



CONFERENCE OF CONSULTING ACTUARIES

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September 18, 2020

ASOP No. 6 Practice Note Work Group
American Academy of Actuaries
1850 M Street NW, Suite 300
Washington, DC 20036

Members of the ASOP No. 6 Practice Note Work Group:

The attached comments were developed through the coordinated efforts of members of the Conference of Consulting Actuaries' (CCA) Healthcare Community and are being submitted to the Members of the ASOP No. 6 Practice Note Work Group. These comments do not necessarily reflect the views of the CCA, the CCA's members, or any employers of CCA members, and should not be construed in any way as being endorsed by any of the aforementioned parties.

The members of the CCA Healthcare Community represent a broad cross section of health care actuaries. The membership includes over 250 leading actuaries whose firms are responsible for cost and liability measurements for retiree medical plans. This response reflects the viewpoint of select members of the Healthcare Community of the CCA who provide valuation and consulting services to retiree medical plan sponsors and whose extensive experience with active and retiree medical plans, including the development of age-specific retiree health costs, provides the framework for our response.

Sincerely,

Edward M. Pudlowski, FCA, ASA, MAAA

Chair of the Healthcare Community Steering Committee

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Dear Members of the ASOP No. 6 Practice Note Work Group:

We have reviewed the Public Policy Practice Note Exposure Draft entitled “ASOP No. 6 – Development of Age-Specific Retiree Health Cost Assumptions for Pooled Health plans, Including Applications to Non-Pooled Health Plans” dated July 2020. We applaud the Work Group’s efforts to bring clarity to this topic and address a practice area that has been in need of guidance. We believe the Practice Note provides guidance that moves toward a best practice standard for developing age-specific retiree health cost assumptions for pooled health plans.

Our comments set forth herein are offered to add additional points of clarity to the topic and offer our insights into best practices. Furthermore, we believe our comments offer important guidance for non-actuarial professionals that interact with the work of actuaries, including accountants and auditors that review the work of actuaries on behalf of health plan sponsors.

Comment #1

Sections II (Definitions/Terminology) and III (Application) of the Practice Note offer definitions and characteristics of Fully Pooled Health Plans and Partially Pooled Health Plans. Fully Pooled Health Plans, as described, are in terms of those plans that only offer a single rate regardless of the group's demographic make-up. However, we suggest the Practice Note recognize that fully pooled health plans may vary the rates charged to a group based on the age of participants but that the rates at each age are consistent across all groups with similar characteristics (area, benefit plan, network option, etc.). In our opinion, varying rates by age does not mean that the groups' experience is not fully pooled. Our concern is that readers may interpret plans that are fully pooled but apply rates by age could be confused in the definition

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as a partially pooled plan. We suggest the use of the term Partially Pooled be reserved for instances where the specific group's experience has some bearing on the rates charged that group.

Comment #2

The Practice Note provides a list of possible complications on page 20 in Section VI. (Methodology) that may require additional analysis or considerations in setting the valuation assumptions to adapt the examples in Appendix A to his or her own situation. We believe that an additional complication that is worth noting is where there exists an implicit subsidy and the retiree cost and retiree premium values trend at different rates in the future. An example of this would be a plan where the Medicare retirees pay the same premium as actives for medical coverage. The actuary should take care in setting assumptions (either cost or trend assumptions) such that the implicit subsidy reflects the appropriate growth or diminishment in value over time.

Comment #3

With respect to all three examples included in the Appendix which pool active employee experience with some or all of the retirees, we believe that the Practice Note would be stronger with a more explicit discussion regarding the potential differences in morbidity between active employees and retirees of the same age. While this difference between an active employee and retiree of the same age is implicitly shown via the Relative Value Factors and the differences between active employees and retirees of the same age, we believe that it is worth a specific mention as a consideration in the text of the example.

Factors that have been attributed to potential differences in cost between active employee and retirees of the same age include the decision to retire and available time. Employees may choose to retire due to an ongoing health condition that makes continuing to be actively at work more difficult. Additionally, an individual in retirement has more time to schedule doctor's visits and other interactions with the health care system than active employees. It has been long considered that these factors create a greater utilization of health care services and the associated cost for retirees versus that of an active employee of the same age.

The industry in which the employees and retirees were associated may influence the degree to which this difference exists. Credible and available data may dictate the extent to which the actuary can assess this difference and make appropriate adjustments. Regardless of the ability for the actuary to determine and

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assess this difference we believe that, at a minimum, this should be specifically mentioned in the Practice Note for the actuary’s consideration.

Comment #4

In examples #2 and #3 of the Appendix, we believe that it is important to add a discussion about checking the implied factor for Medicare integration (including the offset for prescription drugs) after calculating the age-specific costs for non-Medicare population and those retirees on Medicare. Comparing the age 65 cost in the absence of Medicare against the age 65 cost for a Medicare beneficiary will determine the implicit adjustment due to the Medicare integration and Medicare Part D offsets assumed by the analysis. This implicit adjustment should be compared to the actuary’s expectation as to what the Medicare integration and Part D offset methodology would produce as a reasonableness check. Should these differ significantly, the actuary may want to review the approach to determine a means to calculate the age-specific claims cost to better reflect the Medicare integration and Part D offset methodology.

While comments 1-4 are specific to the discussion and examples provided regarding pooled health plans, the following comments (5-9) are more generic with regard to evaluating retiree medical obligations regardless of the pooled nature of the plans. However, given their significance, we ask the Work Group to consider these for this Practice Note and/or for future Practice Notes on ASOP No. 6.

Comment #5

Consider incorporating references to healthcare inflation (trend) in this Practice Note in addition to the aging assumptions. Aging and trend are two critical aspects for plan cost setting. It would be helpful to include comments about the components of trend (service price inflation, utilization, mix of services, technology, etc.) and how these influences the assumption as well as how differing benefit programs and fee schedules (e.g., non-Medicare plans versus plans for Medicare eligible participants) can affect healthcare inflation. Some actuaries include aging indirectly in the trend rate assumptions, so the assumptions include price inflation, utilization increases, and technology changes, and aging. It would be helpful to highlight differences between trend and aging to better establish best practices.

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Comment #6

It would be valuable to highlight the interplay between benefit caps (employer cost sharing and contribution rates) and the application of aging and trend assumptions. As an example, an employer with a lifetime maximum subsidy (e.g., fixed dollar amount like \$3,000 per year, or multiple of 2 times current year expenditures) may need to consider the effect this design will have on aging and trend factors.

Comment #7

Actuaries are regularly asked to do an aging and trend study for clients. In many cases, due to the critical mass required to conduct such a study (and moving parts in the healthcare industry due to plan design, network changes, employee/covered member persistency, etc.) it may not be appropriate to do so. It might be good to highlight key considerations for doing an aging study (e.g., size of data, consistency of plan design, provider networks, insufficient data, etc.) in the Practice Note.

Comment #8

Many in the actuarial community recognize the challenges of getting data from insurance carriers and healthcare consortiums to convert or deconstruct premium rates to make them retiree plan specific and reflect impact of aging and implicit/explicit subsidies. Entities like municipal health plans have their own governance board, which may be made up of participating employers. These entities may have reasons to limit the sharing of data (e.g., anti-selection risk, data confidentiality). As a result, municipal health plans may not act in the same manner as the traditional relationship of employer-insurer, since the employer is a fiduciary in some cases for the insurer in a municipal consortium health plan. It would be helpful to include a sample data request (a short wish list) as an illustrative example in the Practice Note to demonstrate the acceptance within the actuarial community for importance of the required information and consistency on type of data requested. As an example, a large healthcare consortium could include anywhere from 20 to close to a 1,000 groups (municipalities). Some groups will be jumbo cities or counties and others will be very small housing authorities (less than 10 people). Having a consistent approach or guideline might help actuaries from smaller municipalities obtain data in a similar manner of larger municipalities for the same healthcare consortium.

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Comment #9

When healthcare consortiums or insurers release data to the actuary, the data may require adjustments to be consistent with the current environment including (but not limited to) plan design, provider network, and incurred but unpaid reserves, in addition to trend. We recommend highlighting this issue on retiree cost setting which is as important as the focus on age adjustments discussed in the Practice Note.

We appreciate the opportunity to provide feedback on the proposed revisions to the Practice Note for ASOP No. 6 and would be happy to discuss our comments in greater detail.

Sincerely,

Members of the CCA Healthcare Community

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