

**Comment #8 – 4/29/15 – 1:22 p.m.**

With regard to the exposure draft “Determining Minimum Value and Actuarial Value under the Affordable Care Act,” I thank you for the opportunity to provide comments.

A concern I have is that the focus of the document appears to be primarily actuaries practicing in the “insured” product sector, where it is my observation that there is little “leeway” in choosing “what” is covered, and challenges with meeting AV or MV for a group are solely derived from questions of “how much” in terms of cost sharing features. This is because for all practical intents, “insured” plans of any employer size are going to “essentially” cover full EHB requirements, either through the ACA directly (small group) or State Mandates (large group). While there might be some fussing about fine details on a few immaterial odd state variations in benefits, for the most part attention will be spent constructing the cost sharing design (in regards to meeting metal or MV level, at any rate).

**Paragraph 1.2 Scope** does not mention, directly or indirectly, self-insured “small” employer group health plans (which are not concerned at all with “metal level”), and only indirectly does it reference self-insured “large” employer health plans (indirectly because they as a class are embedded within the phrase “large employer-sponsored health insurance plans). I recommend that more inclusive language be utilized here that specifically lists self-insured health plans without reference to “size.” (Some will argue that the definition of “Health Insurance Plan” in section 2.5 takes care of this. I think it does not. A logical reading of the existing 1.2 paragraph leaves no room for small group self-insured plans in either the way the parenthetical (1) and (2) breakout descriptions are treated as mutually “complimentary” subsets of all employer health plans. (1) Does not apply to small group employer health plans, and (2) expressly excludes them by case size. (I am aware that Kristi Bohn just provided a comment concerning this while my document was independently in process of being written.)

Actuaries practicing in benefit plan design for self-insured employers, especially the “newly discovered” large employers who did not provide benefits at all, or only to perhaps 5% of their eligible population, need an additional layer of specificity than the MV calculator and background resources currently provide either directly or indirectly through analysis of the continuance tables, genesis of those table etc. Attempts to ascertain exactly what the calculator categories of medical services/expenses actually mean have generally failed and analysis of what each of those categories is “worth” can lead to paradoxical results from within the calculator and affiliated continuance tables. The MV calculator is a flawed tool at best, but it could be made significantly more useful if CMS/CCIIO provided us with a “crosswalk map” for all detailed benefits of each acceptable EHB standard into the row categories of the MV calculator.

Note that IRS/HHS regulations and guidance releases in fact imply strongly that in order to use the MV calculator, the user should choose from amongst the available EHB standards to define the denominator of the MV ratio for a self-insured employer health plan. This implies that once such an EHB standard is chosen it will, expectedly, define which crosswalk into the calculator categories applies. Such a process,

combined with the detailed cross-walk suggested above, would be extremely useful, and in my view is actually necessary, for anyone attempting to apply this practice note in any market, but it would be particularly useful to those outside the “insured” market arena. That way, when a self-insured employer wishes to exclude sub-categories of services, as is the case in many of the “new” large employer situations, we will know for which row we need to adjust the calculator’s de facto category total value.

However, it may be that all of this is moot given the material change in the definition of what comprises Minimum Value that has been promulgated by regulators (a change which in my professional view was derived from flawed logic). This change requires plans to cover “substantial” inpatient hospitalization and “substantial” physician services in order to even be considered for MV determination, and therefore able to otherwise use the MV calculator or an actuarial certification process. (Plans that do not provide such are not allowed to use the MV calculator, or “any” actuarial certification of valuation.) While I appreciate that this likely has very little impact on the “traditional” carrier based insurance markets (small and large), and will be only a slight nuisance for most actuaries, that is not the case for those of us working within a material subset of the self-insured employer market. I respectfully submit that in light of this development, perhaps this particular proposed ASOP should be sent back to committee/taskforce for further consideration if and when the regulators so deem to tell us what they mean by the word “substantial,” which as of today has not been forthcoming.

Alternatively, perhaps the current proposed applicability should be bifurcated between plans for which there is no question about the inpatient and physician service question, for which this current proposed ASOP (with the appropriate edits recommended by the comments received from others and herein) would apply, and any “other” plan, for which we have to await a better informed regulatory update to modify how it could be used, perhaps in conjunction with the crosswalk I have suggested, along with a metric for the determination of “substantial.” It may be that with the new condition on MV versus AV, it is additionally appropriate to consider separate ASOP’s for AV and MV.

Thanks for your consideration of the ideas and comments included here.

Hobson D. Carroll, FSA, MAAA

President, MedRisk Actuarial Services, Inc.