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DISCUSSION DRAFT—
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● DISCUSSION DRAFT ●

Determining Minimum Value and Actuarial Value under the Affordable Care Act

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

T A B L E O F C O N T E N T S

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 2

Section 2. Definitions 2
2.1 Actuarial Value (AV) 2
2.2 AV Calculator 2
2.3 Bronze, Silver, Gold, and Platinum Metal Levels 2
2.4 Essential Health Benefits (EHBs) 2
2.5 Health Insurance Plan 2
2.6 Minimum Value (MV) 3
2.7 MV Calculator 3
2.8 Non-Standard Plan Designs 3

Section 3. Analysis of Issues and Recommended Practices 3
3.1 Issues and Recommended Practices for Calculating Actuarial Value 3
3.1.1 Use of AV or MV Calcualtor 3
3.1.2 Exceptions to the AV Calculator 3
3.1.3 Acceptable Methods for Determining AV or MV 4
3.1.4 Data Considerations When Making Adjustments 4
3.1.5 Modeling Considerations for Non-Standard Plan Designs 4
3.1.6 Reasonableness of Assumptions 5
3.1.7 Reliance on Data or Other Information Supplied by Others 5
3.2 Unreasonable Results 5
3.3 Documentation 5

Section 4. Communications and Disclosures 6
4.1 Communications and Disclosures 6

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April 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: Health Committee of the ASB

SUBJECT: Discussion Draft, *Determining Minimum Value and Actuarial Value under the Affordable Care Act*

This document contains a discussion draft of a potential Actuarial Standard of Practice (ASOP). The purpose of this discussion draft is to share preliminary draft wording to collect input from interested parties as the ASB Health Committee continues drafting the standard. Please note that, since this is a work in progress, many changes and additions are likely.

The Health Committee may create an exposure draft that would draw on the ideas in this discussion draft, modified by discussions with and comments received from interested parties and unfolding events. Any exposure draft would go through the normal ASOP process as follows:

1. The Health Committee submits the Exposure Draft to the ASB.

2. The ASB revises the Exposure Draft as necessary and releases it for comment.

3. Following the end of the exposure period, the Health Committee revises the Exposure Draft based on comments received and produces a proposed ASOP or a second Exposure Draft, depending on the extent of changes. This document then is reviewed by the ASB and either published as an ASOP or published for a second exposure.

4. An ASOP takes effect only after final ASB approval.

The ASB has neither reviewed nor approved this discussion draft, and the Health Committee has performed only an initial review, given the urgency in releasing this for comment. This is not an exposure draft, and there is no particular deadline for comments. However, the Health Committee is proceeding with this project, so comments received before September 30, 2014 are more likely to be reflected in a proposed exposure draft. Therefore, your feedback on this project is important.

Background

Section 1302 of the Affordable Care Act (ACA) establishes the use of actuarial value to categorize benefit 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 there is a practice note providing information on the subject of determining minimum value and actuarial value under the Affordable Care Act, there is currently no guidance on the subject. Therefore, the ASB requested that the ASB Health Committee explore a potential ASOP to provide guidance to actuaries in these tasks. As a result, the ASB Health Committee charged a task force with developing a discussion draft to gather feedback on such a potential ASOP.

Request for Comments

The ASB Health Committee is releasing this discussion draft to provide members of actuarial organizations governed by the ASOPs and other interested parties an opportunity to comment. While all comments will be considered, the committee is particularly interested in the following questions:

1. Do you think an ASOP is necessary for this subject?

2. Do you believe that this discussion draft has the appropriate level of detail for an ASOP on this subject? Also, is more detail needed for a standard on this subject than is typical of other ASOPs? If so, what additional detail should be provided?

3. There may be cases when the actuary does not agree with the results of the calculator. Is the guidance in this draft appropriate? What additional guidance, if any, should be given in these situations?

4. What other guidance should be included in a potential ASOP on this subject?

Please review this discussion draft and give the Health Committee the benefit of your comments and suggestions. Comments will not be posted to the ASB website and will not receive individual responses; however, the Health Committee will consider them in preparing the exposure draft for ASB approval. Please send comments to discussion@actuary.org. Comments will be reviewed as they are received, but are encouraged to be sent by September 30, 2014.

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

MV/AV Discussion Draft
Actuarial Standards Board
1850 M Street, Suite 300
Washington, DC 20036

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Task Force on Minimum Value under the Affordable Care Act

Tim Wilder, Chairperson

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

Health Committee of the ASB

Nancy F. Nelson, Chairperson

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

MINIMUM VALUE AND ACTUARIAL VALUE DETERMINATIONS 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 benefit plan and testing whether the Minimum Value (MV) requirement is met in accordance with the Affordable Care Act (ACA).

Section 1302 of the ACA establishes the use of actuarial value to categorize benefit plans into catastrophic, 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).

In certain circumstances, the law provides for an actuary who is a member of the American Academy of Actuaries to certify that the plan design and resulting actuarial value calculation is in accordance with generally accepted actuarial principles and methodologies.

An actuary may need to determine actuarial value for other purposes. In this case, the actuary may choose to use this guidance or choose another actuarially sound methodology.

1.2 Scope—This standard applies to actuaries performing professional services with respect to calculating actuarial value and minimum values in accordance with the Affordable Care Act, specifically for purposes of (1) categorizing individual and small group benefit plans into Bronze, Silver, Gold, and Platinum levels; and (2) testing whether large employer plans meet the federally required minimum value.

Other uses and calculations of actuarial values are not covered by this ASOP. 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 covered medical costs that the health insurance plan is contractually obligated to pay.

The actuarial value calculated by the AV Calculator is the percentage of total allowed costs a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. The actuarial value includes only expected benefit costs paid by the plan and not premium costs paid by the enrollee.

The ACA's actuarial value represents an average for a population and does not reflect the actual or even expected cost-sharing experience for each individual. For example, a plan with an actuarial value of 70% means that for a standard population, the plan is expected to pay 70% of their health care expenses, while the enrollees themselves are expected to pay 30% through some combination of deductibles, copays, and coinsurance on average.

2.2 AV Calculator—A spreadsheet released by Health and Human Services (HHS), used to determine the AV, is referred to as an "AV Calculator."

2.3 Bronze, Silver, Gold, and Platinum Levels—Benefit plans are categorized into levels in the non-group and small group markets as follows: bronze (60% AV), silver (70% AV), gold (80% AV), and platinum (90% AV).

2.4 Essential Health Benefits (EHBs)—The ACA requires health plans offered in the individual and small group markets to provide coverage for specific items and services known as essential health benefits. EHBs must include items and services within the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

HHS allows each state to choose from a set of plans to serve as the benchmark plan in their state. All state-required benefits enacted prior to December 2011 are considered to be included in EHBs.

2.5 Health Insurance Plan—A contract or other financial arrangement providing hospital, medical, prescription drug, dental, or vision benefits.

2.6 Minimum Value (MV)—The minimum required actuarial value for employer-sponsored group plans, as applied under the ACA. In the large group market, the MV is a component of the determination of whether an employer is subject to a penalty.

2.7 MV Calculator—A spreadsheet released by Health and Human Services (HHS), used to determine the MV.

2.8 Non-Standard Plan Designs—In various situations, the actuary will need to consider adjusting the results of the AV or MV Calculators because of limitations associated with the calculators or features of unique or innovative plan designs that are expected to have a material effect on the plan's AV. These situations are referred to as non-standard or unique plan designs.

Section 3. Analysis of Issues and Recommended Practices

3.1 Issues and Recommended Practices for Calculating Actuarial Value—The actuary should consider the following:

3.1.1 Use of AV or MV Calculator—When calculating an actuarial value, the first step is to choose an appropriate calculator. HHS requires use of an AV Calculator for non-grandfathered health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges) for the purposes of determining levels of coverage. The minimum value (MV) Calculator is used to determine whether an employer plan meets minimum coverage requirements.

3.1.2 Exceptions to the AV Calculator—If a health plan's design is not compatible with the AV Calculator, the actuary should choose one of the following options:

a. Option 1: Calculate the plan's AV and certify as follows:

1. enter the plan design into the parameters of the AV Calculator in such a way that the results are consistent with the actual coverage levels (i.e. "estimating a fit of the plan design into the AV Calculator"); and

2. certify that the plan design was in accordance with generally accepted actuarial principles and methodologies.

b. Option 2: Calculate the plan's AV and certify as follows:

1. use the AV Calculator to determine the AV for the plan provisions that are consistent with the calculator parameters; and

2. make and certify appropriate adjustments to the AV, identified by the calculator for non-standard plan design features that deviate substantially from the parameters of the AV Calculator, in accordance with generally accepted actuarial principles and methodologies.

3.1.3 Acceptable Methods for Determining AV or MV—Under the ACA, the following methods are acceptable for determining AV or MV:

a. the appropriate AV or MV Calculator;

b. safe harbors established by HHS and the Internal Revenue Service (MV only); or

c. a group health plan may seek certification by an actuary if the benefit plan contains non-standard plan design features that are expected to materially affect the result of the AV or MV calculation. When considering whether particular plan design features would have a material effect on the AV or MV calculation, the actuary should consider both the potential magnitude of the impact to AV or MV and the location of that particular plan's AV within the de minimis range for AV or MV relative to the minimum 60% requirement.

3.1.4 Modeling Considerations for Non-standard Plan Designs—When selecting data and models to address non-standard plan designs, the actuary should consider the extent to which the data, methods, and assumptions used are consistent with the data, methods, and assumptions underlying the AV and MV calculators. While addressing non-standard plan designs will require differences, the approach should be consistent with the MV and AV calculators where possible. For example, the actuary should use a model that is based on data for a population that is consistent with the population underlying the MV and AV calculators.

3.1.5 Modeling Considerations for Non-Standard Plan Designs—The following are examples of value-based plan designs that may require the actuary to modify the calculator's results:

a. condition-based plan provisions (for example, reduced cost sharing to encourage diabetes monitoring/treatment);

b. treatment decisions by insured (for example, place of service) impacting benefit levels; or

c. wellness incentives in plan design, including employer contributions to health reimbursement accounts (HRAs) or health savings accounts (HSAs) that vary based on member involvement in a wellness program.

For most of the value-based plan design benefits, the cost-sharing provisions that apply to a medical service will depend on actions or conditions of the insured. In those instances, the actuary should use reasonable methods to determine the expected portion of the claimant population to which each benefit variation will apply.

3.1.6 Reasonableness of Assumptions—The actuary should review the assumptions for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually. The actuary should determine whether assumptions are reasonable based on the actuary's professional judgment, using relevant information available to the actuary.

The actuary may rely upon others to provide assumptions for developing the rating justification. However, the actuary should review the assumptions for reasonableness. The actuary should use any such assumption only if he or she believes it is reasonable. The actuary should disclose any such reliance in accordance with ASOP No. 41, *Actuarial Communications*.

3.1.7 Reliance on Data or Other Information Supplied by Others—When relying on data or other information supplied by others, the actuary should refer to ASOP No. 23, *Data Quality*, for guidance.

3.2 Unreasonable Results—In some circumstances, the AV or MV Calculator may produce unreasonable results. In these instances, the actuary should document the unreasonable result, the plan design used to produce the initial AV, and the approach used to develop the adjusted AV. Or, if data other than HHS/state data was used to calculate adjustments to the calculator results, the actuary should indicate the data that was used, why it was used, why using that data was appropriate, and how it was used to calculate the adjustments.

The actuary may use the unreasonable results if instructed to do so by state regulators. In such cases, the actuary should note within the actuarial memorandum the nature of the unreasonable results.

3.3 Documentation—The actuary should prepare and retain documentation in compliance with the requirements of ASOP No. 41. The actuary should also prepare and retain documentation to demonstrate compliance with the disclosure requirements of section 4.1.

Section 4. Communications and Disclosures

4.1 Communications and Disclosures—When issuing actuarial communications relating to regulatory filings for health plan entities, the actuary should refer to and follow ASOP Nos. 23 and 41. Actuarial communications should disclose the following:

a. the purpose of the certification including whether the certification is for an employer-sponsored plan(s) or for a plan(s) offered in the individual and small-group markets;

b. for each applicable plan for which an alternative methodology was used, the alternative methodology the certification pertains to, the basis for selecting that alternative methodology, and a description of the process that was used to develop the AV/MV. The actuary should disclose what type of data was used and what adjustments were made when calculating the AV or MV, if any;

c. when adjustments were applied, confirmation whether only permitted factors were used. For example, provider discounts and the plan's own projected demographic changes should not be considered in the calculation;

d. a certification that the plan meets the 60 percent threshold for the MV determination in the case of an employer-sponsored plan; or a certification that the plan meets the AV requirements in the tiers, in the case of plans offered in the individual and insured small-group markets;

e. the actuary's relationship to the issuer or the employer;

f. 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;

g. a statement that the AV/MV certification is for the plan year beginning month/day/year;

h. a statement that the AV/MV was determined based on the plan's benefits and coverage data, the standard population, and utilization and continuance tables published by HHS/state (or in consultation with the U.S. Department of Treasury) for purposes of the valuation of AV/MV. Other data sources used should be specified when applicable;

i. a statement that the AV/MV was determined in accordance with the ASOPs established by the ASB and with applicable laws and regulations;

j. disclosure of the assumptions or types of data other than those provided by HHS/state (or in consultation with U.S. Department of Treasury), and the extent of verification for reasonableness or consistency of the data;

k. disclosure of other limitations, if any;

l. any material information supplied by others and the extent of the actuary's reliance on such information;

m. any unresolved concerns the actuary may have about the information that could have a material effect on the actuarial work product;

n. 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);

o. 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

p. 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.