



What will an “Actuarial Value” Standard Mean for Consumers?

October 2009

Today, consumers trying to buy health coverage on their own face a complex array of plan designs featuring a wide range of covered services and cost-sharing provisions. While large employer-based coverage almost always covers a comprehensive array of medical services, the coverage for individuals purchasing on their own may be very different. Insurers have considerable latitude in what they cover and they can exclude or limit prescription drug coverage, maternity coverage, and other services.¹ The patient cost-sharing provisions can be so complex that it is difficult to understand the actual amount of financial coverage provided. This complexity makes it difficult for consumers to compare plans and identify the best plan for themselves.²

Current federal proposals for comprehensive health reform establish new rules that standardize the financial protection offered by health plans and make insurance shopping easier, particularly for consumers who buy coverage on their own.³

All of the proposed bills would establish new standards for the type of coverage that would count as “qualified coverage.” For example, the proposals require that insurance you buy on your own cover a standardized, comprehensive set of services, including prescription drugs, maternity, mental health and substance abuse. These services will be covered even if the care is related to a pre-existing medical condition. These reforms don’t mean that only one type of coverage will be sold after reform. Health plans would be allowed to vary the *cost-sharing provisions*—things like deductibles and co-pays—of the coverage they sell.

Under Reform, Health Plans Would Conform To Actuarial Value Standards

Among other things, the proposed bills establish guidelines that insurers must follow to indicate the generosity of the coverage. These guidelines use a measure not familiar to

most consumers called *actuarial value* (AV). A health plan’s AV indicates the percent of covered medical expenditures that a plan is likely to pay. For example, an actuarial value of .86 means the health plan is estimated to pay 86% of covered medical expenses for a standard population, with the remaining 14 percent paid by the plan’s enrollees.

What is Actuarial Value?
 Actuarial value is a measure that indicates the percent of covered medical expenditures that a plan is likely to pay, based on the cost sharing provisions. For example, an actuarial value of .86 means that a health plan is estimated to pay 86% of covered medical expenses for a standard population. Importantly, the percentage that an individual patient might pay could be very different from this average. In a typical covered population, most enrollees are low users and a few enrollees are high users. Low users typically pay a higher share of covered expenses, as they may not have met the plan’s deductible.

Under reform, insurers would have their offerings conform to one of approximately four “Actuarial Value Standards.” Table 1 shows the four AV standards (ranging from .65 to .90) included in the Senate Finance Committee bill. Compared to today, these new standards would considerably narrow the range of plans designs available on the individual market. One study of current plans in California found plans with actuarial values as low as .32.⁴

The plan’s cost-sharing provisions determine the portion covered expenses paid by the insurer. Table 1 shows some sample cost-sharing provisions that would correspond to each of the AV standards, although many other plan designs would also be allowed.

Table 1: Actuarial Value Standards in the Senate Finance Committee Proposal

Designation	Actuarial Value Standard (across a standard population, the plan would pay this portion of covered medical expenses)	Sample Plan Design		
		Individual Deductible	Coinsurance (the patients share of charges, after the deductible)	Maximum Patient Out-of-Pocket
Bronze	.65	\$2,100	20%	\$5,950
Silver	.70	\$1,500	20%	\$5,950
Gold	.80	\$650	20%	\$ 2,975
Platinum	.90	\$0	20%	\$1,500

Notes: Plans corresponding to these actuarial value standards would be available to families with incomes that exceed 400% of the federal poverty level (about \$43,320 for an individual or \$88,200 for a family of four). Lower income families and young adults would have somewhat different choices.⁵ The sample plan designs in the table conform to the indicated standards but are only examples and not part of the proposed legislation. Other plan designs could also comply with the standard.

Sources: These proposed actuarial standards are from the Senate Finance Committee bill released 10/19/09. Sample Plan Designs developed and estimated by Watson Wyatt Worldwide⁶.

Actuarial Value Does Not Indicate How Much an Individual Will Pay

AV provides a common measure that can be used to compare different plan designs but it does not guarantee a level of payment. In fact, few enrollees will actually pay the patient's share indicated by the measure.

The Silver plan (above) has an actuarial value of .70. That means *across an average* patient population – containing both high medical users and low medical users – the patient population would pay 30%. However, *most* individual enrollees will pay a larger share. The reason: plan cost-sharing is typically structured so that low users pay a larger *share* of expenses and high users pay a smaller share. For example, low users must pay out-of-pocket until their deductible is met.⁷ If they have a high deductible, say \$1,500, they will pay 100% of medical expenses in a year where their expenses are under that amount. In contrast, an enrollee with very high expenses, say \$100,000, will find their share capped by the patient's out-of-pocket maximum--the plan would pay 100% of covered expenses after this point.

Most enrollees in a typical plan are low and moderate users. As Table 2 shows, these users (those with annual expenses under \$10,000) make up 90 percent of the patient population and they pay more than 30% of their medical costs. Across *all* enrollees, the average still works out to around 30% once the share of expenses paid by high users is factored in.

Table 2: Estimated Share of Expenses Paid by Single Adults Enrolled in a Silver Plan (Senate Finance Committee), at Varying Usage Levels

Annual Medical Spending per Enrollee (for covered services; 2010 dollars)	Percentage of Enrollees	Percentage of Covered Medical Spending Paid by Enrollees
\$0	13%	<i>No expense</i>
\$1-\$2,000	47%	87%
\$2,000-\$10,000	30%	37%
\$10,000+	10%	15%
Average Across All Adults	100%	28%*

* This actuarial value or benefit rate differs slightly from the *overall* rate for the Silver Plan (30%), which includes both single and family enrollees. To simplify presentation, the sample plan design in Table 1 does not show family deductibles or family out-of-pocket maximums. Hence, we restrict Table 2 to single adults for whom the plan provisions are known.

Sources: The proposed Silver actuarial standard is from the Senate Finance Committee bill released 10/19/09. Percentage distribution of enrollees and medical spending paid by enrollees estimated by Watson Wyatt Worldwide.

Do Premiums Correspond to a Plan’s Actuarial Value?

In general, the higher the AV, the higher the premium. A high actuarial value indicates the health plan is paying a large share of medical expenses and premiums must be set to cover these plan expenses. Table 3 shows, *all things being equal*, how premiums might vary between the proposed AV levels.

Table 3: Premium Variation Associated with Varying Actuarial Values (as proposed by Senate Finance Committee)

Designation	Actuarial Value Standard (across a standard population, the plan would pay this portion of covered medical expenses)	Sample Annual Individual Premiums
Bronze	.65	\$4,440
Silver	.70	\$4,780
Gold	.80	\$5,460
Platinum	.90	\$6,150

Notes: These sample premiums are intended to show the impact of differences in actuarial value on premiums, *if all other factors remain the same*. The sample premiums are not an estimate of what any individual would pay under the health reform proposals. These sample premiums assume a 45-year-old enrollee; 2010 prices, an overall enrolled population of average age and health, and reflect the average price of services in the U.S.

Sources: *The proposed Bronze actuarial standard is from the Senate Finance Committee bill released 10/19/09. Sample premiums calculated by Watson Wyatt Worldwide*

However, in the real world, all things are not equal. It is likely that consumers would see considerable variation in premiums around a given actuarial value standard. When health plans set their premiums, they look at factors such as the health of the population expected to enroll in that coverage, costs related to health plan administration, the negotiated fees that are paid to medical providers, profit or the need to add to insurance reserves. Variation in these factors means that insurers could charge very different premiums for plans with identical actuarial values.⁸

Will Actuarial Value Standards Make it Easier to Choose a Health Plan?

Different plan designs can have the same actuarial value. For example, Table 4 shows two plan designs, both of which conform to the *Bronze* standard of .65. Depending on use of medical services, these underlying plan differences may mean that one plan better meets a patient’s needs than another, despite having the same actuarial value. For example, the enrollee may be better off under the plan featuring copays (Design 2) if they

only have prescriptions and office visits, but it will take longer to satisfy the deductible if they need to use other services.

Table 4: Alternate Plan Designs Meeting the Bronze AV Standard of .65

	Sample Plan Design 1	Sample Plan Design 2
Deductible	\$2,100	\$1,900
Copays and Coinsurance (the patient's share of charges, after the deductible)	20% coinsurance on all services	Copays: \$40 PCP \$80 Specialist \$200 Emergency Room \$20/40/60 Rx (3-tier Rx plan) 20% coinsurance on all other services
Maximum Patient Out-of-Pocket	\$5,950	\$5,950

Note: Other plan designs could also comply with the standard.

Sources: These proposed actuarial standards are from the Senate Finance Committee bill released 10/19/09. Sample Plan Designs calculated by Watson Wyatt Worldwide.

While the proposed reforms strengthen financial protections for consumers, significant variation in health plan design will remain. Consumers will likely be confronted with a variety of premiums, cost-sharing provisions, and plan provider networks. With so many dimensions to their choices, consumers may continue to have difficulty comparing their plan options.⁹

Actuarial Value Standards: The Bottom Line for Consumers

The Actuarial Value standards – in conjunction with rigorous limits on out-of-pocket spending and a requirement for a broad scope of covered services -- will greatly benefit consumers. These changes reduce some of the variability in health plan choices available today and provide new protection from unexpected out-of-pocket costs, which today often lead to financial hardship or bankruptcy.

However, the remaining variation in plan design may make it difficult for consumers to compare plans. It will be critical to enact strong rules that standardize insurance terms and require benefit designs be disclosed using a standard format (like nutritional labeling today). Furthermore, the minimum standards for consumer cost-sharing under these plans may leave consumers with out-of-pocket costs that are still unaffordable.

END NOTES

¹ For example, see this story about a healthy 51-year-old who couldn't get comprehensive coverage: <http://www.washingtonpost.com/wp-dyn/content/article/2009/10/16/AR2009101601933.html>

² Consumers Union recognizes that many consumers today cannot buy coverage at all due to pre-existing health conditions or cannot afford coverage at current prices. These consumer issues are addressed by the health reform proposals but are not the topic of this brief.

³ As of this writing, there are three comprehensive reform proposals being considered in the House, the Senate HELP committee and the Senate Finance committee. All three proposals contain similar—although not identical—provisions with respect to the use of actuarial value standards. The bills contain many other provisions that help consumers. They require that all qualified coverage sold to individuals and small groups must (1) cover a standard, comprehensive array of services, (2) cannot feature annual or lifetime benefit maximums, (3) cannot feature patient out-of-pocket maximums that exceed an established amount, and (4) must cover prevent care with no cost-sharing. The enrollee's maximum out-of-pocket amount varies depending on the proposal but is likely to fall in the range of \$5,950 individual; \$11,900 family (for 2010; amounts will increase annually).

⁴ McDevitt, Roland. *Actuarial Value: A Method for Comparing Health Plans*, California Health Care Foundation, October 2008. See <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=133789>

⁵ The Senate Finance Committee's bill calls for a new category of health insurance that could only be sold to Americans age 25 years or younger. These so called "young invincible" policies provide catastrophic coverage with deductibles of up to around \$6,000 but including coverage for preventive care — with cost-sharing. Such policies would have low premiums making it easier for young adults to comply with the individual mandate. Some poor young adults would also be newly eligible to enroll in Medicaid, which up until now has been closed off to most young, childless, non-disabled adults, no matter how poor they are. Finally, while the proposals vary in their approach, insurance plans with lower cost-sharing would be available for families with incomes that were low yet too high to qualify for Medicaid.

⁶ Roland McDevitt, Tina Brust and Ryan Lore at Watson Wyatt Worldwide sampled the MarketScan medical claims database from Thomson Reuters to develop a simulation model for payment of medical claims. The medical claims were trended to 2010 price levels numerous benefit plan designs were developed to guide payment of claims in the model. Plan designs were modified until they produced the targeted actuarial values.

⁷ For purposes of this brief, we use fairly simple plan designs. Many plans – including those that would meet the standards established under the health reform proposals—provide “first dollar” coverage for preventive services. This means that the patient does not have to meet his or her deductible in order to receive reimbursement from the plan. Enrollees using *only* those “first dollar” services would experience a higher benefit from the plan than indicated in Table 2.

⁸ McDevitt, op cit. and Karen Pollitz, Eliza Bangit, Jennifer Libster, Stephanie Lewis, and Nicole Johnston. *Coverage When It Counts. How much protection does health insurance offer and how can consumers know?*, Center for American Progress Action Fund, May 8, 2009.

⁹ Quincy, Lynn and Steve Findlay. *Simplifying Health Insurance Choices*, Consumers Union, June 2009.