California HealthCare Foundation

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Health Reform in Translation

What Is Actuarial Value?

Actuarial Value

Actuarial value (AV) measures the average percentage of health care costs covered by an insurance plan, allowing policymakers, consumer advocates, and other market observers to assess how much financial protection a particular benefit design provides. Across a large pool of consumers, a plan with 60% actuarial value would cover 60% of aggregate health care costs, leaving consumers responsible for 40% of medical costs through deductibles, co-payments, and co-insurance. When considered along with premium cost, network design, and customer service, AV is a tool for assessing the comprehensiveness and value of health insurance.

Actuarial Value and the Affordable Care Act (ACA)

The federal Affordable Care Act, also known as "Obamacare," requires most health insurance plans to follow new actuarial value standards.[1] For most plans, the law requires a minimum actuarial value of 60%, meaning that a typical group of consumers will be responsible for no more than 40% of their total medical costs. It also requires plans[2] to fit into four tiers, identified by "precious metal" categories:

- Platinum: AV of 90% or more
- Gold: AV of 80% to 90%
- Silver: AV of 70% to 80%
- Bronze: AV of 60% to 70%

Actuarial value does not measure other important aspects of coverage. Even when benefits are identical, the network of providers from which consumers may choose varies from plan to plan. Health plans also differ in consumer service, quality of care, and the ability to manage population health. The AV measures none of these. The AV calculation does not incorporate premium cost. Typically, premiums and AV are correlated: the higher the AV, the higher the product's monthly premium.

What This Means for California

California legislation establishing Covered California, the state's health benefit marketplace, went beyond the minimum requirements of the ACA. Under that legislative authority, Covered California's governing board standardized benefits, requiring every insurance carrier selling through the marketplace to offer the same benefit design within each precious metal tier. As a result, Covered California customers will be able to directly compare plans with identical consumer cost-sharing and covered services (and therefore identical AV). Holding benefits and AV constant, customers will then shop on the basis of differences among networks and premiums.

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In California, the ACA will shore up the level of financial protection afforded by individual market coverage. Currently most individual (non-group) benefit plans in California have high deductibles, copayments, and other consumer cost-sharing. Prior to ACA passage, the *average* AV of plans purchased in California's individual market was about 55%, and many products had an AV considerably below that.[3] Starting in 2014, the minimum AV for these poli-

cies will be 60%. That expanded protection comes at a cost — premiums for individual plans will rise. However, under the ACA low- and modest-income consumers will qualify for tax credits to help offset premium costs if they purchase insurance through the Covered California marketplace.

Under the ACA, individual coverage will remain less comprehensive than employer-sponsored coverage. The AV of typical employer-sponsored plans is in the range of 80% to 90%.

Putting It All in Context

AV is an important tool for assessing and comparing comprehensiveness of health plan benefits for a large pool of purchasers. It is particularly useful in helping to structure and organize the marketplace, providing a tool that makes it possible to compare levels of financial protection provided to a group of typical consumers.

However, AV does not predict a particular consumer's share of her total medical costs. For example, an individual enrolled in a Covered California "Silver" plan could pay a very different share of costs depending on her health care needs. In general, the fewer services a consumer uses, the larger her share of total costs. Someone with extraordinary health care needs — a premature birth, traumatic injuries, or a complicated course of care for a chronic disease — could pay a small share of a very large annual medical bill. A healthy person with few health care needs, on the other hand, would typically pay a larger share of a smaller total bill, as shown in the following table.

Illustrative Annual Costs and Consumer Share, Covered California Silver Plan, Actuarial Value 70%

HEALTH CARE USE	ANNUAL COSTS, OUT OF POCKET	ANNUAL COSTS, TOTAL	CONSUMER'S SHARE OF TOTAL
Low: Two primary care outpatient visits and two generic prescriptions	$ 120	$ 250	48%
Moderate: Several outpatient visits, several generic and brand name prescriptions, several lab tests, one 2-day hospitalization	$1,700	$5,800	29%
High: Multiple primary and specialty outpatient visits, multiple brand name prescriptions, one multi-day hospitalization	$2,700	$24,000	11%
Standard non-group population, overall average	$1,800	$6,000	30% (equivalent to 70% AV)

Additional Resources

www.chcf.org/publications/2008/11/actuarial-value-a-method-for-comparing-health-plan-benefits

http://kff.org/health-reform/issue-brief/what-the-actuarial-values-in-the-affordable/

http://laborcenter.berkeley.edu/healthcare/financial_protection10.pdf

www.commonwealthfund.org/Publications/Issue-Briefs/2012/Aug/Choosing-the-Best-Plan-in-a-Health-Insurance-Exchange.aspx

www.coveredca.com/PDFs/English/CoveredCA-HealthPlanBenefitsComparisonChart.pdf

Endnotes

1. Certain health plans in place prior to the March 2010 passage of the ACA are "grandfathered" and do not have to conform to ACA Actuarial Value and Essential Health Benefit requirements.
2. A less comprehensive "catastrophic" benefit design with a lower AV will be available to young adults and others purchasing individual market coverage for whom purchasing Bronze coverage is deemed unaffordable.
3. Jon Gabel et al., "Trends in the Golden State: Small-Group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet," *Health Affairs* 26, no. 4 (2007): w488–w499, http://content.healthaffairs.org/content/26/4/w488.full.pdf+html.