Standardized Health Plans: Four Tiers of Coverage

Beginning in 2014, all new health plans sold to individuals and small businesses will need to meet new requirements for standardization in terms of the scope and value of health insurance coverage. Research has shown that too many plan choices can confuse consumers and gives more power to insurers to use benefit design to attract and enroll healthier people and avoid individuals with high cost health conditions. Standardization of plan coverage will help individuals and businesses make better informed comparisons among insurance options and help guard against insurance company efforts to use benefit design to 'cherry pick' the healthiest people and avoid more costly people.

Under the Affordable Care Act (ACA) health plans will be required to provide four levels of coverage: bronze, silver, gold and platinum. In the exchanges, participating plans must offer, at a minimum, one silver and one gold plan.

Each plan in each level must cover the ***same set*** of essential health benefits. But while the *scope* of benefits will be the same among the plans, the *value* of those benefits will vary across the bronze, silver, gold and platinum levels, based on the amount of cost-sharing required. Bronze plans will be the least generous, with higher out-of-pocket costs for covered benefits, and platinum plans will be the most generous, with less cost-sharing.

However, no plan will be allowed to impose total out-of-pocket costs – deductibles, copayments or other forms of cost sharing – greater than the amount imposed by high deductible plans (for 2012, the limit would be $6,050 for an individual and $12,100 for a family).[1] And plans sold to small businesses are barred from charging deductibles greater than $2,000 per year for individual coverage or $4,000 per year for family coverage (this amount will be annually adjusted to account for inflation).

How will the levels of coverage differ?

The four levels of coverage are based on "actuarial value." Actuarial value is a measure of the level of financial protection a health insurance policy offers and indicates the percentage of health costs that, for an average population, would be covered by the health plan. Under the ACA, the actuarial values for each level are:

Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

[1] The out-of-pocket maximum applies to benefits that fall into the Essential Health Benefits (EHB) package, as defined by the states. There is no limit on cost-sharing for services and treatments that are not part of the EHB.

In other words, for a bronze plan, the health plan would cover 60% of all health care costs for an average population, and enrollees, on average, would be responsible for paying 40%. For a platinum plan, an average individual would pay 10% out of pocket for their covered benefits and the plan would pay 90%. However, individuals with high cost health conditions could end up paying significantly more than the average.

Actuarial value is different from the premium for the plan. Premiums for plans that have the same actuarial value will almost always vary from one plan to another, based on the health status of enrollees, the prices of health care services negotiated by the plan, and how tightly the plan controls patient use of services. For example, a plan that covers mostly younger, healthier enrollees will have lower premiums than a plan that covers older, sicker individuals. And a plan that has limits on the number of visits allowed for a certain service may have a lower premium than a plan that has no limits on visits.

In addition to the four levels of coverage, some individuals will be able to purchase “catastrophic” plans that cover essential health benefits but have high deductibles. The only people who can purchase catastrophic coverage are young adults (under 30) and individuals who’ve been exempted from the individual mandate because there’s no available affordable coverage.