# Actuarial Value Under the Affordable Care Act

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# What is actuarial value?

- A health insurance plan's actuarial value indicates the average share of medical spending that is paid by the plan, as opposed to being paid out of pocket by the consumer
- The calculation takes into account various plan features:
  - Cost-sharing elements, such as deductibles, coinsurance, copayments, and out-of-pocket limits, and
  - The range of services covered by the plan
- For example, an actuarial value of 70% means that, on average, the plan pays for 70% of medical spending and consumers pay the remaining 30% out of pocket

# What is actuarial value? (cont.)

- There is no uniform method of determining an actuarial value
- The appropriate method will vary depending on the goal of the calculation

# Actuarial value under the ACA

- Actuarial value will be used to:
  - Categorize plans by benefit tiers
  - Benchmark the premium and cost-sharing subsidies for low- and moderate-income individuals and families
  - Establish minimum value requirements for employer-sponsored plans

# The ACA specifies four benefit tiers

| Benefit Tiers | Actuarial Value |
|---|---|
| Platinum | 90% |
| Gold | 80% |
| Silver | 70% |
| Bronze | 60% |

Additional Catastrophic Plan available for individuals up to age 30 and to those exempt from mandate (coverage level set at current HSA level)

Regardless of benefit tier, maximum out-of-pocket limits are based on those for HSA-qualified health plans ($6,050 for individual coverage and $12,100 for family coverage in 2012)

# Actuarial value from a consumer perspective

- Benefit tiers can help consumers choose between plans
  - Benefit tiers provide a gauge of the relative generosity of different plans
  - Plans within the same benefit tier are roughly actuarially equivalent
- Limitations of using actuarial value when choosing a health insurance plan:
  - Actuarial values do not predict out-of-pocket costs for any individual
  - Actuarial values do not provide a precise measure of the extent of coverage under a health plan
  - Actuarial values do not incorporate information about provider networks and quality

# Regulatory considerations when specifying actuarial value details

- Determining the general approach
- Defining a standard population
- Other considerations

# Determining the general approach

- Option 1: Plans with identical coverage and cost-sharing provisions should have the same actuarial values
  - Actuarial value differences between plans would reflect only plan design differences
- Option 2: A plan's actuarial value should correspond more directly with the expected share of spending paid by the plan
  - Provider discounts and utilization patterns of each plan would be incorporated into the actuarial value calculation

# Defining a standard population

- ACA requires that coverage levels be determined based on a standard population
- Using a standard population means actuarial values won't be skewed if a plan enrolls a disproportionately high- or low-cost population
- ACA does not provide details on how a standard population is defined or what data are used
- Option 1: Use a common standardized dataset
- Option 2: Allow plans to use their own data

# Other considerations

- Defining medical spending
  - Medical spending is defined according to the essential benefits package
  - The more broadly the essential benefits package requirements are defined, the less clear it becomes regarding which spending is included in the actuarial value calculation
- Geographic variations
  - Incorporating regional variations in health spending would result in actuarial values that better reflect local markets
  - Cross-area comparisons of plan designs would be more difficult

# Bottom line

- Method for calculating actuarial value needs to strike a balance between helping distinguish plans by coverage tiers and administrative simplicity
- Because actuarial value calculations are done on an average basis for a given population, different plans may be more or less valuable to any particular individual, even among plans in the same benefit tier

# Cost-sharing assistance for low- and moderate-income families

- To be eligible, must enroll in a plan in the silver level of coverage
- Cost-sharing assistance includes:
  - Reductions in out-of-pocket (OOP) limits, and
  - Increases in actuarial value

# Reductions in out-of-pocket limits

- Standard OOP maximum limits are reduced for people with incomes less than 400% FPL

| Income Level | Reduction in OOP Max Limit* |
|---|---|
| 100–200% FPL | 2/3 reduction |
| 200–300% FPL | 1/2 reduction |
| 300–400% FPL | 1/3 reduction |

* Standard maximum OOP limits are based on those for HSA-qualified health plans ($6,050 for individual coverage and $12,100 for family coverage in 2012)

# Increases in actuarial value

- Cost-sharing subsidies are available to people with incomes less than 250% FPL

| Income Level | Actuarial Value |
|---|---|
| 100–150% FPL | 94% |
| 150–200% FPL | 87% |
| 200–250% FPL | 73% |

- Aside from specified reductions in maximum OOP limits, plans have flexibility in how to achieve increased actuarial value through combination of deductibles, copayments, and coinsurance

# Interplay between OOP limit reductions and increases in actuarial value

- People with incomes 250%–400% FPL have reduced OOP limits, but actuarial value for silver plan must not exceed 70%
- Therefore, other cost-sharing provisions may need to be increased to offset decrease in OOP limits
  - HHS Secretary directed to adjust the OOP limits, if necessary, to ensure they do not cause actuarial values to exceed specified levels

# Silver tier plan requirements, by income

| Income Level | Actuarial Value | Maximum OOP Limit* |
|---|---|---|
| 100–150% FPL | 94% | 2/3 reduction |
| 150–200% FPL | 87% | 2/3 reduction |
| 200–250% FPL | 73% | 1/2 reduction |
| 250–300% FPL | 70% | 1/2 reduction |
| 300–400% FPL | 70% | 1/3 reduction |
| 400%+ FPL | 70% | standard limit |

* Standard maximum OOP limits are based on those for HSA-qualified health plans ($6,050 for individual coverage and $12,100 for family coverage in 2012)

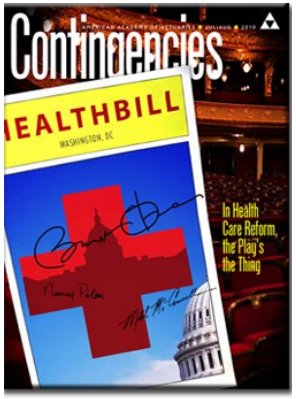
# Minimum value determinations for employer-sponsored coverage

- Premium subsidies are not available to people offered employer-sponsored coverage unless:
  - It is not affordable
  - The employer coverage does not meet minimum value requirements
- Minimum value = plan's share of total allowed costs of benefit provided under the plan must be at least 60% of such costs
  - Plans offered by large employers and self-funded plans do not need to offer essential health benefits

# Academy activities
## *Actuarial value*

- Publications (available at www.actuary.org)
  - "Actuarial Value Under the Affordable Care Act" (July 2011)
  - "Critical Issues in Health Reform: Actuarial Equivalence" (May 2009)
- Briefings for and meetings with congressional staff
- Presentations for policy experts and consumer advocates
- Discussions with the CMS Center for Consumer Information & Insurance Oversight (CCIIO)
  - When draft regulations/guidance are released, we will submit comments

# Academy activities
## *Communicating with members*

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