

GASB Liability Information

The Local Choice (TLC) program is a self-funded health benefit program, administered by the Commonwealth of Virginia that allows local Virginia municipalities, schools and political subdivisions to benefit from the Commonwealth's purchasing power. From an employer's perspective, TLC works like an insured arrangement in which each TLC group pays the Commonwealth on a fixed per contract per month basis for the health care program that they choose. If the TLC group has more than one benefit option, they have different rates for each option. This fixed payment represents the full cost to the group during the plan year in return for reimbursement of all covered expenses, claims and administrative cost for the group.

Annually, each TLC group is presented with a renewal rate for the next coverage year and may either agree to the new fixed rate or leave the program. New groups can enter the program at any time by agreeing to the proposed fixed rate. There is no settlement from the group or refund to the group if expenses are more or less than the fixed contract payment. A settlement is only applied if a group terminates coverage while the pool in which they participated is in a deficit position or in the case of groups over 300 employees, if their plan experiences a deficit. This settlement for terminating groups is known as an Adverse Experience Adjustment.

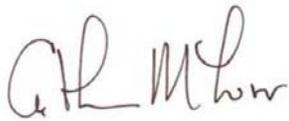
The rates charged for TLC are developed based on competitive industry practices for prospective premium development for groups of similar size. For example, the rates for groups under 300 are developed on a prospective basis using a community rating by class methodology. Community rates are developed for the block of business. These demographically adjusted community rates are then blended based on a size specific medical claim credibility factor with group specific claims experience. The rates for groups over 300 are 100% prospectively experience rated. Rates for outpatient prescription drug, dental and mental illness and substance abuse are pooled for all TLC groups regardless of size.

For groups with Retirees Not Eligible for Medicare, the group is either charged separate active employee and Stand-Alone Retiree Not Eligible for Medicare rates or rates are blended with active employee rates. All groups under 50 lives are charged a blended rate which is 102% of the active only rate. Groups over 50 lives may choose either a blended rate or Stand-Alone rates. Stand-Alone Retiree Not Eligible for Medicare rates are two (2) times the active rate. The Retiree Not Eligible for Medicare loading represents the additional morbidity costs of the Retirees Not Eligible for Medicare in the population covered.

The Commonwealth maintains a separate health insurance fund for TLC in which premiums are deposited and from which claims and administrative costs are paid. The program administrator's goal is to pay claims and maintain an adequate balance in the fund to cover required IBNR reserves, other liabilities and a contingency margin. Any fund deficits are the responsibility of the Commonwealth and may not be charged to a TLC group that remains in the plan.

Since a TLC group's only liability is the fixed fee paid to the Commonwealth for coverage, it is our opinion that these prospectively rated groups should not use actual group claims experience in the development of GASB liability but should use the actual rate charged in the development of their claim cost assumption.

Sincerely,



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