# GN21: Actuarial Reporting on Post-Retirement Medical Plans

***Classification***
Recommended Practice

***Legislation or Authority***
Institute of Chartered Accountants in England and Wales.
*Accounting for Pensions Costs.* Statement of Standard Accounting Practice No. 24. 1988.

Financial Accounting Standards Board (USA). *Employers accounting for post-retirement benefits other than pensions.* Statement of Financial Accounting Standards No.106. 1990.

Accounting Standards Board. *Accounting for post-retirement benefits other than pensions.* Urgent Issues Task Force Abstract 6. 1992.

Institute of Chartered Accountants in England and Wales.
*Accounting for deferred tax.* Statement of Standard Accounting Practice No.15. 1992.

***Application***
Any actuary responsible for calculating costs in respect of a UK post-retirement medical plan. This Guidance Note should be read in conjunction with GN13 and GN17.

***Author***
Wider Fields Board

***Status***
Approved under Due Process.

| ***Version*** | ***Effective from*** |
|---|---|
| 1.0 | 23.06.94 |

## Introduction

1. A post-retirement medical plan is any arrangement under which an employer meets all or part of the cost of private medical care for acute medical conditions, or insurance in respect of such care, for retired employees and/or directors and their dependants. This definition can encompass arrangements under which the employer's contribution to costs is implicit rather than explicit; for example, where an employer subsidises former employees by allowing them to pay premiums based on the average cost of the plan for retired and active employees.

2. The usual purpose of an actuarial report on a post-retirement medical plan is to advise the employer or another party on the accrued liabilities, and the cost of providing these arrangements. The purpose of this Guidance Note is to provide guidelines as to the factors that should be taken into account in undertaking such an actuarial review. The intention is not to discuss specific issues relating to the need to produce costs for disclosure in accordance with an accounting standard.

3. This Guidance Note has been specifically framed to relate to UK plans that provide post-retirement medical care for acute medical conditions; these are commonly known as private medical insurance schemes and are often arranged through an insurance company. However, similar considerations will generally apply to arrangements providing other post-retirement benefits and to overseas plans. When valuing overseas arrangements, it should be expected that costs and utilisation statistics from the UK will not be appropriate.

4. In many instances an actuarial report on a post-retirement medical plan will be required in order to produce figures for disclosure in accordance with an accounting standard. Urgent Issues Task Force Abstract 6 Accounting for Post-Retirement Benefits other than Pensions (UITF6) requires the principles of the pension accounting standard SSAP 24 to be applied in relation to all post-retirement benefits. Figures may also be required in accordance with the Statement of Financial Accounting Standards No 106 Employers Accounting for Post-Retirement Benefits other than Pensions (FAS106) in the USA. In this case results are to be produced in accordance with the requirements of the accounting standard.

5. In this Guidance Note, the term ‘medical risk cost trend’ is used to denote the increase in claims costs due to factors other than a changing risk profile for the covered population. The medical risk cost trend includes not only cost increases, but also changes in utilisation due to changes in claim frequency and claim severity.

**Reporting**

6. Any actuarial report on a post-retirement medical plan should state the membership of the plan. In particular, the following should be summarised:

(i) The former employees and directors that are members of the plan or will become members of the plan at a future date.

(ii) The entitlement, if any, of spouses and other dependants of members to benefits under the plan.

(iii) The groups of current employees and directors that may be entitled to membership of the plan, and the eligibility conditions to be satisfied for membership.

(iv) Any uncertainty as to the precise membership of the plan; in many cases formal documentation for a plan may be minimal.

7. A report should also include a summary of the benefits of the plan and the limits, if any, on the treatment provided. Financial limits on cover should be noted, together with a summary of historic and assumed future increases in these limits. The extent to which such limits may help to contain future increases in plan costs should be discussed.

8. Where a plan is employer-subsidised, rather than employer-paid, the nature of the subsidy should be made clear. Any anticipated change in the subsidy, as a proportion of plan costs, should be explained.

9. All assumptions used to calculate plan liabilities and costs should be stated with explanation.

10. Any allowance made for changes in plan benefits, eligibility conditions or other features of the plan that were not implemented at the effective date of the report should be stated.

11. A wide variety of factors can influence future plan costs; these include economic trends, medical developments and changing medical practices, social trends, political factors and changes in the balance between the National Health Service and the UK private health sector. The importance of such factors, and the resultant uncertainty over future plan costs, should be emphasised in the report. Sensitivity tests should be used to illustrate this uncertainty; for example by varying the assumed medical risk cost trend.

12. Any departure from this Guidance Note should be noted in the actuarial report and the reasons for the departure fully explained. No such note is required if the departure is necessary in order to comply with an accounting standard. It should be noted that FAS106 is generally more prescriptive on the costs and methodology to be used than this Guidance Note.

**Methodology**

13. Determining the accrued liabilities and periodic costs of a post-retirement medical plan requires analogous actuarial techniques to determining the liabilities and periodic costs of a defined benefit pension plan, and similar methodologies should be followed. Projected pension benefits payable in a given year should be replaced by the projected medical claim costs.

14. The projected medical claim costs will depend on the age and sex of the beneficiary, the date of incurrence of the projected claim costs, the medical risk cost trend, the medical benefits of the plan and other factors specific to the plan and the employer.

15. Where a plan is arranged through an insurance contract, it should be noted that long-term costs are likely to be determined by claim costs for the covered employees plus the insurer’s charges for expenses and profit. It is therefore important to consider claim costs as well as the premium rates currently charged by the insurer.

16. Where results are required for the purpose of any accounting standard, the methodology employed should be consistent with the requirements of the standard. GN17 provides guidance on validity of methodologies for the purposes of SSAP 24.

**Estimating Future Costs**

17. Claims experience under the post-retirement plan and under any plan for active employees will normally provide the best guide to future plan costs since this will reflect a variety of factors influencing plan costs such as geographic location, occupation and social factors. Any pattern of moving to a different geographical area on retirement may affect future plan costs.

18. For many plans it will be appropriate to consider claims experience arising over a period of up to five years in order to increase the credibility that can be given to claims experience.

19. For plans which, because of the size or lack of historical data, no (or insufficient) credible claims data are available, an alternative approach must be adopted. Premium rates for private medical insurance, adjusted to remove loadings for administration and profit, provide one guide to plan cost. The experience of the actuary in relation to the costs of other similar plans is another guide.

20. Allowance should be made either explicitly or implicitly for the cost of administration including the payments of claims, and for any profit loading by insurer.

21. The allowance made for the medical risk cost trend should reflect all the factors that will affect cost and utilisation changes. As well as price inflation, other relevant factors include the impact of external factors, such as expanding private health care services and NHS controls, on claim frequency and claim severity under the medical plan. Changing medical practices will influence cost, frequency and severity. Consideration should also be given to the influence of plan-specific features such as occupational risk and plan design. Collectively these factors will be usually allowed for by assuming a medical risk cost trend that is in excess of the assumed level of increase in earnings for employees. The assumed medical risk cost trend should be reviewed against the long-term economic growth rate for the economy implied by other elements of the actuarial basis.

22. The actuary is responsible for making appropriate assumptions on the variations in medical claims costs due to age and sex. Standard tables for this purpose are not available in the UK and the actuary will need to identify appropriate date sources. Considerable judgement will need to be exercised by the actuary, even when there is access to a large volume of age- related claims data. Possible sources of relevant data include insurance companies offering private medical insurance, employers, third party administrators and the Department of Health. In the absence of credible data, one possible source of age-related utilisation data is the Hospital In-Patient Enquiry 1985. It should be noted that this data source is now some years out of date and pertains to hospitalisation in National Health Service hospitals rather than under private medical insurance contracts.

23. The assumed discount rate should reflect the method by which plan costs are financed and the effect of taxation. The discount rate should be determined on a basis consistent with the economic assumptions underlying the choice of medical risk cost trend. An explanation of the choice of discount rate and the adjustment for taxation should be given to the employer.

24. It should be noted that different tax and funding situations usually apply to post-retirement medical plans and to pension plans, and to the choice of net discount rate for these arrangements. Post-retirement medical plans are frequently unfunded. In this event, it is theoretically appropriate to base the discount rate on the internal rate of return likely to be achieved by the employer in the long term. In practice, assessment of this long-term rate of return is highly subjective. The long-term return expected from marketable equity investments gives one guide; the actuary should not assume that a significantly higher long-term return can be achieved by the employer.

25. Tax relief is usually available to the employer at the time of paying medical claims or PMI premiums. Book reserves for post-retirement benefits are usually established with no allowance for tax relief on benefits; to reflect the value of tax relief, a separate deferred tax provision is usually established in accordance with SSAP15 (as revised by the Amendment to SSAP15 issued in December 1992). The actuary should liaise with the employer and its auditor to determine the appropriate allowance to be made for future tax relief on benefits and the manner in which this will be presented in the employer's financial statements.

26. The assumptions regarding mortality and withdrawal experience are generally of greater significance in the valuation of post-retirement medical plans than in the valuation of pension plans. Often only a small proportion of pension scheme members will be eligible for post-retirement medical benefits, and thus pension scheme assumptions are not necessarily appropriate to this smaller group. Since post-retirement benefits are often provided for senior employees only, experience in relation to mortality and withdrawals can often be lighter than for the pension scheme as a whole. Consideration should be given to future improvements in mortality for members of post-retirement medical plans.

27. The withdrawal experience assumption can be particularly critical as there is often no vesting of benefit on withdrawal. In this situation, it is important not to give too much credibility to recent withdrawal experience.

28. Cost estimates will be dependent on the assumed pattern of retirement before Normal Retirement Date. Assumptions concerning early retirement should reflect the actual experience of the scheme, where this is credible, over a period of years. Consideration should be given to any special factors that may affect early retirement patterns; eg any requirement for a minimum period of service to be completed before post-retirement medical benefits are vested.

29. Sensitivity tests should be carried out to illustrate the sensitivity of results to changes in the underlying assumptions. Of particular importance will be the assumptions regarding medical claims inflation, withdrawal rates, and the assumed cost levels for different risk groups.