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Actuarial Value of Health Plan Benefit Designs

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Details on Actuarial Value of Health Plan Benefit Designs

HHS has recently released guidance describing a proposed method for estimating the actuarial value of health plan benefit designs in 2014. The actuarial value measures the percentage of expected medical costs that a health plan will cover. It can be considered a general summary measure of health plan generosity. As such, it can help consumers make sense of their health plan options by providing an overall measure of coverage in addition to discrete information on deductibles, copayments, and coinsurance, etc. The recent guidance on essential health benefits focuses on overall service categories not the overall package of benefits that contain cost-sharing provisions. The purpose of the new bulletin on actuarial value begins to clarify cost-sharing comparisons for individuals and employers.

The concept of actuarial value has key role in the major 2014 reforms included in the Affordable Care Act. In 2014, actuarial value will be used to categorize health plans sold in the individual and small group markets into coverage tiers. These plans must conform to one of four coverage levels – Bronze, Silver, Gold and Platinum – with actuarial values of 60 percent, 70 percent, 80 percent and 90 percent, respectively.

In turn, federal tax credits that middle-to-lower income households can use to purchase individual and family plans in the Exchange are tied to the cost of a Silver plan (70 percent actuarial value). Federal cost-sharing reduction payments -- which provide additional financial protection for lower-income households -- are also defined in terms of actuarial value. Finally, the coverage offered by larger employers will be assessed to see whether or not it can be considered to offer "minimum value."
This minimum value threshold is defined in terms a 60 percent actuarial value threshold.

The recent bulletin addresses many – but not quite all – of the questions surrounding how actuarial value will be calculated for these important functions. An overarching goal for the use of the metal tiers (e.g., Platinum) is to help consumers navigate their health plan choices. Consumer testing has shown that the varied and complex cost-sharing provisions associated with health insurance products make it very difficult for consumers to arrive at a "bottom line" for how much coverage they are being offered. Other research has shown that grouping coverage into coverage tiers provides an intuitive and easy-to-use way for consumers to navigate their choices by providing a

sense of the *relative* value of one plan compared to another.

Isolating Differences In Cost-Sharing

In order to realize these potential consumer benefits, the method of actuarial value estimation could accurately isolate and reflect differences in cost-sharing. HHS has proposed to use a central "calculator" based on a "standard population" of claims data for creating the estimates. By using a common model to produce the estimates, differences in actuarial value will accurately reflect cost-sharing differences and not differences in modeling approaches.

HHS notes that this population would reflect the non-elderly population likely to be covered by private plans in the small and non-group markets. HHS proposes to allow states to use their own standard dataset or to adjust the federal dataset using demographic and other adjusters if they want to recognize different prices for care or utilization patterns in their state. State adjustments to the standard population could yield accurate estimates of the relative differences in actuarial value within the state, as long as the underlying dataset is significantly robust.

A Trade-Off Between Simplicity And Accuracy

The bulletin highlights a potential tension between simplicity and accuracy in the estimation of actuarial value. HHS initially proposes to use a calculator that would utilize the "handful" of cost-sharing features that have a large impact on a plan's actuarial value, such as deductible, co-insurance, and maximum out-of-pocket. This approach may not take into account more subtle features of a plan, such as service specific deductions or exceptions to the out-of-pocket limit.

Reduced Cost-Sharing For Lower-Income Households

Under the ACA, lower-income households could benefit from more favorable cost-sharing than would normally be associated with plans at the 70 percent benchmark standard (Exhibit 1) – even though their premium (and tax credit) will be tied to that standard. The bulletin provides details on how the cost-sharing reduction payments would be calculated and paid.

Importantly, when insurers improve their Silver (70 percent) plans to hit these more generous actuarial value targets, HHS intends to require that these variations use *only* lower cost-sharing to achieve the targeted value. That means that plans could not raise some cost-sharing elements while significantly lowering others to hit the targets. It could provide peace of mind to the consumers eligible for these products that they will not be worse off in any dimension of coverage.

Lower-income patients will pay their reduced cost-sharing amounts at the point of service. HHS proposes making periodic advance payments to insurers to "fill in" the amount of the reduction. In addition, there would be an end-of-the-calendar-year reconciliation to make sure the advance payments to insurers tally to the actual cost-sharing reduction amounts. This is similar to the approach taken in the Medicare Part D low-income subsidy program.

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Addressing A Tension Between Actuarial Value And Out-Of-Pocket Maximums

HHS also resolves a potential mathematical tension between actuarial value targets for lower income households and the out-of-pocket limits that are required for the same households. In 2014, out-of-pocket limits for higher income households will be capped at the level required for HSA-qualified high-deductible plans—currently $6,050 for individuals and $12,100 for families—but lower limits are envisioned for lower income families.

Depending on the actuarial model being used, some researchers have found it impossible to hit the required actuarial value targets and the lower out-of-pocket limit requirements simultaneously. While it may seem counter-intuitive, allowing for a *higher* out-of-pocket maximum means lower deductibles can be offered while still hitting the required actuarial value target (Exhibit 2). As many consumers will not hit their out-of-pocket maximum, flexibility to use higher out-of-pocket limits benefits a greater number of consumers.

In a nutshell, HHS proposes to let actuarial value targets trump maximum out-of-pocket rules if this conflict arises. HHS intends to publish an annual notice providing guidance as to the out-of-pocket levels that would be consistent with the actuarial value targets for households with incomes from 100 percent to 250 percent of FPL, presumably reflecting the types of estimates being produced by the federal calculator. For households with incomes of 250 percent to 400 percent of FPL – which are also entitled to lower out-of-pocket maximums under the ACA but remain tied to the standard actuarial value benchmark of 70 percent – HHS proposes to do away with the requirement for lower out-of-pocket maximums altogether.

The bulletin is silent on how actuarial value will be calculated for the purposes of determining an employer's minimum value. In 2014, if an employer offers coverage with an actuarial value of less than 60 percent, its employees are eligible to receive premium tax credits through the exchange, and the employer will owe a penalty of $3000 for each employee who receives tax credits. This issue will be addressed by further guidance.