fyi®

For your information

Volume 35 | Issue 15 | March 9, 2012

Actuarial Value Bulletin Addresses Treatment of High-Deductible Health Plans Linked to HSAs and HRAs

The Department of Health and Human Services (HHS) issued a Bulletin outlining the method it proposes for determining the actuarial value of plans under health care reform. Although this Bulletin only addresses how actuarial value may be determined for the individual and small group markets, it may have important implications for plan sponsors that offer health savings accounts (HSAs) or health reimbursement arrangements (HRAs) linked to high-deductible health plans.

Background

On February 24, 2012, HHS issued the Actuarial Value and Cost-Sharing Reductions Bulletin. This Bulletin describes the approach HHS is considering for defining actuarial value of individual and small group health plans under the Patient Protection and Affordable Care Act (PPACA). Actuarial value "is a measure of the percentage of expected health care costs a health plan will cover" across an average population.

$$\text{Actuarial Value} = \frac{\text{Health care costs paid by the plan}}{\text{Total health care costs}}$$

For example, if a health plan is expected to reimburse, on average, 80% of the eligible expenses covered under the plan, the actuarial value of that plan is 80%. The individuals covered under the plan would pay the remaining 20% through plan features such as deductibles, copayments, coinsurance, etc.

Starting in 2014, actuarial value will be used for several purposes under PPACA.

- In the individual and small group (100 or fewer employees) markets, actuarial value will be used by insurers to categorize health plans into "metal tiers" – bronze, silver, gold and platinum – which must have actuarial values of 60%, 70%, 80% and 90%, respectively.
- Actuarial value will be used to determine reduced cost-sharing on benefits in the individual market for individuals whose household income is below 400% of the Federal Poverty Level.

- Employers that do not offer coverage with a minimum actuarial value of 60% could be subject to penalties if employees enroll in an exchange plan and receive a federal premium subsidy or qualify for reduced cost-sharing.

Actuarial value for the first two purposes is based only on essential health benefits (EHB). (See our December 22, 2011 For Your Information.) Further guidance is needed on what benefits will be taken into account in determining actuarial value for purposes of the employer penalty.

Although the HHS Bulletin only addresses the use of actuarial value with respect to the first two purposes, it has possible implications for the third.

INSIGHT

The HHS Bulletin states that guidance will be issued "in the near future" on the determination of minimum value for employer-sponsored plans (item 3 above). This guidance will enable employers to determine whether they may be subject to the penalty for providing coverage that does not satisfy minimum-value requirements.

Calculation of Actuarial Value

HHS proposes to have all plans use standardized populations, claims data and utilization rates in calculating actuarial value, allowing for geographic adjustments by state. A publicly available actuarial value calculator will also be available to all plans to determine actuarial value using a common methodology. The use of standard assumptions and the calculator will allow for clearer comparisons across all plans, because plans with the same design will have the same actuarial value. Plans that cost less as the result of better utilization management or cost controls will then "stand out as having the lowest premiums in the metal tier."

Treatment of HSAs and HRAs

The Bulletin also discusses how the actuarial value of high-deductible health plans (HDHPs) linked to HSAs or HRAs should be determined. Noting that the exclusion of the value of a linked HSA or HRA from the calculation of the HDHP's actuarial value could understate the value of coverage while full inclusion could overstate the actuarial value, the Bulletin proposes that only a portion of the employer contribution to the HSA or HRA for a year be taken into account. To that end, the employer contribution would be adjusted to provide the same credit in the actuarial value as "the same amount of first-dollar insurance coverage."

INSIGHT

The guidance does not provide any further clarification regarding the adjustment of the employer HSA or HRA contribution. However, as an example of how this

"first-dollar" adjustment might work, consider a PPO plan that provides $500 in first-dollar coverage (e.g., no deductible, coinsurance or copayments) each year for accidents. If half of all plan participants are expected to use the first-dollar accident benefit, the actuarial value of that benefit would be $250 a year, and not the full $500 available. If this approach is adopted in determining whether an employer plan satisfies the employer "60% minimum actuarial value" requirement, some employers with HDHPs could be subject to penalties.

In the individual market, HSA contributions made by the individual would not count toward the actuarial value. The Bulletin does not discuss the treatment of HSA contributions by employees in employer plans.

Conclusion

Although the guidance doesn't directly address how the actuarial value of large employer plans must be determined, it does suggest the approach that may be applied. The proposed use of standardized assumptions and calculators for determining actuarial value would certainly simplify the determination of actuarial value for large employers. As guidance is developed, large employers that offer HDHPs may need to review their designs to see if they satisfy the 60% minimum actuarial value requirement.

Buck has prepared a Health Care Reform Timeline and Health Care Reform Comparison in Brief that provide an overview of the health care reform requirements, reflecting current guidance.

Buck Can Help

- Review the implications of actuarial value for employer plans
- Review strategies for HDHPs linked with HSAs and/or HRAs