.4 c	Replace parenthetical in 3.5.4(c)  From  (for example, payments under Original Medicare, Medicare Advantage plans)  With  (for example, payments under Original Medicare, Medicare Advantage plans, and Employer Group Waiver Plans)	Part D Employer Group Waiver Plans are very prominent today.
3.6.5	Leave in the pension data comments from current 3.6.5	Sometimes pension data needs to be used for OPEB work
3.7	Change first sentence in 3.7  From  “When health benefits are provided, the actuary should develop an initial per capita health care cost assumption based on credible claims experience.”  To  “If claims and exposure data are available, the actuary should develop an initial per capita health care cost based on credible claims experience. If credible claims data is not available, the actuary should consider developing initial per capita healthcare care cost using premium information with adjustments if appropriate.”	Suppose the sponsor provides health benefits through a fully insured pre-paid HMO. Then health benefits are provided but claims experience may not be available.
3.7.1	Change to: Claims Data—The actuary should request claims data, if credible and practical, regardless of whether the underlying plan is insured or not.	It is often not practical to get claims data for fully insured plans. The insurance company may refuse to release it.

3.7.1 a	Consider the deleting the first sentence “Gross claims data ...or other elements”	Section 3.7.1(a) may not adequately explain Gross vs. Net Claims.
3.7.6	Change to: The actuary should take into account the proportions of retired participants and their dependents that may not be covered for Part A or Part B, or who are enrolled in various types of Medicare plans such as Original Medicare, Medicare Supplement Insurance or Medicare Advantage plans.	There are a lot of different types of Medicare plans, and they generally should be handled differently
3.7.6	<p>Replace first paragraph, second sentence of 3.7.6</p> <p>“Such costs should reflect the Medicare integration approach for the benefit plan or how the benefit plan supplements Medicare.”</p> <p>With</p> <p>“Such costs should reflect the coordination with Medicare benefits such as Medicare integration, Medicare Supplement, or Medicare Advantage. Cost should also reflect the delivery of Medicare Part D prescription drug benefits such as Prescription Drug Plan or Employer Group Waiver Plan.”</p> <p>Replace second paragraph, first sentence, parenthetical of 3.7.6</p> <p>(for example, the retiree drug subsidies for plan sponsors and direct subsidies for Part D plans)</p> <p>With</p> <p>(for example, the Part D retiree drug subsidies provided to Employer Group Waiver Plans or fully insured Prescription Drug Plans)</p>	<p>Draft ASOP No. 6 provides minimal commentary on Medicare programs that are more relevant today.</p> <p>Update and clarify examples so that Part D offsets for per capita costs can be used in accounting valuations.</p>
3.7.7. b	Change 3.7.7 b 2 to: costs do not vary significantly by age for the type of benefit plan being valued (for example, medical plans with a sufficiently low annual benefit limit; or some dental, vision and Medicare Advantage plans that, in the actuary’s judgement, are not significantly impacted by age).	We should leave the judgement up to the individual actuary about the specific plan and we shouldn’t cause a problem with GASB no matter what the actuary decides.
3.8	<p>Add following sentence at end of paragraph:</p> <p>Actuary should consider the appropriateness of the mortality table and interest rate assumption that generally depends on how death benefits are funded and the level of death benefits.</p>	Applying a pension mortality table for a significant death benefit may not appropriate. Fully insured death benefits may include significant profit and risk margins that may not be captured if the actuary uses a pension mortality table.
3.10.1	<p>Section 3.10.1, last sentence:</p> <p>Replace</p> <p>“but not be of sufficient size to set per capita health care costs by location”</p> <p>With</p> <p>“may not be sufficiently credible to set per capita health care costs for a specific region or employee group”</p>	Comment is meant to provide more clarification and specificity
3.13.2	<p>Add following sentence at end:</p> <p>Actuarial assumptions and methods used to value self-insured long-term care benefits should follow the requirements of ASOP No. 18, Long-Term Care.</p>	Fully insured LTC benefits that are financed during the employee’s lifetime can clearly be valued under the provisions of ASOP No. 6. In this case, the employer’s obligation is based on the portion of the future premium expected to be paid by the employer. Current LTC premiums, at each age and gender, are generally available from the insurer. However, premium renewals could be volatile.

		Self-insured LTC benefits are much more difficult to value. Very few sponsors are able to self-insure LTC programs. A few examples include large statewide public sector employers, and religious orders that operate hospitals and LTC facilities and offer LTC benefits to members of the religious order.
3.13.5	Add following sentence at end:  The actuary should consider whether the aging factors are appropriate for the benefit design and claim experience, and that overall average costs are consistent with the age distribution used to develop age adjusted costs. The actuary should disclose the basis of the aging factors and any limitations or concerns.	Aging factors depend on the design and delivery of benefits. For example, aging factors could be significantly different among: HMO versus PPO plans, medical versus prescription benefits, and original Medicare versus Medicare Advantage plans.  The actuary may not have access to reliable normative database and may be forced to use outdated or standard aging factors that may be inconsistent with claims experience.
3.13.10	first sentence, 2nd paragraph: Replace “Unless inconsistent with the purpose of the measurement, the actuary should assume...” And substitute “When consistent with the purpose of the measurement, the actuary may assume...”  final sentence: We request clarifications on how to use “explicit probabilities” and its practical application. If this method has not been used in practice and not vetted in professional forums, the sentence should be dropped.	Many plans will not continue indefinitely. Many retiree health benefit plans in the past have been terminated or drastically reduced. The ASOP should not ignore that. When accounting standards require such as assumption, the substitute language allows that assumption.  The second paragraph of Section 3.13.10 states that the actuary should measure uncertain future changes using assumptions for “explicit probabilities.” That seems overly prescriptive when the plan sponsor reserves the unilateral right to change anything and everything, including termination. Other methods that don’t use explicit probabilities have been published (without written objection).
3.15(Current ASOP)	Suggest retaining this paragraph in its current form.	See comment for 2.20 above
3.21	Add the following sentence at the end of the section:  The actuary should perform periodic validation or reasonableness checks where approximations are used over multiple valuation cycles, particularly if such approximations could materially affect the results.	The section appropriately permits the use of approximations. It would be helpful to strengthen guidance around validation, particularly when approximations are used over multiple valuation cycles.
3.23.1	Add the following sentence at the end of the first sentence:  Examples of expected versus actual comparisons may include premium trends versus actual premium experience and claims cost trends versus actual claims experience, where applicable.	The section focuses on comparing expected versus actual cash flows. It may be helpful to provide more specific examples of such comparisons in the retiree health context, which would make the guidance more actionable and aligned with how we typically review results.
3.28	Add following risks examples: <ul style="list-style-type: none"><li>• Asset/liability mismatch risk (i.e., the potential that changes in asset values are not matched by changes in liability values.)</li><li>• Contribution risk</li></ul>	ASOP No. 51, section 3.2, includes asset/liability and contribution risks. These risks are also applicable to OPEB plans, especially OPEB plans with pre-funding policies.  DRAFT ASOP No. 6 – 3.28 makes reference to “Benefit improvement/reduction risk” but ASOP No. 51 – 3.2 does not. Benefit changes are generally driven by the plan sponsor, bargaining agreement, or legislative action.  Medicare risk is more nuanced since it is based on design changes at the federal level, CMS revenue that depends on experience, and market forces including migration to less-costly plans, in the near-term, such as Medicare Advantage Plans. The sponsor has less control over Medicare risk.
3.28.e	Replace  “the risk that mortality or other demographic experience will be different than expected”  With  “the risk that participation, mortality, or other demographic experience will be different than expected”	For an OPEB valuation, participation is a more important demographic assumption than mortality.
3.29	Consider indenting the final paragraphs to align with the format of 3.29.2, which is indented.	It seems these paragraphs concern only the LDROM portion of 3.29, which is designated as 3.29.2, and thus should be aligned with the paragraphs of 3.29.2.
3.29.1	Add the following examples of Plan Maturity Measures.  For pay-as-you-go plans and pre-funded plans: <ul style="list-style-type: none"><li>• Ratio of retirees actuarial accrued liability to total actuarial accrued liability</li><li>• Ratio of benefit payments to contributions</li><li>• Duration of actuarial accrued liability</li></ul> For pre-funded plans: <ul style="list-style-type: none"><li>• Cash flows to market value of assets</li></ul>	ASOP No. 51, sections 3.7 and 3.8 provide examples of Plan Maturity Measures and Historical Values. However, Draft ASOP No. 6, section 3.29.1 only provides a comment on Plan Maturity Measures without providing any examples.

	<p>Add a Historical Values section with following items:</p> <ul style="list-style-type: none"> <li>• Actual trend rate experience shown separately for claims and premiums and non-Medicare versus Medicare costs</li> <li>• Ratio of actual to expected claim costs</li> <li>• Significant plan changes factors used to normalize claim cost experience</li> <li>• Average morbidity factors shown separately for non-Medicare and Medicare members</li> <li>• Ratio of retiree contributions to total annual claims</li> <li>• Ratio of actual employer contributions to ADC</li> <li>• Actuarial gains and losses</li> </ul>	
3.29.2	We would ask the ASB to clarify whether LDROM applies only to pre-funding OPEB valuations	For rationale, see response in Section II, question 2.

**IV. General Recommendations (If Any):**

Commentator Recommendation (Identify relevant sections when possible)	Commentator Rationale (Support for the recommendation)
Consider a new section useful to the actuary working with clients aware of financial economic approaches to risk and uncertainty.	To be more credible in the finance, human resource and business world, actuarial standards need to acknowledge that many retiree health programs, past, present and future, are not regulated like pensions and are subject to unilateral change and termination by the sponsor. That has been central to the history over the last 40 years and, while some programs appear stable, it is likely that many programs, especially those yet to start, will operate in a future climate of uncertain long-term employer commitment. The exposure draft is insufficient in this regard and would be more credible inside and outside the profession if it was more realistic in challenges actuaries face under these circumstances.

**V. Signature:**

Commentator Signature	Date
Annette V James, FSA, MAAA, FCA Vice President, Health, American Academy of Actuaries, on behalf of the Retiree Benefits Committee	05/15/2026