



**ACTUARIAL STANDARDS BOARD**

---

● **EXPOSURE DRAFT** ●

**Determining Minimum Value and Actuarial Value  
under the Affordable Care Act**

**Comment Deadline:  
May 1, 2015**

**Developed by the  
Actuarial Value/Minimum Value Task Force of the  
Health Committee of the  
Actuarial Standards Board**

**Approved for Exposure by the  
Actuarial Standards Board  
December 2014**

---

## TABLE OF CONTENTS

Transmittal Memorandum iii

### STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date	1
1.1 Purpose	1
1.2 Scope	1
1.3 Cross References	1
1.4 Effective Date	1
Section 2. Definitions	1
2.1 Actuarial Value (AV)	1
2.2 AV Calculator	1
2.3 AVC-AV	2
2.4 Essential Health Benefits (EHBs)	2
2.5 Health Insurance Plan	2
2.6 Minimum Value (MV) Requirements	2
2.7 MV Calculator	2
2.8 MVC-AV	2
2.9 Non-Standard Plan Designs	2
Section 3. Analysis of Issues and Recommended Practices	2
3.1 Use of AV or MV Calculator	2
3.2 Exceptions to the AV Calculator	2
3.3 Exceptions to the MV Calculator	3
3.4 Evaluating Non-Standard Plan Designs	3
3.5 Reasonableness of Assumptions for Non-Standard Plan Designs	3
3.6 Unreasonable Results	3
3.7 Documentation	4
Section 4. Communications and Disclosures	4
4.1 Actuarial Certifications	4
4.2 Other Communications and Disclosures	5
Appendix—Background and Current Practices	6
Additional Resources	7

December 2014

**TO:** Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Determining Minimum Value and Actuarial Value under the Affordable Care Act

**FROM:** Actuarial Standards Board (ASB)

**SUBJ:** Proposed Actuarial Standard of Practice (ASOP)

This document contains the exposure draft of a proposed actuarial standard of practice, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*. Please review this exposure draft and give the ASB the benefit of your comments and suggestions. Each response will be acknowledged, and all responses will receive appropriate consideration by the drafting committee in preparing the final document for approval by the ASB.

The ASB accepts comments by either electronic or conventional mail. The preferred form is e-mail, as it eases the task of grouping comments by section. However, please feel free to use either form. If you wish to use e-mail, please send a message to [comments@actuary.org](mailto:comments@actuary.org). You may include your comments either in the body of the message or as an attachment prepared in any commonly used word processing format. **Please do not password protect any attachments. If the attachment is in the form of a PDF, please do not “copy protect” the PDF.** Include the phrase “ASB COMMENTS” in the subject line of your message. Please note: Any message not containing this exact phrase in the subject line will be deleted by our system’s spam filter.

If you wish to use conventional mail, please send comments to the following address:

Minimum Value Actuarial Value Draft  
Actuarial Standards Board  
1850 M Street, NW, Suite 300  
Washington, DC 20036

The ASB posts all signed comments received to its website to encourage transparency and dialogue. Unsigned or anonymous comments will not be considered by the ASB nor posted to the website. The comments will not be edited, amended, or truncated in any way. Comments will be posted in the order that they are received. Comments will be removed when final action on a proposed standard is taken. The ASB website is a public website, and all comments will be available to the general public. The ASB disclaims any responsibility for the content of the comments, which are solely the responsibility of those who submit them.

**Deadline** for receipt of responses in the ASB office: **May 1, 2015**

## Background

Section 1302 of the Affordable Care Act (ACA) establishes the use of an actuarial value to categorize health insurance plans into bronze, silver, gold, and platinum tiers, specify a minimum level of coverage, and help consumers compare different plan designs and cost-sharing provisions. Similarly, Section 1401 of the ACA added Section 36B to the Internal Revenue Code of 1986, which creates a minimum value requirement for employer-sponsored plans (defined in terms of the plan's share of total costs). Although a practice note provides information on the subject of determining minimum value and actuarial value under the Affordable Care Act, no guidance for actuaries on the subject exists other than the regulation. Therefore, the ASB requested that the ASB Health Committee explore a potential ASOP to provide guidance to actuaries performing these tasks. As a result, the ASB Health Committee issued a discussion draft in April 2014 to gather feedback on such a potential ASOP.

A question regarding whether an ASOP is necessary for this subject was posed in the discussion draft. This question generated comments on both sides of the issue. Following discussions among the reviewers—which included the task force, Health Committee, and ASB—the decision was made to issue this exposure draft.

The task force appreciates the comments that were made on the discussion draft. The comments were carefully considered in the preparation of this exposure draft.

## Request for Comments

The Health Committee would appreciate comments on the proposed ASOP and would draw the reader's attention to the following areas in particular:

1. Does this ASOP provide appropriate guidance to actuaries who are determining actuarial values for purposes of meeting the various ACA AV and MV requirements?
2. Is the ASOP clear that it applies only to the calculation of actuarial value as required by the ACA, and not to other uses and determinations of actuarial value?
3. Do the descriptors AVC-AV and MVC-AV in sections 2.2 and 2.7 add clarity to the ASOP? We note that the American Academy of Actuaries' practice note uses the terms "Metal AV" and "MV" for these two values.
4. Is the guidance of the ASOP sufficient for situations where the actuary does not agree with the determination of the AV made by the AV or MV calculator?
5. Should the title of this proposed ASOP be changed to be more specific regarding testing of minimum values? If so, what change should be made?
6. Is the detail proposed for a certification in section 4 appropriate? Should additional items be added?

The ASB voted in December 2014 to approve this exposure draft.

Task Force on Actuarial Value/Minimum Value under the Affordable Care Act

Tim Wilder, Chairperson

David V. Axene	Gregory G. Fann
Richard Burd	Nancy F. Nelson
April Choi	Donna Novak
Elaine Corrough	Ngoc Trang

Health Committee of the ASB

Nancy F. Nelson, Chairperson

David Axene	John Lloyd
Robert G. Cosway	Donna Novak
Shannon Keller	Ross A. Winkelman

Actuarial Standards Board

Patricia E. Matson, Chairperson

Michael S. Abroe	Thomas D. Levy
Christopher S. Carlson	Robert G. Meilander
Maryellen J. Coggins	James J. Murphy
Beth E. Fitzgerald	James F. Verlautz

*The Actuarial Standards Board (ASB) sets standards for appropriate actuarial practice in the United States through the development and promulgation of Actuarial Standards of Practice (ASOPs). These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.*

**DETERMINING MINIMUM VALUE AND ACTUARIAL VALUE UNDER THE  
AFFORDABLE CARE ACT**

**STANDARD OF PRACTICE**

Section 1. Purpose, Scope, Cross References, and Effective Date

- 1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries performing professional services with respect to determining the **actuarial value (AV)** of a **health insurance plan** and testing whether the **minimum value (MV) requirement** is met in accordance with the Affordable Care Act (ACA).
- 1.2 Scope—This standard applies to actuaries performing professional services with respect to calculating **actuarial values** and testing **minimum value requirements** in accordance with the ACA and related regulations, specifically for purposes of (1) categorizing individual and small group **health insurance plans** into metal levels; (2) testing whether large employer-sponsored **health insurance plans** meet the federal **minimum value requirements**; or (3) making any required certifications.  
  
This ASOP does not apply to actuaries performing calculations of actuarial values for other purposes. For example, the calculation of an **actuarial value** used for converting from allowed costs to plan-incurred costs when calculating plan-level premiums is not covered by the standard.
- 1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.
- 1.4 Effective Date—This standard will be effective for any actuarial work product covered by this standard’s scope issued on or after four months after adoption by the Actuarial Standards Board (ASB).

Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice.

- 2.1 Actuarial Value (AV)—A measure of the proportion of total allowed medical costs for a specified population that the **health insurance plan** is contractually obligated to pay.
- 2.2 AV Calculator (AVC)—A spreadsheet released or approved by Health and Human Services (HHS) that is used to determine the **AV** of a **health insurance plan**.

## EXPOSURE DRAFT—December 2014

- 2.3 AVC-AV—The actuarial value calculated using the **AV Calculator**, including any adjustments for **non-standard plan designs**.
- 2.4 Essential Health Benefits (EHBs)—The specific items and services that the ACA requires health plans to cover in benefit plans offered in the individual and small group markets. EHBs must include any benefit defined by the Secretary of Health and Human Services. In addition, some EHBs may be defined by individual states.
- 2.5 Health Insurance Plan—A contract or other financial arrangement providing hospital, medical, prescription drug, dental, or vision benefits, including a self-insured employer plan.
- 2.6 Minimum Value (MV) Requirement—The minimum required **actuarial value** for certain employer-sponsored health insurance plans, as defined by regulations issued pursuant to the ACA.
- 2.7 MV Calculator—A spreadsheet released by HHS that is used to determine whether the **MV requirement** is met.
- 2.8 MVC-AV—The actuarial value calculated using the **MV Calculator**, including any adjustments for **non-standard plan designs**.
- 2.9 Non-Standard Plan Designs—Unique or innovative plan designs that include benefits not appropriately reflected in the **AV** or **MV Calculators**.

### Section 3. Analysis of Issues and Recommended Practices

- 3.1 Use of AV or MV Calculator—The actuary should use the appropriate calculator when calculating the actuarial value.

HHS requires use of an **AV Calculator** for certain **health insurance plans** offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), for the purpose of determining metal levels of coverage.

HHS and the Internal Revenue Service (IRS) requires use of the **MV Calculator** to determine whether an employer-sponsored health insurance plan meets minimum coverage requirements, unless the actuary determines that the safe harbor requirements established by HHS or the IRS are met.

- 3.2 Exceptions to the AV Calculator—If a **health insurance plan's** design is a **non-standard plan design**, the actuary should determine the plan's AVC-AV using one of the following options:

## EXPOSURE DRAFT—December 2014

- a. adjust the inputs to the **AV Calculator** in such a way that the results are consistent with the actual coverage being provided (i.e. estimating a fit of the plan design into the **AV Calculator**); or
  - b. use the **AV Calculator** to determine the AVC-AV for the plan provisions that are consistent with the calculator's parameters and then make appropriate adjustments.
- 3.3 Exceptions to the MV Calculator—If a **health insurance plan's** design is a **non-standard plan design** and the safe harbor test is not met, then the actuary should determine the plan's MVC-AV using one of the following options:
- a. adjust the inputs to the **MV Calculator** in such a way that the results are consistent with the actual coverage being provided (i.e. estimating a fit of the plan design into the **MV Calculator**); or
  - b. use the **MV Calculator** to determine the MVC-AV for the plan provisions that are consistent with the calculator's parameters and then make appropriate adjustments.
- 3.4 Evaluating Non-Standard Plan Designs—The AV and MV Calculators do not accommodate all plan designs. In situations of a non-standard plan design, the ACA requires the actuary to evaluate the plan and to certify the value of the plan. When evaluating **non-standard plan designs**, the actuary should confirm that the data, methods, and assumptions used are consistent with those underlying the applicable **AV** or **MV calculator**, as required by regulations. For example, the actuary should use a model that is based on data for a population that is consistent with the population underlying the applicable **AV** or **MV calculator**, where possible.
- 3.5 Reasonableness of Assumptions for Non-Standard Plan Designs—The actuary should review the assumptions used for making adjustments for **non-standard plan designs**. These assumptions should be reasonable in the aggregate and for each of these assumptions individually. The actuary should determine whether these assumptions are reasonable based on the actuary's professional judgment, using relevant information available to the actuary.
- 3.6 Unreasonable Results—In some circumstances, the **AV** or **MV Calculator** may, in the actuary's professional judgment, produce unreasonable results. The actuary may use unreasonable results from the **AV** or **MV Calculator** if required to do so by regulators. In such cases, the actuary should consider documenting within the actuarial memorandum the nature of the unreasonable results.

When the **AV** or **MV Calculator** produces an unreasonable result for either a standard plan design or a **non-standard plan design**, the actuary should consider documenting the value of the unreasonable result, the plan design used to produce the initial **AV**, why the actuary considered the result unreasonable, and by what authority the actuary was



## EXPOSURE DRAFT—December 2014

required to use the unreasonable result.

If the unreasonable result was after adjustment for a **non-standard plan design**, the actuary should document the approach used to develop the adjusted **AV**.

- 3.7 Documentation—The actuary should prepare and retain documentation in compliance with the requirements of ASOP No. 41, *Actuarial Communications*. The actuary should also prepare and retain documentation to demonstrate compliance with the disclosure requirements of section 4.1 of this ASOP.

The actuary should document results from the **AV** or **MV Calculator** and the plan design used to produce the initial **AV**.

In addition, for a **non-standard plan design**, the actuary should document the approach used to develop the adjusted **AVC-AV** or **MVC-AV**. If data other than HHS or state data was used to calculate adjustments to the calculator results, the actuary should indicate the data that was used, the rationale for using that data, and how it was used to calculate the adjustments.

### Section 4. Communications and Disclosures

- 4.1 Actuarial Certifications—When issuing actuarial certifications related to work subject to this standard, the actuary should also produce an actuarial report. The actuary should include the following information in the certification:
- a. a statement that the actuary is a member of the American Academy of Actuaries, meets the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States promulgated by the American Academy of Actuaries, and has the education and experience necessary to perform the work;
  - b. a statement describing the actuary's relationship to the issuer or the employer;
  - c. the purpose of the certification, including whether the certification is for an employer-sponsored health insurance plan(s) or for a plan(s) offered in the individual and small group markets;
  - d. the plan year for which the **AVC-AV** or **MVC-AV** certification applies;
  - e. a statement that the **AVC-AV/MVC-AV** was determined in accordance with the ASOPs established by the ASB and with applicable laws and regulations; and
  - f. a certification that the plan meets the minimum requirement for the **MVC-AV** determination in the case of an employer-sponsored health insurance plan; or a certification that the metal levels were appropriately assigned based on

## EXPOSURE DRAFT—December 2014

applicable law, in the case of plans offered in the individual and small group markets.

4.2 Other Communications and Disclosures—When issuing other actuarial communications related to work subject to this standard, including the actuarial report accompanying a certification, the actuary should refer to and follow ASOP Nos. 23, *Data Quality*, and 41. In addition to the disclosures required by ASOP Nos. 23 and 41, the actuary should include the following, as applicable:

- a. for a **non-standard plan design**, the approach and assumptions used to develop the adjusted AVC-AV or MVC-AV. If data other than HHS or state data was used to calculate adjustments to the calculator results, the actuary should indicate the data that was used and its source, the rationale for using that data, and how it was used to calculate the adjustments;
- b. a statement that the AVC-AV or MVC-AV are based on prescribed methodology and, therefore, may not reasonably reflect the actuary's estimate of the portion of allowed costs covered by the health plan;
- c. the disclosure in ASOP No. 41, section 4.2, if any material assumption or method was prescribed by applicable law (statutes, regulations, and other legally binding authority);
- d. the disclosure in ASOP No. 41, section 4.3, if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and
- e. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

**Appendix**

**Background and Current Practices**

*Note:* This appendix is provided for informational purposes only and is not part of the standard of practice.

Background

Section 1302 of the Affordable Care Act (ACA) establishes the use of actuarial value to categorize health insurance plans into bronze, silver, gold, and platinum metal levels. Section 1401 of the ACA adds Section 36B to the Internal Revenue Code of 1986, which creates a minimum value requirement for employer-sponsored health insurance plans.

In certain circumstances, ACA regulations require an actuary who is a member of the American Academy of Actuaries to certify that the actuarial value calculation is in accordance with generally accepted actuarial principles and methodologies.

Section 1302 of the ACA establishes the use of actuarial value (AV) to help consumers compare different plan designs and cost-sharing provisions. Similarly, Section 1401 of the ACA added Section 36B to the Internal Revenue Code of 1986, which creates a minimum value (MV) requirement for employer-sponsored health insurance plans. The AV of a health plan is a measure of the percentage of health care costs, on average, that the plan is expected to cover. AV is a measure of the level of a plan's cost sharing provisions, whereas MV is the minimum AV that certain employer-sponsored health insurance plans must provide.

In the individual and small group markets, the AV is defined as the ratio of (i) total expected payments by the plan for essential health benefits (EHBs) computed in accordance with the plan's cost-sharing provisions for a standard population over (ii) the total allowed costs for the EHB that the standard population is expected to incur. Benefits that are not considered part of EHB are not included in the AV calculation.

AV is a key concept in the ACA. AV is used to categorize health plans sold in the individual and small group markets into coverage tiers. These tiers are referred to as "metal levels"—bronze, silver, gold, and platinum—with AVs of 60 percent, 70 percent, 80 percent, and 90 percent, respectively. Federal tax credits for certain individuals and families with qualifying incomes are tied to the cost of a silver plan. Federal cost-sharing reductions for certain individuals and families with qualifying incomes are also defined in terms of AV.

The benefits offered by applicable large employers will be assessed to see whether or not they can be considered to meet the "minimum value" requirement, currently set at 60 percent. In the large group market, the MV requirement is a component of the determination of whether an employer is subject to a penalty.

## EXPOSURE DRAFT—December 2014

### Current Practices

The AV and MV calculators were developed using standardized populations that are applied across all geographic locations. The calculators take into account cost-sharing parameters; the AV Calculator accounts for induced demand in the underlying assumptions while the MV Calculator does not. Beginning in 2015, a state may elect to utilize state-specific tables in the AV Calculator, with HHS pre-approval.

The AV calculated with the AV and MV calculators may differ from AVs that may be used in pricing, and several items are reflected in health plan premiums that are not considered in the Federal AV/MV Calculators. These items include, but are not limited to, provider negotiated payments, administrative costs, and the impact of care management and utilization management programs. In addition, the calculators use a standard population with a prescribed nationwide data set and specific assumptions on price and utilization, which may differ significantly from a specific health plan's population, price and utilization assumptions, and other assumptions used to develop premium.

The AV and MV Calculators are not intended to be used as pricing tools. As a result, two plan designs with the same Federal AV/MV may not have the same premium for the reasons stated above. The intent of the AV and MV calculation process is to apply a standardized population and cost structure.

### Additional Resources

The following resources may assist in furthering actuaries' understanding of AV and MV.

- The Patient Protection and Affordable Care Act  
<http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>
- The Center for Consumer Information & Insurance Oversight, Regulations and Guidance  
<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/>
- American Academy of Actuaries, Health Council Practice Note, *Minimum Value and AV Determinations Under the Affordable Care Act*, April 2014  
[http://www.actuary.org/files/MVPN\\_042314.pdf](http://www.actuary.org/files/MVPN_042314.pdf)
- Final HHS Rule for Standards Related to Essential Health Benefits, AV, and Accreditation  
<http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>
- Minimum Value of an Employer-Sponsored Health Plan, IRS Notice 2012-31  
<http://www.irs.gov/pub/irs-drop/n-12-31.pdf>