



AMERICAN ACADEMY *of* ACTUARIES

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December 13, 2002

Mr. Karl Johnson  
OPEB Project Manager  
Governmental Accounting Standards Board  
401 Merritt 7  
Norwalk, CT 06856-5116

Dear Sir:

The American Academy of Actuaries<sup>1</sup> (the Academy) has been following, with great interest, your progress on a new accounting standard for postretirement benefit plans (OPEBs). We recognize that the statement will define the accounting and financial reporting standards for post-retirement benefit plans for governmental employers. We have been pleased to work with you on the standard's development and also know you appreciate the importance of the actuarial components that are integral to OPEB reporting.

Actuaries who have followed the progress of your deliberations are concerned about two particular aspects of the proposed standard that have been added in 2002. They are:

1. The use of a "common premium" concept to determine whether an employer is subject to the accounting and reporting aspects of this standard.
2. The use of an alternative (non-actuarial) approach that could be used by small employers.

The current GASB approach to these two aspects, as we understand it from recent conversations and a reading of recent meeting minutes, is contrary to well-established actuarial and financial reporting standards. As deviations from commonly accepted approaches, these GASB proposals need more debate and external discussion than they have received. While we understand the Board and staff may feel they have given adequate consideration to the proposed deviations, we feel you have underestimated the ramifications of the common premium approach. We believe there will be significant

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<sup>1</sup> The American Academy of Actuaries is the public policy organization for actuaries of all specialties within the United States. In addition to setting qualification standards and standards of actuarial practice, a major purpose of the Academy is to act as the public information organization for the profession. The Academy is nonpartisan and assists the public policy process through the presentation of clear actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal and state elected officials, regulators and congressional staff, comments on proposed federal and state regulations and legislation, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualifications and practice, and the Code of Professional Conduct for all actuaries practicing in the United States.

resistance to such approaches from the actuarial, accounting, and financial communities. We suggest the language used in the exposure draft to present these approaches be crafted carefully to allow the Board to return to more standard approaches without a second exposure draft.

We recommend that the GASB expose these issues in terms of two alternatives and ask for comments about and reasons for the adoption of one alternative versus the other. This would allow for an open forum to discuss these points and not require a re-exposure if the Board was persuaded to change tentative conclusions based on the comments.

The principal concern revolves around the “common premium” concept. This is the use of an average premium, calculated for a group of active and retired participants at all ages, to determine the cost related to retirees. It is common knowledge that health care costs vary significantly by age. Less well known, however, is the magnitude of differences by age. Analysis of private data typically indicates the rate for early retirees is about twice that of active employees or a combined group. Decision makers such as city council members are often unaware of such significant differences in the cost structure when they approve the extension of active benefits to retirees. Our concern is that by establishing rules that allow employers not to report OPEB obligations because retirees contribute 100 percent of the average cost, retiree obligations will be omitted, public awareness of costs will be diminished, and the financial information could be materially misleading.

As to the small plan alternative, we remain sympathetic to the search for ways of affording small entities the capability to comply with the likely accounting standard. The Academy, as a professional body, will not endorse methods that will not meet actuarial standards, but we will not discourage individual actuaries from assisting you in meeting your goal. We also trust that language in your standard that introduces or defines a non-actuarial method for small plans will carefully note the informational risks inherent in such a method and emphasize that preferred approaches, even for small plans, conform to actuarial standards.

At this point, the aspect of the proposed alternative method that we feel will most substantially compromise the accuracy of financial reporting is use of unadjusted premium in the method. The main criticisms parallel those we have for the common premium approach, so the appendix to this letter focuses on our criticism of the common premium approach.

### **Implications**

We strongly believe that the use of the common or average premium approach will have the following consequences. We will discuss our reasons in this letter. Illustrative examples are included in an appendix to this letter.

1. The reader of the financial statement may be misled regarding retiree liabilities.

2. The use of the common premium approach to determine applicability of the statement while using age based rates to calculate benefit obligations for employers to whom it does apply will result in a significant lack of comparability from employer to employer.
3. Financial statements based on the common premium approach will be in conflict with actuarial standards of practice. An actuary asked to opine on the actuarial aspects of the financial statements will not be able to give an unqualified opinion.
4. Lenders and bond rates will not understand the differences between these rules and those established by the FASB and the AICPA with regard to postretirement benefit obligations.
5. Rules that do not reflect economic reality (that health care costs are age-related), will drive employers to adopt or modify plans to achieve beneficial financial results.
6. Increasing attention in the press will create pressure to explain why the accounting rules produce results that are inconsistent with economic realities.
7. Decisions about OPEB plans will be based on faulty information, sanctioned by GASB, about present costs and hidden subsidies. Eventually, this could impact all employee health care costs and lead to labor strife and plan discontinuation.

### **Small Plan Alternative**

The alternative method being tested for small plans would likely use the common premium concepts discussed above for all calculations, regardless how the contributions are divided between employer and retiree. This is certainly appealing from the standpoint of simplifying the calculations. Nevertheless, as the appendix notes, this will, in most circumstances, result in an OPEB obligation that is *systematically* understated. If the Board adopts a small employer alternative, perhaps this flaw could be remedied by requiring an aging factor to be applied to the common premium, which would increase that cost to a level more reflective of the retiree age group. The Academy would be pleased to work with the Board during the comment period to develop an appropriate approach to address the aging factor issue.

We also have other concerns. First, we do not believe that there will be significant cost savings because, (1) many employers will have to use outside professionals to do these calculations; and (2) more extensive audit work will be required when auditors cannot rely on the work of a specialist.

Second, we are concerned that there will be a significant number of entities that attempt to do these calculations and will not do them correctly. There is a real risk of invalid results in these circumstances.

Finally, the field test has yet to compare the calculations of the alternative approach to a true actuarial valuation.

### **Recommendation**

We believe that financial analysts, the press and other interested parties will have concerns similar to those expressed in this letter. We recommend that the GASB expose both of these issues in terms of two alternatives and ask for comments about and reasons for the adoption of one alternative versus the other. This would allow for an open forum to discuss these points and not require a re-exposure based on the comments. This approach has been used successfully by other standard setters.

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The GASB and the Academy have had a successful history of cooperation. We offer these comments and recommendations in the spirit of improving the proposed standard by bringing to bear the skills and experience of the actuarial profession. If you have any questions or need further input on this matter, please contact Dennis Polisner, chair of the Academy's Pension Accounting Committee, at (312) 665-5254.

Very truly yours,



Janet M. Carstens  
Vice President, Health Practice Council



John P. Parks  
Vice President, Pension Practice Council



Patricia A. Teufel  
Vice President, Financial Reporting Practice Council

## APPENDIX

The actuarial concern about the use of common premium as the benchmark to determine if retirees are paying the full cost of the benefits may best be understood through the use of examples. We have compiled several examples in this appendix to demonstrate how the use of the common premium approach is inappropriate. Before proceeding to the examples, however, background on the basis for our concern is given. That concern centers on the differences by age found in health care costs and utilization.

We appreciate the many opportunities we have had to consult with the GASB staff and Board and the close relationship. We may not, however, have been clear enough earlier about the significance of health cost differences due solely to age. Despite being large, the differences are not always obvious and quantifying them is not easy. This often means decision-makers responsible for an organization's employee benefits are unaware of hidden subsidies and future payment commitments.

Nonetheless, the magnitude of the obligations that can be obscured is great enough that the FASB and the AICPA standards chose to recognize the inappropriateness of ignoring subsidies when reporting OPEB obligations. The Actuarial Standards Board made it a point of particular emphasis in its recent revision of the standard regarding retiree health benefits. As a result of these decisions by other professional bodies, GASB would stand alone if it adopts the common premium approach. The decision to place governmental accounting in this isolated position should be the subject of wide intentional debate, with careful consideration given to realities and situations such as those we have outlined below.

Studies by health care analysts and actuaries have long identified an individual's age as a significant indicator of risk for health care utilization and cost. Advancing age correlates strongly with higher utilization and cost. Insurers and other underwriters taking on the financial risk of providing health care make pricing and cost decisions accordingly. Underwriting references commonly indicate that health claims rates for those in the age 40 to 44 age group are less than half the rates of those ages 60 to 64.

A soon-to-be-published actuarial paper that surveyed actuaries who work with postretirement benefits found that rates between the ages of 50 and 64 rose almost 4% for each year of age. A typical example would show the rate for a retiree at age 64 to be 72% higher than the rate for a retiree age 50. The study also showed general agreement among actuaries surveyed that retirees and active employees at the same age will have different claim levels, with the retiree rate being the higher. As a result, early retirees will more often than not have cost and utilization rates that are double those for a group combining early retirees and active employees. There are variations in the age differences depending upon a number of factors, the most important of which may be the type of health care service. While the age differences for dental and vision care are smaller than those indicated above, the age differences for hospital care are higher.

For those above age 65 and eligible for Medicare, these differences persist. The most recent Medicare data available is for 1998 and shows that payment rates for short-stay hospitalization for those over age 80 are more than twice those for participants in the age 65 to 69 group. Age differences for skilled nursing facilities are greater than that; they are less for physician and supplier services. For all payments under the fee-for-service Medicare program for 1998, the rate for those over age 85 was 92% higher than rates in the age 65-to-74 age band (only 10-year age bands were available). The actuaries surveyed for the paper mentioned above indicated significant differences by age for the cost of benefits that are secondary to Medicare.

When insurers offer a health insurance plan to the public, the rates are age adjusted. When policies are offered to groups of a certain size, where regulation is less and the general age makeup of the participants can be ascertained, the underwriter will, before proposing one-year term coverage, determine expected aggregate costs. Then an average premium rate will be given to the group policyholder. The rates are similar to what has been referred to in GASB discussions as “the common premium.” It should be noted, however, that in these circumstances, coverage is almost always guaranteed for a year or less. This reason does not apply to postretirement coverage.

With that background, we have furnished below several examples of situations where interpretation of the common premium as the true rate of liability for a retiree group leads to uninformed management or investment decisions. All of the examples use coverage before age-65 Medicare eligibility because it is that coverage where misinformation has the most significant dollar impact. This group can almost always be examined separately from older retirees because insurers will rarely offer the same set of rates for Medicare-eligible retirees as for actives or early retirees in the same organization.

Nevertheless, we do want to point out that the common premium problem also affects cost analysis of Medicare eligible retirees. Actuarial models that project health care rates for a group of retirees for long periods of time incorporate age factors as standard operation. We are concerned that the small plan alternative does not incorporate age factors, which is why we state in the body of the letter that the small plan alternative systematically understates the projection of obligations.

These examples all assume that there is no medical inflation or any reason for health cost increases other than aging. Trend adjustments will be used in actuarial calculations but in these examples they would tend to obscure what the standard is really doing. The analysis works if the health care trend is zero or double digit, so we have assumed it is zero to simplify the examples.

### **Example I**

Cities A and B each have 400 active employees and 100 retirees. There is a health plan for the active employees but not the retirees, who are not yet eligible for Medicare and have been exerting pressure on their former employers to continue the health plan they had as actives, even if they have to pay something for it. Each city is paying \$80,000 per

month for the health coverage, and has made inquiries of their insurer as to the cost of covering retirees.

City A understands that their premium rate would increase from \$200 per month to \$240 per month if they added the 100 retirees, bringing their total cost to \$120,000 per month. City A decides that it cannot afford to subsidize the retirees but offers the coverage to retirees at full cost, \$240 per month.

City B's understanding of the cost is \$40,000 per month for the 100 retirees. City B feels it can afford \$16,000 per month, which amounts to a 40% subsidy of the required cost. City B offers the plan to its retirees for 60% of the additional cost, or \$240 per month.

**Comment:** Both cities have been told that adding coverage for 100 retirees will bring additional costs of \$40,000 per month. They have chosen to understand that differently. From the viewpoint of most analysts, City B has performed the more comprehensive review of the financial situation and more clearly understood its costs for the retirees. The insurer will be charging \$400 per month for each retiree. Under the common premium approach, however, City B would be required to perform an actuarial valuation and establish an OPEB liability for 500 participants, while City A would understand that there was no long-term liability stemming from its decision and no need to analyze the situation further. From just about every perspective the two plans are the same, with retirees required to contribute \$240 a month for eligibility, but City B, which has been more conscientious, is required to book a liability, while City A will remain unaware of the ramifications of its decision. Additional examples below outline those ramifications, using City B's approach as the most informed approach.

### **Example II**

City C has 400 employees and 100 retirees. The city has used a common premium approach for the 10 years since deciding to let its first retirees continue coverage if they paid the premium, which is now \$240 per month. It has never come to the attention of city managers that there is another approach, since they do not understand they are subsidizing the retirees. They do wonder why their rate is \$240 a month when that of the surrounding cities is \$200 a month. Their broker has simply indicated their experience warrants a higher rate and that no insurer will quote a lower rate, given their experience.

**Comment:** City C's state of knowledge about the financial impact of adding retiree coverage is much more common than the fuller knowledge held by City B in Example I. The plan costs 20% more than other plans because of the decision made 10 years before. With proper information that could be provided by an accounting approach such as that in FAS 106, the higher rate could have been predicted at that time. If an accounting standard that uses a common premium approach is adopted, City C will not do any analysis to further understand their situation. Nor will lenders be given any notice that City C's plan has the same liabilities as City B.

### **Example IIIa.**

Cities D, E and F are fast-growing outer suburbs that expect their current workforces of 200 to double in the next 10 years. They also have their first retirees this year, each being 60 years old. The prospective retirees report to their managers that individual health insurance will cost them \$600 a month. They request to continue in the city plan with the \$50 a month they have had to pay as an employee. Each manager knows that the average rate for an employee is \$200 a month and that the city has subsidized \$150 (or 75%) of the cost.

Each city consults its broker and learns that, while \$600 a month for their coverage for a 60 year old is what the individual insurance market is currently asking, a group rate is available for them. But each city is told something a little different. City D is told the addition of one retiree will hardly raise their rate at all. City E learns that the group rate for 60 year olds will be \$400. City F learns that their total cost will increase \$100 a month, from \$40,000 a month for 200 employees, to \$40,100 a month for 201 participants when a 28 year old is hired to replace the 60 year old retiree (who will remain under coverage).

**Comment:** Employers learn about the cost of retiree health in many different ways, most of them with limited knowledge and heedless of the long term implications. Each of these cities will soon have 100 retirees, who will have rates more than double what the average active employee costs. This will be true no matter what the common premium seems to be.

#### **Example IIIb.**

Cities D, E, and F decide to extend coverage to their first retiree, but not at \$50 per month. Each decides the retiree should pay the cost of the additional coverage. City D requires a \$200 monthly contribution, its “common premium”, which seems to be the extra cost for a retiree. City E requires a \$400 monthly contribution, which it was told was the extra cost for a retiree. City F requires a \$100 monthly contribution, which it was told was the extra cost for a retiree.

**Comment:** The cost situation is exactly the same for each of the three cities and each wants to charge its retiree the cost of the additional coverage. Nonetheless, each ends up with a very different contribution amount required of the retirees, and thus a different amount paid for by the city for every year until they make a change. Footnote 14 to Paragraph 35 of FAS 106 provides accountants and actuaries a tool to educate plan sponsors about the future cost of retiree coverage that will not be recovered by retiree contributions. Governments and the financial community would be well served if the GASB standard also encouraged such fuller understanding of future costs.

#### **Example IV**

If, 10 years earlier when costs were lower, Cities D, E and F had been in the Example III situations, they would now have 400 employees and 100 retirees, as was assumed for the cities in Examples I and II. The retirees would be incurring one-third of the plan costs and probably still paying contributions that varied from city to city.



**Comment:** Each city might have reason to feel the retiree contributions covered retiree costs. If the accounting standard is not clearly written, then each might have reason to consider they have no obligation for subsidizing retirees. This would especially be true if insurers felt there was a marketing advantage to structuring a particular contract so that its group policyholder did not have to include an obligation in its financial reports. Because group health rates are subject to little if any regulation, such structuring might be inevitable given a standard that equates retiree cost with whatever insurance premium is associated with a retiree. Self-insured governments also would be able to engage in the same kind of structuring, which few if any auditors could efficiently challenge.

### **Example V**

City G has 400 employees and 100 retired participants under age 65, who are required to pay \$240 monthly for coverage. The claims rate is \$200 monthly for actives and \$400 for retirees under 65. City H, which 20 years before had 400 employees and 100 retired participants under age 65, now has 200 employees and 200 retired participants under age 65. It has the same claims rate as City G and requires \$240 monthly for coverage. City G's common premium would be \$240; City H's common premium would be \$300.

**Comment:** Under the common premium approach to determining liability, City G would have no liability but City H would have to accrue costs for its full obligation as it projected out for future years. Depending how the standard is written, the initial net claim cost could be either \$60 a month (the difference between the common premium of \$300 and the retiree contribution of \$240) or \$160 a month (the difference between the real retiree rate of \$400 and the retiree contribution of \$240). If the standard defines the obligation as the former, then it would seem that every GASB calculation would be against actuarial standards and that the standard is not much improved over pay-as-you-go accounting.

If the standard defines the obligation as the latter, then the question becomes, "How does the standard define the crossover point when the calculation moves from the common premium as base cost to the real retiree rate as base cost?" City G may eventually find itself in City H's situation. Common premium amounts will have to rise as the proportion of retirees grows. At that point, City G either has to raise its retiree contributions for the new generation of retirees (creating generational inequity which could have been foreseen with real retiree rates) or maintain contributions at levels below the increasing common premium.

In the example above, it might be that one year the proportion of retirees is such that the common premium moves to \$245 from \$240, but the contribution does not. (Remember that all examples assume future health cost inflation to be zero, so this increase in common premium will happen solely because the common group is getting older.) Will the projection be based on initial claim cost of \$5 a month (the difference between the common premium of \$245 and the retiree contribution of \$240)? Or will it be \$160 a month (the difference between the real retiree rate of \$400 and the retiree contribution of \$240)? It is a very large difference between \$5 and \$160 when projected for all active and retired employees for all future years. Yet it would have to be absorbed into the

financials in a single year, which that year's city management could consider quite unfair, the result of smoke and mirrors on the part of previous management, abetted by an accounting standard.

### **Example VI**

The relative values of health claim rates by age typically range in the proportions implicit in these examples. The average claim rate for the group will be quite different than the average claim rate for the youngest or oldest quartile. The average for the youngest quartile would typically be about half that of the group average and the average for the oldest quartile about double that of the group average, although this would vary depending upon the age distribution of the group and whether maternity coverage was significant.

The expected claim rates for the oldest quartile would be about four times that of the youngest quartile. Using the rates from the previous examples, this would mean \$100 for those under age 30, \$200 for those around age 40, and \$400 for those over age 50. Rates would extend below and above this range for those who were the youngest and the oldest active employees. Because an individual insurance policy includes additional costs and risk margins, a person whose claim rate might be \$400 could have to pay \$600 for an individual insurance policy.

**Comment:** Differences in age-adjusted rates are far more significant than those associated with any other variable. Age is the one variable that actuaries are required to isolate when measuring long-term medical costs. In the rate situation from the examples, a 64-year old would have a claim rate over \$500. A 65-year old eligible for Medicare might have a postretirement plan rate of \$150, for coverage secondary to Medicare. The rate for an 80-year old might be \$250. The average rate for those age 65 and above might then be around \$200, very close to the average rate for those under age 65. But to consider these averages as the same rate when projecting future claims for the individuals would be highly misleading.

The 80-year old would have a projection that started at \$250 per month (\$3,000 annually) and increased from there. The 65-year old would have a projection that started at \$150 and increased from there for a longer period than the 80-year old. A 64-year old would have a projection that started at \$500 or so, dropped to \$150, and then increased from there. (Health care inflation is being ignored.) A 58-year old would have a projection that started at \$400 or so, increased from there for six years, dropped to \$150, and then increased.

Regarding long-term liabilities, the present value of the obligation for the 58-year old is clearly the highest of these, but it is much higher than the others because of so many years without Medicare. The present value for the 58-year old is probably double that of the 64-year old and many times that of the 80-year old. It is not uncommon to analyze the FAS 106 APBO for a plan and find that more than half the APBO is for the relatively few years of retiree risk before age 65. A plan that offers its early retirees coverage if they pay the common premium will have significantly higher obligations than a plan that requires retirees to pay 80% of the age-adjusted retiree claim rate. The former will

project from a base claim cost of \$160 (\$400- \$240) while the latter will project from a base of \$80 (\$400 \* 20%). Yet an accounting standard that uses the common premium approach will show the opposite relationship, because the \$160 base will be regarded as zero.

**Example VII.**

City X and City Y both have begun to offer coverage to early retirees, which will be discontinued upon Medicare eligibility. City X has a requirement of 20 years of service and age 60; as a result, most of its early retirees have coverage for just a few years. City Y has a requirement of 15 years of service and age 50; as a result, most of its early retirees have coverage for quite a few years. The average rate for the City X retirees is higher, however, and that pushes the “common premium” for City X to a higher level than at City Y. Both cities set their retiree contribution at the same level, equivalent to the City Y common premium

**Comment:** The City Y eligibility requirements can be found in many police, fire and public service plans. Under the common premium approach, City Y has no obligation, while City X does. Under a more realistic approach, City Y has a much larger obligation than City X, because City Y will be subsidizing the retirees for up to 15 years, while the City X subsidy is limited to 5 years. The common premium approach amounts to pay-as-you-go accounting for City Y.

**Conclusion**

The actuarial community feels that accounting standards should encourage managers to look at cost structures as realistically as possible. Given the general understanding of most people (including the FASB and the AICPA) that health costs increase with age, we feel it would be a step backward to give credibility to the common premium approach.