

Criteria and Methods for Estimating the Impact of Benefit Mandates on Actuarial Value

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California Health Benefits Review Program (CHBRP)
University of California, Berkeley

The authorizing statute¹ of the California Health Benefits Review Program (CHBRP) requests consideration of the financial impacts of proposed health insurance benefit mandates on health insurance regulated by either the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). Health care service plans licensed by DMHC provide benefit coverage to enrollees through plan contracts (referred to as “plans”), and health insurers licensed by CDI do so through policies.² As part of its analyses, CHBRP will consider the possibility of a proposed mandate impacting the actuarial value of DMHC-regulated plans and CDI-regulated policies associated with Covered California, the state’s health insurance marketplace. The purpose of this document is to inform stakeholders on issues relating to actuarial value and health benefit mandates and to explain CHBRP’s approach to estimating possible impacts.

Actuarial Value

The Affordable Care Act (ACA)³ introduced the concept of actuarial value to give consumers a general indication of the relative level of cost sharing associated with particular plans and policies. Actuarial value is the estimated average percentage of allowed health costs that are paid for by the health plan or insurer, with the remaining costs paid by the enrollee through the cost-sharing provisions (such as deductibles, copays, and coinsurance) associated with the enrollee’s particular plan or policy. For example, for a plan or policy with an 80% actuarial value, the issuing health care service plan or health insurer would be expected to pay 80% of the total allowed health care costs. Enrollees utilizing covered benefits would be expected to pay the remaining 20%. Actuaries estimate actuarial value for a particular plan or policy by considering its cost-sharing provisions and projecting the total allowed health care costs of a specified population.

As part of regulatory compliance, all nongrandfathered⁴ individual and small-group plans and policies are assigned an actuarial value. The actuarial value of a plan or policy is determined using the federal Actuarial Value Calculator (AV Calculator). The AV Calculator⁵ and a description of its methodology⁶ are available online. The AV Calculator uses claims experience from a historical database that has been adjusted to have characteristics similar to that of the individual and small-group health insurance markets. The AV Calculator estimates the actuarial value by applying the cost-sharing provisions of a particular plan or policy relevant to each of several major benefit categories to the claims experience. Major benefit categories include emergency room services, inpatient hospital services, primary care visits, specialist visits,

¹ CHBRP’s authorizing statute is available at: <https://www.chbrp.org/about> .

² Not all insured Californians are enrolled in DMHC-regulated plans or CDI-regulated policies. See *Estimates of Sources of Health Insurance in California*, available at: <https://www.chbrp.org/other-publications> .

³ The federal “Patient Protection and Affordable Care Act” (P.L.111-148) and “Health Care and Education Reconciliation Act” (P.L. 111-152) were enacted in March 2010. These laws are referred to as the ACA.

⁴ A group health plan created (or an individual health insurance policy purchased) on or before March 23, 2010, is “grandfathered” and exempt from many ACA requirements but may lose grandfathered status if certain significant changes that reduce benefits or increase costs to consumers are made. See: www.healthcare.gov/glossary/grandfathered-health-plan/.

⁵ Available at: www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-final.xlsm.

⁶ Available at: www.cms.gov/CCIIO/Resources/Files/Downloads/av-calculator-methodology.pdf.

etc. See Appendix A for the data requested by the 2015 federal AV Calculator. The intended use of the calculated actuarial value of a plan or policy is to assign it to one of the four metal levels listed in Table 1. As noted in the table, the U.S. Department of Health and Human Services (DHHS) has defined actuarial value ranges for each metal level.⁷

Table 1. Actuarial Value for Individual and Small-Group Market Plans

Metal Level	Range of Actuarial Value	
	Low	High
Platinum	88.00%	92.00%
Gold	78.00%	82.00%
Silver	68.00%	72.00%
Bronze	58.00%	62.00%
Catastrophic	N/A*	N/A*

Source: U.S. Department of Health and Human Services (DHHS)

Notes: * The federal AV Calculator is not applicable (N/A) to catastrophic plans and policies, which have defined benefits and a separate risk pool.

Benefit Mandates and Actuarial Value

If enacted, a proposed benefit mandate could impact actuarial value in a variety of ways. Possible scenarios are described as follows:

- **No Impact:** A proposed mandate requiring non-essential health benefits (non-EHB) coverage would have no impact on actuarial value as it is calculated by the federal AV Calculator. As per current guidance, for the AV calculator, “Percentage of the total allowed costs of benefits means the anticipated covered medical spending for EHB coverage.”^{8,9} An example of a new mandate that would not affect actuarial value could be a mandate to cover advanced fertility services, which are not currently considered EHBs in California.
- **Potentially No Impact:** A proposed mandate requiring benefit coverage (that does not exceed EHBs), but imposes no restrictions on cost-sharing provisions, would not impact actuarial value, so long as plans and insurers make cost sharing for newly covered benefits match cost sharing (as a percentage of total allowed costs) for previously covered benefits. An example of a mandate that would potentially have no impact could be a mandate to cover chiropractic services that imposes no cost-sharing provision restrictions (so long as plans and insurers apply similar cost sharing to the newly covered benefit as is being applied to other covered benefits).
- **Some Impact:** A proposed mandate imposing cost-sharing restrictions on currently covered benefits (or on newly required benefit coverage) could increase the percentage of total allowed costs paid by plans and insurers not already compliant with the new requirement. Such a change could increase the actuarial value of some plans and policies. An example would be a mandate to limit cost sharing for specialty prescription drug coverage to a specified annual maximum.

Other scenarios exist, but these three are provided as examples. It should also be noted that the impact of a new benefit mandate on actuarial value may vary among plans and policies depending on pre-mandate benefit coverage and cost-sharing provisions.

⁷ See pages 70645 and 70656, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, November 26, 2012. Available at: www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf.

⁸ Available at: www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

⁹ See page 12866, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, February 25, 2013. Available at: www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.

An Approach to Estimating a Benefit Mandate's Potential Impacts on Actuarial Value

When analyzing proposed mandates, CHBRP will use the final 2016 federal AV Calculator¹⁰ as the primary tool to estimate a benefit mandate's potential impact on the actuarial value of plans and policies associated with Covered California. Covered California requires plans and policies with standard cost-sharing provisions for its marketplace. Depending on the proposed mandate, it is possible that the input parameters of the AV Calculator may not be sufficient to model the mandate's provisions. In these situations, generally accepted actuarial principles and methodologies will inform modifications made either to the inputs or outputs of the AV calculator to determine the mandate's potential impact on actuarial value.

In its analyses, CHBRP will present a proposed mandate's potential impacts on the actuarial value of plans and policies associated with Covered California in the format described in Table 2.

Table 2. Format for Reporting Potential Impacts of a Proposed Benefit Mandate on Actuarial Value of Covered California Standard Plans and Policies, With Sample Values

Metal Level	Covered California Standard ^a Plans and Policies	
	Individual Market	Small-Group Market
Platinum	No impact	No impact
Gold	No impact	No impact
Silver	Less than 0.1%	Less than 0.1%
Bronze	Less than 0.2%	Less than 0.2%
Catastrophic	Less than 0.2%	N/A ^b

Source: California Health Benefits Review Program, 2015.

Notes: (a) Impacts are expected to fall within the above range for the copay, coinsurance, and health savings account (HAS) versions of Covered California's standard plans and policies. (b) Catastrophic plans are not available in the small-group market.

Key: N/A=not applicable.

A review of potential actuarial value impacts, like those presented in Table 2, will give some idea as to whether a mandate is likely to push plans or policies out of their metal level ranges. For example, the figures in Table 2 indicate potential impacts of less than 0.2%. Changes of this magnitude by themselves would be unlikely to push a plan or policy out of the 4.0% actuarial value assigned to its metal level range.

Reactions to Potential Impacts on Actuarial Value

Because CHBRP analyzes *proposed* benefit mandates, CHBRP's analyses are conducted in advance of enactment. In its analyses, CHBRP "holds all else constant" in order to make stakeholders aware of effects directly attributable to the mandate. Therefore, CHBRP's analyses present potential impacts in the absence of the kind of post-enactment reactions discussed below. However, should a proposed mandate be enacted and be thought possible of causing a change in actuarial value, health care service plans and health insurers, as well as Covered California, may make other modifications to the plan's cost sharing if the change would otherwise cause the plan's actuarial value to be outside the allowable range for its metallic level. Health insurers may so modify policies they issue, and plans may be modified by issuing health care service plans. Because there is generally time between enactment and mandate-required compliance, plans and policies may be modified for the upcoming year to ensure that their actuarial values continue to fall within their metal level range (see Table 1). Cost-sharing provisions could be altered, perhaps through increasing the deductible,

¹⁰ Draft methodology released for the 2016 AV Calculator seems to indicate no significant differences between the 2015 and 2016 federal AV Calculators. The 2016 draft is available at: www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2016-AVC-Methodology-MASTER-for-112114.pdf.

increasing the out-of-pocket maximum, or increasing copayments or coinsurance for benefits unrelated to the mandate. Covered California may also react. Should an enacted mandate have the potential to impact the actuarial value of Covered California's standard plan/policy designs, Covered California could modify the design's cost-sharing provisions in manners similar to those already discussed. In any case, plan and policy premiums, which do not directly depend on actuarial value, may still be impacted by an enacted mandate.

APPENDIX A: Data Requested by the 2015 Federal Actuarial Value Calculator

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?
- Apply Inpatient Copay per Day?
- Apply Skilled Nursing Facility Copay per Day?
- Use Separate OOP Maximum for Medical and Drug Spending?
- Indicate if Plan Meets CSR Standard?
- Desired Metal Tier: Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	<input type="checkbox"/>
Annual Contribution Amount:	

Tier 1 Plan Benefit Design		
	Medical	Drug
Deductible (\$)		
Coinsurance (% , Insurer's Cost Share)		
OOP Maximum (\$)		
OOP Maximum if Separate (\$)		

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSA)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$150.00
Primary Care Visit to Treat an Injury or Illness (exc. Well Baby, Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$0.00
Specialist Visit	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$10.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$10.00
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$20.00
Rehabilitative Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$10.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$10.00
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	80%	
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		\$50.00
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty High-Cost Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	<input type="checkbox"/>
Set a Maximum on Specialty Rx Coinsurance Payments?	<input type="checkbox"/>
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	<input type="checkbox"/>
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input type="checkbox"/>
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
# Copays (1-10):	

Output

Calculate

Status/Error Messages: Calculation Successful.
 Actuarial Value: 80.6%
 Metal Tier: Gold

About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource [Academic Rigor on a Legislature's Timeline](#).

To read any of the 200+ bill analyses CHBRP has completed, see the [Completed Analysis](#) page on [CHBRP's website](#). In addition to analysis of introduced legislation, CHBRP produces [other publications](#) including several annually updated resources, as well as issue briefs and explainers.