Appendix E

American Academy of Actuaries Public Policy Practice Notes

What Is a Public Policy Practice Note?

A Public Policy Practice Note (or Practice Note) is intended for to be used by the actuary only as a reference tool. It is not a substitute for (a) a legal opinion or (b) an interpretation of a law or regulation. Moreover, it is not (a) a promulgation of the AAA ASB, (b) binding on an Academy Member and (c) an ASOP. Moreover it is not a definitive statement of what constitutes appropriate or generally-accepted actuarial practice.

Practice Notes discussed in this Appendix include are as follows:

One. Minimum Value and Actuarial Value Determinations under ACA
Two. Large Group Medical Insurance Reserves, Liabilities and Actuarial Assets
Three. Large Group Medical Insurance
Four. Long Term Care Insurance Compliance with the NAIC Model Regulation Relating to Rate Stability
Five. Credibility Practice Note.

Item One. Minimum Value and Actuarial Value Determinations Under the Affordable Care Act

Introduction

This Note provides information to health actuaries who will be determining AV and MV for health plans (both by the published tables and by independent actuarial certifications) as provided by the ACA.

Actuaries review employer-sponsored insurance (ESI) plans for compliance with the MV requirements as mandated by the ACA. ESI plans seem to

exclude the metal plans; i.e., ESI are the large fully insured and all self-funded plans. The IRS has (a) published a proposed rule, (b) on MV requirements, (c) for ESI plans which includes an (d) independent actuarial certification as (e) set forth in the ACA. This MV may be determined by three methods: (a) the MV Calculator, (b) safe-harbor provisions or (c) independent actuarial certification.

The IRS Proposed Rule also provided initial guidance on safe-harbor plan designs. It is anticipated that most plans will show MV compliance by either the MV Calculator or the Safe Harbor provisions. That is, the actuarial determination method should be seldom used. All of the Rules are proposed and therefore subject to change.

IMPORTANT. There is a considerable overlap both (a) conceptual and (b) mathematical between the (a) AV (required for individual and small group plans where metal values are involved) and (b) MV (required for (i) large group plans and (ii) both small and large self-funded plans) where metal values are not involved).

Comparing AV with MV

Similarities

They are similar in three ways: (a) actuarial equivalence logic is applied to a standard population, (b) modeling considers plan parameters and (c) modeling variables may or should be many and complex.

Differences

The AV and the MV differ in five respects:

Respect One. Covered Populations
Actuarial Value. These populations include the fully insured individual and small group plans that will be covered beginning 1-1-2014. These are the so-called ***Metal Plans.***
Minimum Value. These populations include (a) the fully insured (over 50 lives) and (b) all self-funded plans.

Respect Two. Benefit Plans
Actuarial Value. These are the ***Metal Plans*** that must provide the essential health benefits as covered by the regulations. There is some latitude but far less than with the large-group market.
Minimum Value. What characterized the ESI plans is that they do not (a) have to provide essential health benefits or (b) meet the metal plan standards.

Respect Three. Under Lying Data
Actuarial Value. The HHS MV Calculator was based on fully insured small group claims experience.
Minimum Value. This was based on self-funded claims experience.

Respect Four. Thresholds
Actuarial Value. There are four metal tiers with a de minimis one-half % range.
Minimum Value. There is a strict 60% threshold.

Discussion

It is expected that the AV and the MV calculators will accommodate most plans as would a safe harbor – but not all. If the AV or the MV Calculator do not fit, it is a judgment call of the actuary whether or not the difference may be ignored or whether the actuarial determination method should be used.
Three different situations will be met: (a) the AV/MV Calculator may be adjusted to fit the non-standard benefits, (b) the AV/MV calculators can not be made to fit the non-standard benefits and (c) value-based insurance designs.

The Av/MV Calculators help to support some very important ACA provisions. There are numerous (a) tax and (b) coverage implications for both the (a) employer and (b) participant that result from such calculations.

Actuarial Value and minimum Value

For the sake of precision, these definitions should be used:
Metal AV. This term means the AV used to determine benefit packages that meet defined metal levels for all non-gandfathered individual and insured

employer-sponsored small-group market plans. In the individual and small-group market, the metal AV is expected to be used by consumers to compare the relative generosity of health plans with different cost-sharing parameters. The calculator used to determine such values will be called the AV Calculator.

MV. This term means the minimal value for all employer-sponsored group plans. In the group market, the MV determines whether an employer is potentially subject to a penalty (applies to large –100 – employers only). The calculator that is used to make this safe-harbor determination is called the MV Calculator.

Federal AV/MV. This term means both the (a) metal AV and the (b) MV.

The publication date of the calculators was February 2013.

Definition of Metal AV. This applies only to the individual and small group market. The definition is the ratio of (a) total expected benefits by the subject plan (involving only Essential Benefits) to (b) the total expected benefits (involving only Essential Benefits) when applied to a standard population.

Definition of MV. This definition is the same as that of the Metal AV except (a) it is only for the self-funded and large fully insured markets only and (b) it is not subject to the Essential Benefits provisions.

Both the AV and the MV Calculators consider benefit parameters, only the AV Calculator accounts for induced demand in the assumptions.

Cost-sharing parameters (deductibles, co-pays, coinsurance, out-of-pocket limitations). The AV/MV calculators consider only in-network parameters. The MetalAV Calculator consider the factor called *induced demand* which is not considered in the MV Calculator. The use of actuarial equivalence for other purposes would contemplate other factors such as (a) net-working, (b) provider discounts, (c) network usage, (d) care management, (e) wellness, e,g,

Plan Designs Not Accommodated by the Calculators

There will be some situations where the benefits will not fit the MV Calculator. In that event, the actuary must do one of two things: (a) adjust

the input to the MV Calculator or (b) making an adjustment to the result of the Calculator,

Item Two. Large Group Medical insurance Reserves, Liabilities and Actuarial Assets

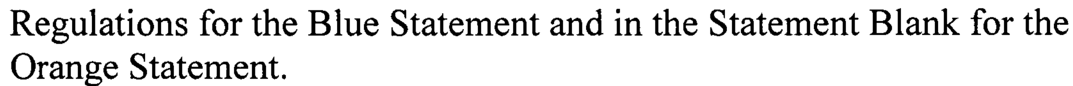
What is this Practice Note About?

This Practice Note deals with the relationship of the (a) the responsibilities of the valuation actuary under (b) these six state or professional regulations:

NAIC Accounting Practices and Procedures
NAIC Model Actuarial Opinion and Memorandum Regulation
NAIC Health Insurance Reserves
NAIC Health Insurance Guidance Manual
NAIC Health Annual Statement Instructions
American Academy of Actuaries Selected ASOPs

The primary focus is statutory accounting; however, GAAP accounting is referenced where needed. Self-funded group health plans are excluded.

Some issues of distinction are noted: (a) reporting requirements for the Life&Health (Blue) statement and the Health-Only (Orange) Statement are somewhat different and (b) actuarial opinions are addressed in the Insurance



Regulations for the Blue Statement and in the Statement Blank for the Orange Statement.

How Is Large Group Medical Business Defined?

LGM Insurance includes (a) usual forms of group health, (b) HMO and PPO, (c) all forms of consumer-driven plans, (d) minimum premium and (e) stop-loss. The benefit would include (a) Rx. dental, vision and disability. Definition of small ranges from 50 (common cut-off point for fully insured plans) to 100 (the ACA cut-off point).

What Funding Arrangements are Currently Used?