Comment #9 – 4/30/15 – 5:00 p.m.

Response to Exposure Draft
Determining Minimum Value and Actuarial Value
under the Affordable Care Act

I am writing to the Actuarial Standards Board's request for comments on the recent exposure draft for *Determining Minimum Value and Actuarial Value under the Affordable Care Act.*

I would like to begin by congratulating the Actuarial Standards Board ("ASB") and its Health Committee for their initial draft for this topic. The remainder of my response addresses the questions posed on page iv of the exposure draft transmittal letter.

Q1. Does this ASOP provide appropriate guidance to actuaries who are determining actuarial values for purposes of meeting the various ACA AV and MV requirements?

Overall, the proposed ASOP provides appropriate guidance for actuaries who are calculating the various actuarial values under the ACA. Smaller details are addressed in my responses to other questions.

Some of the language used in the exposure draft would benefit from more clarity. For example, in paragraph 1.2, the second purpose cited, "testing whether large employer-sponsored health insurance plans meet the federal minimum value requirements", uses the phrase "large employer-sponsored health insurance plans" whereas the law is careful with its use of terminology to state that the minimum value requirement applies to "self-funded and large employers" because it applies to all self-funded plans and employers not participating in the SHOP (Small Health Options Program) marketplace. I suggest a minor change: to eliminate the adjective "large" from this sentence and leave it up to the actuary to understand whether or not it applies to the client. I would also suggest that "large" be removed from the first sentence in the last paragraph on page 6 and that "large group" be replaced by "employer" in the second sentence. This paragraph would then read as, "The benefits offered by applicable 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 employer market, the MV requirement is a component of the determination of whether an employer is subject to a penalty."

Also, the term "actuarial value" is defined in paragraph 2.1 and used in paragraphs 2.3 and 2.8 but not capitalized. Additionally, for both the AV and MV calculations, generally, only in-network cost sharing is considered. I believe that limitation should be included in this document. In addition, if a plan has a "tiered network" design, then all tier cost sharing designs must be incorporated in the AV/MV calculation. To be clear, "tiered network" means that the cost sharing varies depending in which "tier" the provider is identified as covered.

It would also be appropriate to include a comment that for the MV calculation, the actuary should be aware of, and comply with, all applicable regulations regarding services that must be covered. This statement would make sure the actuary is aware of various benefit and payment rules issued by CMS, for example the latest ruling which deemed plans that exclude inpatient services as failing to meet the 60 percent minimum value rule.

Paragraph 3.1 uses the term "affordable insurance exchanges" which isn't a widely used term. I suggest the reference in the second paragraph be changed to, "…. markets, both inside and outside the ACA individual health exchange and the ACA Small Business Options Program (SHOP), for the purpose…."

In the second paragraph of paragraph 3.1, I suggest adding, "Except as noted in 3.2," at the beginning of the paragraph, which would then read, "Except as noted in 3.2, HHS requires…." Similarly, in the third paragraph of paragraph 3.1, I suggest adding "Except as noted in 3.3," at the beginning of the paragraph, which would then read, "Except as noted in 3.3, HHS and Internal Revenue (IRS) requires…"

The use of the term "AV" in paragraph 3.6 was somewhat confusing. At first read, it appeared that referents had changed from the provisions applying to both AV and MV calculations to just AV. But upon rereading, it is apparent that the term applies to the generic definition of actuarial value. I suggest to avoid this confusion that it would be better to spell out "actuarial value" to avoid confusion.

Q2. 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?

I found that the exposure draft was clear that it only applied to the calculation of actuarial values as required by the ACA.

Q3. 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.

I found the descriptors to be clear as they were used in the exposure draft.

Q4. 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?

I believe the guidance in the exposure draft allows enough flexibility for the actuary to perform the work and is sufficient when the actuary does not agree with results of the calculator.

Q5. 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?

No change is suggested.

Q6. Is the detail proposed for a certification in section 4 appropriate? Should additional items be added?

The detail proposed for a certification in Section 4 is appropriate for the certification of the results of the Actuarial Value calculation, when it is accompanied by other documentation of the plan filing. An actuarial report produced for the Minimum Value calculation will generally not have any other supporting documents. Therefore, unless it is included with other documents, the Minimum

Value report should include a summary of the plan designs and the source of the plan design information.

Paragraph 4.2.a. states that if data other than HHS or state data is used, it should be disclosed. If HHS or state data are used, shouldn't that be disclosed as well? It is suggested that this paragraph include the following: "The actuary should indicate the data that was used and its source (e.g., HHS or state data) to calculate adjustments to the calculator results, the rationale for using the data, and how it was used to calculate the adjustments."

I hope my comments and suggestions will be a help to the Board in further developing actuarial practice.

Sincerely,

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