ANALYSIS METHODOLOGY:

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

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California Health Benefits Review Program (CHBRP)
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The authorizing statute[1] 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.[4] 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 nongrandfathered[5] 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 Calculator[6] and a description of its methodology[7] are available online. The AV Calculator uses claims

[1] See CHBRP's authorizing statute.
[2] Not all insured Californians are enrolled in DMHC-regulated plans or CDI-regulated policies. See CHBRP's resource, *Sources of Health Insurance in California*.
[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] Allowed cost is the maximum amount a health plan or insurer will reimburse health care professionals or facilities for a covered benefit used by an enrollee. See CHBRP's explainer *An Overview of Claims Data and How CHBRP Estimates Utilization and Unit Cost* for more information.
[5] 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.
[6] The AV Calculator is available from the Centers for Medicare & Medicaid Services (CMS).
[7] See the methodology for the AV Calculator.

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, etc. See Appendix A for the data requested by the 2026 federal AV Calculator. The intended use of the calculated actuarial value of a plan or policy is to assign it to one of the 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.[8]

Table 1. Actuarial Value for Individual and Small-Group Market Plans, 2026

Metal Level	Range of Actuarial Value	
	Low	High
Platinum	86%	92%
Gold	76%	82%
Silver	66%	72%
Silver (Cost-Sharing Reduction) (a)	69%	71%
Bronze	56%	62%
Bronze (Expanded) (b)	56%	65%
Catastrophic	N/A*	N/A*

Source: Centers for Medicare & Medicaid Services, 2025 (actuarial value ranges); Department of Health and Human Services, 2025 (definitions in footnotes).
Notes: * The federal AV Calculator is not applicable to catastrophic plans and policies, which have defined benefits and a separate risk pool.
(a) To be eligible for cost-sharing reductions, enrollees must choose a Silver plan and meet income requirements. Cost-sharing reductions include lower deductibles, copayments, and coinsurance.
(b) Expanded bronze plans are required to cover at least one major service, exclusive of preventive care, before the deductible is met or be a high-deductible health plan that qualifies for a health savings account.

Benefit Mandates and Actuarial Value

If enacted, a proposed benefit mandate could impact actuarial value in a variety of ways. Possible scenarios include but are not limited to:

- **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, AV is calculated as a percentage of total allowed costs of EHB coverage.[9,10] 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 that requires benefit coverage (that does not exceed EHBs) and 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

[8] See pages 70645 and 70656, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, November 26, 2012.
[9] See CMS Regulations and Guidance.
[10] See page 12866, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, February 25, 2013.

previously covered benefits.[11] 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.

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

When analyzing proposed mandates, CHBRP will use the current federal AV Calculator and most recent associated rules as the primary tools 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 that are available through its marketplace use standard cost-sharing provisions. 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

	Covered California Standard Plans and Policies (a)	
Metal Level	**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 copayment, coinsurance, and health savings account (HSA) 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.

[11] When analyzing bills, CHBRP generally assumes that cost sharing for a new benefit matches that for previously covered benefits, unless stated otherwise in bill language.

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 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 any kind of post-enactment behavior health care service plans and health insurers may engage in to ensure that plans and policies are in compliance with actuarial value ranges postmandate. 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 plans and policies may also be modified by their issuing entities.

Because there is generally time between enactment of a bill 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, 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 2026 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 MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount:	

Tiered Network Option	
Tiered Network Plan?	☐
1st Tier Utilization:	
2nd Tier Utilization:	

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

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑			☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑			☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑			☐	☐
Specialist Visit	☑	☑			☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑			☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑			☐	☐
Speech Therapy	☑	☑			☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑			☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑			☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑			☑	☑			☐	☐
Skilled Nursing Facility	☑	☑			☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☑			☑	☑			☐	☐
Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑			☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:
Name:
Plan HIOS ID:
Issuer HIOS ID:
AVC Version: 2026_1d

Output

Calculate

Status/Error Messages:
Actuarial Value:
Metal Tier:

Additional Notes:

Calculation Time:
Revised Final 2026 AV Calculator

Source: Centers for Medicare & Medicaid Services, 2025.
Current as of May 8, 2025

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.