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ASOP No. 6 Exposure Draft Provisions Relating to Community-Rated HMO Contracts

by J. Richard Hogue

In October, 2000, the Actuarial Standards Board issued an Exposure Draft of a proposed revision of Actuarial Standard of Practice (ASOP) No. 6 (Measuring Retiree Group Benefit Obligations) with a comment deadline of 3/31/01. There were 22 comment letters containing several very worthwhile suggestions. (To get the comments file, send an e-mail to *comments@actuary.org* with Retiree Group Benefits in the subject line.)

Determination of Initial Per Capita Health Care Rate Addressed

I was particularly interested in section 3.4.5 of the Exposure Draft because it addressed the determination of the initial per capita health care rate for a plan being financed through a community-rated HMO contract. For the benefit of the reader who does not have a copy of the Exposure Draft, the following is section 3.4.5:

> 3.4.5 Use of Premium Rates—Although an analysis of the plan sponsor's actual claims experience is preferable, premium rates may be used as a substitute, with appropriate analysis and adjustment. Current premium rates will rarely be appropriate without adjustment for changes in benefit levels, covered population, or program administration. If premium rates are used as the basis for initial per capita health care rates, the actuary should make due allowance for the premium rate basis.
>
> In most cases, a community-rated premium rate is not appropriate for retiree group benefit measurement purposes unless the rate is not affected by factors specific to the covered population of the retiree group (for example, the same rate would be offered to the plan if only non-Medicare retirees were covered).
>
> If appropriately adjusted premium rates are used as the basis for initial per capita rates in the measurement, the actuary should make an appropriate disclosure and consider the factors described in sections 3.4.6-3.4.11.

Apparent Lack of Agreement Within Actuarial Community

What I liked about section 3.4.5 was that it would seem to clarify that in most situations the use of an unadjusted community-rated premium rate to value pre Medicare eligible retiree healthcare liabilities would not be acceptable. I was surprised to see that more than a few of the comments to the Exposure Draft seemed to imply that unadjusted premium rates should be acceptable.

This lack of agreement within the actuarial community is important because these two approaches (i.e. "unadjusted" versus "adjusted") to valuing pre-Medicare eligible post retirement healthcare liabilities can result in significantly different valuation results.

Example

For example, let's assume that pre-age 65 initial per capita health care rates increase at the rate of 3% per year and that the average age of the employer's total pre-age 65 population is 38. Within such population is a subset of early retirees whose average age is 62.

The unadjusted approach would use the community-rated premium rates without adjustment as the basis for the initial per capita healthcare rates for the pre-Medicare eligible retirees.

One adjusted approach to determining the age 62 initial per capita healthcare rate would be to multiply the community rate

by 2.03 (i.e. 1.03^{24}). The age 62 initial per capita healthcare rate would be appropriate for valuing pre-Medicare eligible retirees from ages 60 to 64. Starting with the five-year age bracket from 65 to 69, an appropriate assumption for the Medicare payments should be made.

Please note that the above approach using an age-adjusted premium to calculating the pre-Medicare initial per capita healthcare rate assumes that the community rate was based only on pre-Medicare claims and enrollment and ignores the different demographics between the employer and community populations. It also uses a simplified approach to age adjusting in the sense that the arithmetically correct way would be to base the adjustment on age distributions as the aging curve is not necessarily linear.

Effect on Valuation Results

The effect on the valuation results would depend on certain other variables such as the following:

- Duration of plan benefits
- Portion of current retirees who are eligible for Medicare, and
- Retirement rates for active employees

The two approaches would produce the greatest percentage variation in valuation results in the case of a plan that paid benefits only prior to Medicare eligibility. In this situation the post-retirement healthcare costs would roughly double assuming a plan whose eligibility age was 60. The age-adjusted rate would be for a central age 62 (for ages 60-64) but the unadjusted rate would be for a central age of 38.

At the other extreme would be a valuation of a healthcare plan that paid benefits only to retirees who were eligible for Medicare. In this situation, there would be no effect on the valuation results because there would be no pre-age 65 benefits considered in the valuation.

ASOP No. 6 Related to Accounting Standards

It is important to understand that ASOP #6 is expected to apply to all post-retirement benefit valuations and not just those performed for the purpose of complying with FAS 106. If the valuation is performed in a situation where an accounting standard does apply (FAS 106 or some other accounting standard), the actuary must insure that both actuarial and the applicable accounting standards are satisfied. Thus it is particularly important for the actuary to be aware of potential conflicts between ASOP #6 and whatever accounting standard applies. To my knowledge there are no provisions of FAS 106 that would require the actuary to use an actuarial method or assumption that violates ASOP #6. However, if some of the section 3.4.5 comments carry any weight in the drafting of the final version of ASOP #6, I believe the actuarial standard would permit the use of methods that are inconsistent with FAS 106. There would be nothing contradictory with this since ASOP #6 does not preclude the use of more stringent standards when warranted. It does mean, however, that actuaries practicing in this area must be aware of such potential conflicts.

Potential Conflicts with FAS 106

If the final ASOP #6 permits the use of unadjusted HMO community rates in valuing pre-Medicare eligible retiree healthcare liabilities, I believe that a potential conflict would exist between the actuarial standards and paragraphs 10 and 35 of FAS 106. Paragraph 10 requires a separate accounting of plans covering active employees and retirees. Paragraph 35 requires the actuary to calculate the assumed initial per capita healthcare rate on a basis that recognizes the fact that such rates vary by age.

Taken together, it is clear that FAS 106 does not permit substantial cross subsidies over the age spectrum when developing the assumed initial per capita healthcare rate. This is an important concept since many insured retiree medical plans offering pre-age 65 retiree coverage do so under the same contract that covers the active employees. In these plans, the experience of the active employees and retirees is usually pooled to arrive at a single set of rates for the group rather than one set of rates for the actives and a separate set of rates for the retirees. For these plans, setting the assumed initial per capita healthcare rate equal to the unadjusted group rate would not be correct for an FAS 106 valuation. There does not seem to be any substantial disagreement in the actuarial community in this situation or in the other common situation of the self-funded plan.

Source of Community-Rated HMO Plan Problems

The problem arises in community-rated HMO plans for the following two reasons:

1. The experience of the employer is not used directly in the determination of the rate. Some think that this point is strengthened in the case of an employer whose HMO contract is subject to regulation. With a regulated contract, the argument is made that the employer could rely on future access to healthcare coverage for any portion of his or her current or former employees.
2. The answer to question 11 of "A Guide to Implementation of Statement 106 on Employers' Accounting for Post-retirement Benefits Other Than Pensions." Question 11 and the answer thereto are as follows:

Question: Are there any circumstances in which an employer may measure its postretirement healthcare benefit obligation by projecting the cost of premiums for purchased healthcare insurance?

Answer: Yes. For a plan that stipulates that the benefit to be provided is the payment of certain healthcare insurance premiums for retirees rather than the payment of their healthcare claims, the employer should project the cost of those future premiums in measuring its benefit obligation. That projection requires an assessment of how future healthcare costs will affect future premiums.

For a plan that stipulates that the benefit to be provided is the payment of retiree's healthcare claims, the cost of premiums for insurance that an employer

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expects to purchase to finance its obligation may be used to measure the obligation if it produces a reasonable estimate of the future cost of benefits covered by the plan. In some situations, such as in a community-rated insurance plan that provides the type of benefits covered by the employer's plan and in which the premium cost to the employer is based on the experience of all participating employers, the claims experience of a single employer generally will have little impact on its premiums. Accordingly, in those situations a projection of future premiums based on the current premium structure and expected changes in the general level of healthcare costs may provide a reasonable estimate of the employer's obligation. However, if premiums are adjusted for the actual claims experience or the age and sex of the plan's participants (an experience-rated plan), the foregoing projection of the employer's obligation may not produce a reasonable estimate of the future cost of the underlying benefits of the plan.

Question #11 Answer Assumes Rate Based on Retiree Experience Only

With respect to the second point, I was informed several years ago by one of the FASB technical support staff that the answer to question 11 assumes that the underlying rates for the community-rated plan in question, to be consistent with FAS 106, paragraph 10, were based on retiree-only experience. Unfortunately, such assumption was not stipulated in the answer.

Conclusion

In my opinion, FAS 106, paragraph 10 would preclude any rate that applies to both an organization's active and retired participants from being used without age adjustment. Whether the employer's experience directly affects the rate and/or whether the rate is regulated is not even a consideration. Simply having the rate apply to the employer's active employee population would imply a rate based at least in part on active employee experience.

If the employer had a closed block of retirees to which the community rate is being exclusively applied, I would agree that the use of such rate on an unadjusted basis would be appropriate for FAS 106 purposes.

Always holding out the possibility that I might be overlooking something, I would encourage others who disagree with this position to come forth with their reasoning.

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Letter from the Editor...

by Jeffrey D. Miller

Greetings! By this time you've read more than you want to read about our new world after September 11, 2001. Many assumptions about our business have certainly changed. Personal accident coverage, for one, is not nearly as attractive to insurers as it once was. However, we know that health insurance is a line of business requiring aggressive and diligent management on a daily basis. Thus, as health actuaries, we simply keep doing our job.

Jeff Miller

Many thanks go to Tony Whitman, Bernie Rabinowitz, and many others who recruited authors for this edition of *Health Section News*. I'm continually amazed at the quantity and quality of material that people of our section produce when they are asked to do so.

This edition includes some very practical thoughts on pricing aggregate stop-loss coverage from Bob Mallison and some more esoteric thoughts from Harry Poteat (a guest writer) on use of clinical insight modeling in claim reserving. Richard Hogue has contributed some useful insight on retiree healthcare costs incurred by community-rated HMOs. Cabe Chadick provides us with a summary of the NAIC Web Cast on health reserves. Rowen Bell also contributes with a useful summary of NAIC activities from the perspective of a practicing health actuary. I even threw in a piece on my recent experiences in Latin America.

We hope this edition finds you and your loved ones at peace for the holiday season. We all hope for a peaceful and prosperous 2002.

Best regards,

Jeff Miller