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WHAT LEVEL OF COVERAGE WILL HEALTH REFORM LIKELY PROVIDE? THE BASICS OF ACTUARIAL VALUE

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Each of the major health reform proposals Congress is considering sets standards for the coverage that the insurance plans offered through new health insurance exchanges would provide. To measure whether an insurance plan meets these standards, the bills rely on the use of “actuarial value.” This analysis explains the concept of actuarial value, its strengths and limitations, and how the major health reform proposals would use it. The main observations and findings are as follows:

- Actuarial values estimate the share of a typical population’s costs for covered health services that a particular health insurance plan would pay for. (Note: Actuarial values do not take into account the costs for health benefits and services that an insurance plan does *not* cover.)
- Actuarial values do not show how much any given individual or family would pay under a particular plan. Actuarial values measure the average amount of coverage that a plan would provide to an *overall beneficiary population*.
- In general, the health reform proposal the Senate Finance Committee has just approved would provide less comprehensive coverage (with higher out-of-pocket costs) than the bill three House committees have approved (H.R. 3200) or the bill passed by the Senate Health, Education, Labor and Pensions (HELP) Committee. This is reflected in the fact that the health plans available under the Finance Committee bill would have lower actuarial values.
- Under all three bills (the Finance Committee, HELP Committee, and House bills), the lowest “tier” of health insurance plans generally would provide coverage that is *more* comprehensive than the coverage provided by plans typically offered in the individual health insurance market, but *less* comprehensive than many employer-sponsored plans.
- For low- and moderate-income households, the actuarial values of the coverage that would be available under the bills reflect, in part, the levels of cost-sharing assistance (i.e., help with deductibles and co-payments) these households would receive. That the Senate Finance Committee bill would provide insurance coverage with lower actuarial values for low- and moderate-income people than the other two bills means that the Senate bill would provide such households less overall help with out-of-pocket costs.

Important differences also exist in the ways the bills measure actuarial value. Under the House and HELP Committee bills, the differences in actuarial value among the insurance plans would primarily reflect differences in the various plans' charges for deductibles and co-payments. Health insurance plans in different coverage "tiers" would generally offer similar benefit packages but carry different levels of cost-sharing charges (i.e., charges for deductibles and co-payments, as well as out-of-pocket limits). The more a plan requires beneficiaries to pay, in terms of deductibles and co-payments, the lower the plan's actuarial value, and vice versa.

Under the Senate Finance Committee bill the situation is somewhat more complicated. The bill appears to allow insurance companies to vary the benefit packages they offer to a greater degree than under the other bills. As a result, differences between insurance plans' actuarial values would reflect *both* differences in the nature and scope of the health services and treatments they cover *and* differences in the cost-sharing charges. (Allowing greater variation in benefit packages would likely produce some deleterious side effects. Insurance companies would have a greater ability to structure benefit packages in ways designed to cherry pick healthier people and deter those who are sicker. It also could make the choice of insurance plans bewildering for consumers and thus make it harder for people to make informed decisions about which plan to select. For a further discussion of these issues, see the box on page 5.)

What Is Actuarial Value?

Actuarial value in its most basic form measures how much a particular health insurance plan is expected to cover of a typical population's costs for covered medical services. It usually is expressed as a percentage of those costs, although it also can be converted into a dollar value. For example, a plan with an actuarial value of 75 percent would be expected to pay 75 percent of the medical expenses for covered health services for a typical population.¹

Actuarial value can also show the share of covered medical costs that an overall population would be expected to pay out of pocket. In the example of a plan with an actuarial value of 75 percent, beneficiaries overall would be expected to pay about 25 percent of the costs for covered medical services, with the insurance plan paying the other 75 percent.

The actuarial value of a health insurance plan thus typically reflects the cost-sharing rules for beneficiaries, such as rules for deductibles and co-payments, and any limits on a beneficiary's total out-of-pocket expenses.² The actuarial value does *not* reflect the costs that a beneficiary incurs for any items or services the insurance policy does not cover. For example, if an insurance plan does not cover prescription drugs, its actuarial value would not include the cost of any medications a typical population uses.

If two or more plans have the same actuarial value, they are said to be "actuarially equivalent."

¹ Roland McDevitt, "Actuarial Value: A Method for Comparing Health Plan Benefits," prepared for California HealthCare Foundation by Watson Wyatt Worldwide, October 2008.

² John M. Bertko and Cori E. Uccello, "Comparing Health Benefit Plans: Demystifying Actuarial Equivalence," The American Academy of Actuaries, July 11, 2008.

How Is Actuarial Value Typically Used Today?

Insurance companies, employers, and some government health benefit programs use actuarial-value calculations in several ways: to estimate the value of insurance coverage, to set standards for health plans, and/or to compare various health plans. For example, insurers might compare the actuarial-value estimates for various possible benefit designs to determine their relative costs.³ Employers might use actuarial-value estimates when deciding what plans to offer to their workers.

In Medicare, private insurance companies that provide prescription-drug coverage under Medicare Part D can offer plans that diverge from the standard benefit design required by federal law as long as these alternative designs are at least actuarially equivalent to the standard coverage (i.e., as long as they have at least the same overall actuarial value).⁴ Similarly, in operating the Children’s Health Insurance Program (CHIP), states must provide benefits packages that match one of three specified benchmark plans or are actuarially equivalent to one of these benchmark plans.

What Doesn’t Actuarial Value Measure?

It is important to recognize what actuarial value does and does not express. As noted, a plan with a 75 percent actuarial value would not necessarily cover 75 percent of the covered health costs of a *particular individual*. Similarly, the overall estimate of the share of costs that beneficiaries would pay for covered medical services — 25 percent in this case — does not mean that every enrollee would pay 25 percent of his or her medical costs under the plan or that the plan would charge co-payments of 25 percent for physician visits or other services. Any given individual or family could end up being covered for much more or much less than 75 percent of its medical costs.

Moreover, two insurance plans that are actuarially equivalent can, and often will, have very different real-world impacts on individual beneficiaries. A plan could have a very high annual deductible and still be equivalent, in actuarial terms, to a plan with a much lower deductible, as long as the high-deductible plan has other features that balance out its greater upfront costs for a typical population. Similarly, one plan, such as an HMO, may have a very limited provider network or generally not cover services furnished by out-of-network providers, but be actuarially equivalent to a plan (like many Preferred Provider Organization plans) that has a more open network of providers.

How Does Health Care Reform Use the Concept of Actuarial Value?

The House and Senate Finance Committee bills use actuarial values to define a *minimum level of coverage that all plans in a health insurance exchange would be required to provide*.⁵ All three major bills

³ Bertko and Uccello, *op cit*.

⁴ For a detailed description of the actuarial-value tests required for Medicare drug plans, see, “Actuarial Equivalence for Prescription Drug Plans and Medicare Advantage Prescription Drug Plans under the Medicare Drug Program,” American Academy of Actuaries’ Actuarial Equivalence PDP/MA-PD Practice Note Work Group, March 2008. Alternative Medicare drug-benefit designs must meet more than just a test of actuarial value; additional requirements limit variation among these plans to a greater degree than would actuarial equivalence alone.

⁵ The HELP Committee bill sets minimum standards for coverage in an exchange but does not specify a minimum actuarial value.

Congress is considering also use actuarial value to measure how much assistance, in terms of subsidies to help defray deductibles and co-payments, would be provided to people with low and moderate incomes. (These subsidies would be in addition to the tax credits to help such people pay health insurance premiums.) In addition, the health reform bills use actuarial value to place plans in different “tiers” in terms of the comprehensiveness of the coverage they offer so that people can more easily sort through the options and choose the plan best suited for them.

How Do the Actuarial Values Compare in Current Health Reform Proposals?

The three major health proposals at this time (the House bill, the Senate HELP Committee bill, and the Senate Finance Committee bill) all specify actuarial-value percentages for the different levels of coverage that plans available through the health insurance exchanges would offer.

In the House bill, *all* plans sold through the exchange would have an actuarial value of at least 70 percent. Plans with a 70 percent actuarial value would be considered to offer a “Basic” level of coverage. Plans also would be available with an actuarial value of 85 percent — which would be considered an “Enhanced” level of coverage — and an actuarial value of 95 percent, which would be termed a “Premium” level of coverage.

In the Senate Finance Committee bill, all plans sold through the exchange would need to have an actuarial value of at least 65 percent. Plans with that level of coverage would be termed “Bronze” plans. Insurance plans also would be available with actuarial values of 70 percent, 80 percent, and 90 percent; these plans would be termed “Silver,” “Gold,” and “Platinum” plans, respectively.⁶

Under the Senate HELP Committee bill, “Basic” plans would have an actuarial value of 76 percent. The next level of plans would have a value of 84 percent, and the level above that would have a value of 93 percent.⁷

In general, this means that insurance plans would offer more comprehensive coverage under the House and HELP Committee bills than under the Finance bill. As explained below, however, the various bills do not calculate actuarial value in exactly the same way, so the actuarial value percentages are not perfectly comparable. Rules regarding the medical services that plans would have to cover, which the Secretary of Health and Human Services or a new standard-setting entity would establish, also could affect the comparability of the actuarial values under the various bills.

What Do Differences in Actuarial Value Among Various Insurance Plans Signify?

Under the House bill, plans with different actuarial values would vary primarily in terms of their deductible and co-payment charges and out-of-pocket limits. Insurance plans would *not* vary widely in terms of the benefits they covered or the scope of such benefits. For example, a Basic plan with a

⁶ The Senate Finance bill also includes separate catastrophic insurance plans for young adults and certain other populations. These plans could have actuarial values lower than 65 percent.

⁷ The Senate HELP Committee bill has actuarial-value tiers, specifically defined for subsidy-eligible people, that are similar to those in the House bill.

70 percent actuarial value and an Enhanced plan with an 85 percent actuarial value might both cover physical therapy to roughly the same extent (i.e., they both might have the same limits on the number of covered visits). But a Basic plan would likely require the beneficiary to pay more out of pocket, perhaps \$20 per visit compared to \$10 under an Enhanced plan. The Senate HELP Committee bill is similar to the House bill in this regard.

The Senate Finance Committee bill, in contrast, appears to give insurers considerably greater leeway to vary the scope of the benefits (i.e., the extent to which particular services and treatments are covered).⁸ For example, the Finance Committee bill might allow a Bronze plan to cover fewer physical therapy visits each year than a Silver plan, in addition to charging the patient a higher copayment. Also, the Finance Committee bill appears to permit significant variation *among plans in the same tier* in terms of both the health services they would cover and the scope of that coverage, as well as with regard to their cost-sharing charges. As a result, comparing various plans and options, either with the same or different actuarial values, would be considerably more complicated since the plans could differ from one another across multiple dimensions.

Allowing Wide Variation in Covered Benefits Would Lead to Significant Problems in Insurance Exchanges

The Senate Finance Committee bill would allow insurance companies much greater leeway to vary the nature and scope of the health services that their plans cover. This feature of the Finance bill is problematic. Insurers could use the greater latitude to craft benefit policies in ways that would attract primarily healthy people and discourage enrollment by those who are sicker.

For example, an insurance company apparently would be allowed to scale back the number of days of hospitalization a plan would cover or include only bare-bones coverage for physical therapy, both of which are benefits likely to be needed only by people with significant medical costs. An insurer could take this course and still meet the necessary actuarial value by enhancing coverage of other benefits that are more attractive to healthier individuals.

This is what occurs now in the Medicare Advantage program, an alternative to traditional Medicare in which private health insurance companies provide the coverage. Under Medicare Advantage, insurers are permitted to scale back Medicare-covered benefits so long as the actuarial value of the overall benefit package is no less than the value of the overall package provided under traditional Medicare. Some insurance companies have taken advantage of this by imposing substantially higher cost-sharing than traditional Medicare does for extended hospital stays or costly treatments like chemotherapy, as a way to deter sicker people from signing up with them. These same insurers may then offer *lower* co-payments for other services that healthy beneficiaries use, and some insurers offer supplemental benefits such as discounts on gym memberships. As a result of these practices, many Medicare Advantage plans attract a healthier-than-average beneficiary pool, which tends to increase their profitability. And some seniors who enroll in Medicare Advantage but subsequently become sick and require costly treatments can end up paying far more out of pocket than if they had enrolled in traditional Medicare.

⁸ The Finance bill gives some authority to the HHS Secretary to define and update the minimum categories of covered treatments, items, and services listed in the legislation. Unlike the House and Senate HELP bills, the Finance bill does not ensure that this process would set a minimum *scope* of benefits that insurers would have to cover. Nor does the bill specify that a minimum benefits package would be consistent across plans within each tier and across tiers.

What Types of Benefit Packages Might Result from the Actuarial Values in the Bills?

In general, the insurance plans that would be offered under the House bill and the Senate Finance Committee bill would be more comprehensive than the plans typically available in the individual health insurance market today. The Congressional Budget Office said in a recent analysis that policies sold in the individual market are estimated to have an average actuarial value of about 60 percent.⁹ This is similar to a finding that that individual-market coverage in California had an average actuarial value of 55 percent in 2006.¹⁰

Nationally, insurance policies sold in the individual market commonly charge annual deductibles of \$1,800 to \$3,000 and 20 percent to 40 percent in co-payments for services such as physician visits and laboratory tests.¹¹ Individual-market policies also may have significant gaps in benefits. With 70 percent and 65 percent actuarial values, respectively, the Basic tier in the House bill and the Bronze tier in the Finance Committee bill (the bottom tiers in each proposal) would generally provide greater coverage than plans available in the individual insurance market.¹²

The Basic and Bronze tiers in the House and Senate Finance Committee bills are likely to have higher out-of-pocket costs, however, than employer-based coverage typically requires. Based on “illustrative” benefit packages, the Congressional Research Service estimated that preferred provider organization (PPO) plans offered by small and large employers tend to have an actuarial value of 80 to 84 percent.¹³ The CRS study also estimated an actuarial value of 87 percent for the Blue Cross and Blue Shield Standard Option plan, the most popular option in the Federal Employees Health Benefits Program (FEHBP).¹⁴ CBO recently said that employment-based plans are estimated to have an average actuarial value of about 88 percent.¹⁵ (Estimates of the actuarial values of existing

⁹ Congressional Budget Office, “An Analysis of Premiums Under the Chairman’s Mark of the America’s Healthy Future Act,” letter to the Honorable Max Baucus, September 22, 2009.

¹⁰ Jon Gabel, Jeremy Pickreign, Roland McDevitt, *et al.*, “Trends in the Golden State: Small-Group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet,” *Health Affairs*, June 14, 2007. The actuarial values in this study reflect person-weighted averages. The study found that in 2006, the average annual deductible for the individual-market plans in California was \$2,136, the average copayment for office visits was \$27, and the average out-of-pocket maximum (for plans that had them) was \$3,998.

¹¹ “Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits,” America’s Health Insurance Plans Center for Policy Research, December 2007.

¹² The actuarial value of the Senate HELP bill’s lowest plan tier is, at 76 percent, higher than the actuarial value for plans in the lowest tiers in the House and Senate Finance Committee bills.

¹³ CRS considered plans with a \$700 deductible (for small employers) or \$400 deductible (for large employers), 20 percent coinsurance for office visits and inpatient hospitalization, co-payments for prescription drugs of \$10 to \$45, and overall out-of-pocket maximums of \$3,500 (for small firms) and \$2,000 (for large firms). Chris L. Peterson, “Setting and Valuing Health Insurance Benefits,” Congressional Research Service, April 6, 2009. The actuarial-value estimates are based on 2007 data. The estimates assume standard prices for items and services, consider only the use of in-network care, and include a select menu of benefits.

¹⁴ The FEHBP benefits package examined had a \$250 annual deductible, \$15 co-payments for office visits, \$100 inpatient hospital co-pay plus 10 percent co-insurance, 25 percent co-insurance for prescription drugs, and \$4,000 overall out-of-pocket maximum.

¹⁵ CBO, *op cit.*

types of coverage vary because of differing methods and assumptions. The actuarial values cited here are not all directly comparable to each other or to the actuarial-value percentages in the health reform bills, but they provide a general sense of what the coverage options in a health insurance exchange would look like.)

CRS also looked at an employer-sponsored high-deductible insurance plan of the type that qualifies for a Health Savings Account (HSA). This plan, excluding any employer contribution to an HSA, had an estimated actuarial value of 76 percent, somewhat lower than the other employer-sponsored options,¹⁶ but still higher than the Basic and Bronze tiers in the House bill and the Senate Finance Committee bill. (This actuarial value, 76 percent, is the same as the value for plans in the lowest tier under the Senate HELP Committee bill.)

The coverage provided under the Blue Cross and Blue Shield Standard Option available through the FEHBP could be similar to the coverage offered in the House bill's Enhanced tier, which has an 85 percent actuarial value. This does not mean the Enhanced plans would necessarily resemble the specific benefit design of the FEHBP standard option plan, but rather that the Enhanced plans would likely be close to the FEHBP plan in terms of the share of costs the insurance plans cover for covered health services for a typical beneficiary population.

How Do the Actuarial Values Relate to Subsidies for Low- and Moderate-Income People?

Both the House bill and the Senate Finance Committee bill use actuarial values to establish the amount of cost-sharing protection that people with low and moderate incomes must receive.

The House bill would vary cost-sharing amounts on a sliding scale so that as a family's income falls, the actuarial value of the coverage they receive increases.¹⁷ The higher actuarial value translates into greater cost-sharing assistance and, thus, lower out-of-pocket charges for deductibles and co-payments.

As an example, under the House bill, a family of three with income at 200 percent of the poverty line enrolled in a Basic plan would pay less in cost-sharing than families with higher incomes enrolled in the same Basic plan. While the actuarial value of a Basic plan would be 70 percent for people with incomes too high to qualify for cost-sharing assistance, the actuarial value would be 93 percent for families at 200 percent of the poverty line because of the assistance they would receive with deductibles and co-payments.

The Finance Committee bill uses a similar approach, except that the level of cost-sharing assistance and the actuarial values would be lower. After cost-sharing assistance is taken into account, the coverage available to a family of three with income at 200 percent of poverty would have an actuarial value of 80 percent, 13 percentage points lower than the value of the coverage the family would get under the House bill.

¹⁶ The benefits package considered had a \$1,500 annual deductible, 20 percent co-insurance for office visits and prescription drugs, and a \$3,000 overall out-of-pocket maximum.

¹⁷ January Angeles and Judith Solomon, "Finance Committee Health Reform Bill Makes Improvements, But Still Falls Short of What Is Needed for Many People to Afford Health Care," Center on Budget and Policy Priorities, October 13, 2009.

Estimated Family Premium Contributions and Actuarial Value of Coverage, House Bill and Senate Finance Framework

Income for a Family of Three		House Bill ^a		Senate Finance Committee Bill ^b	
Percent of Poverty Line	Annual Income Level	Initial Annual Premium Contribution	Actuarial Value of Coverage ^c	Initial Annual Premium Contribution	Actuarial Value of Coverage ^c
133%	\$24,352	\$365	97%	\$889	90%
150%	\$27,465	\$824	97%	\$1,236	90%
200%	\$36,620	\$2,014	93%	\$2,563	80%
250%	\$45,775	\$3,662	85%	\$4,349	70%
300%	\$54,930	\$5,493	78%	\$6,592	70%
350%	\$63,085	\$6,939	72%	\$7,690	70%
400%	\$73,240	\$8,789	70%	\$8,789	70%

^a The table reflects the House bill as amended by the House Energy and Commerce Committee. While the premium contributions would initially be calibrated to income, the share of premiums that enrollees must pay would be held constant over time.

^b The actual premium contribution requirement may be different. The individual and family premium contributions range from 2 percent of income at 100 percent of the poverty line, rising to 12 percent of income for people at 300 percent of the poverty line. The premium contribution would remain at 12 percent of income for people between 300 percent and 400 percent of the poverty line. This table assumes (as the CBO estimate assumes) that the contribution requirement would increase on a linear or “straight-line” basis over the income range between 100 percent and 300 percent of poverty. As under the House bill, premium contributions would initially be calibrated to income and enrollees’ share of premiums would be held constant over time. The premium subsidy would be tied to the cost of the Silver plan, which has an actuarial value of 70 percent.

^c The actuarial values are not directly comparable between the proposals because they are calculated somewhat differently and because details that have yet to be determined, such as what specific benefits will be covered, also could differ across the proposals.

In general, families and individuals eligible for cost-sharing assistance would pay more under the Finance Committee bill than under the House bill. The Senate HELP Committee bill generally falls in between the other two proposals in terms of the actuarial values of coverage available to people with low and moderate incomes.¹⁸

The chart above shows the estimated premium contributions and cost-sharing under the House bill and the Finance Committee bill for people eligible for cost-sharing assistance.

¹⁸ The HELP bill would provide families with subsidies on a sliding scale so that those with the lowest incomes could buy a plan with a higher actuarial value, which would result in lower cost-sharing.