

Issues Involved in Designing a Basic Benefit Package and Determining Actuarial Equivalence

Executive Summary

A standard, or basic, benefit package is a plan of medical health insurance coverage that can be mandated by a governmental body. The plan may represent a minimum set of benefits to be equaled or exceeded by health insurance carriers. For certain populations or programs, it may be the only set of benefits that are offered. It generally consists of a list of health care services required to be covered, along with limitations on reimbursement such as cost sharing, maximum reimbursement, and exclusion of coverage for certain procedures or benefits.

Basic benefit plans are a key element in any health care reform proposal. Such standardized benefit plans can ensure a minimum level of coverage, control cost, and facilitate comparison among plans. The cost of a benefit can be a deciding factor in the public or private insurers' decision to include or exclude it in a policy. A detailed understanding of benefit packages with their limitations of coverage, cost-sharing characteristics, and anticipated utilization is necessary in order to be able to estimate or actuarialize program costs for covered services.

Actuarial equivalent is defined as "equal actuarial present value, determined as of a given date on the basis of the same set of actuarial assumptions."¹ In other words, a plan is equal or greater in value at this moment in time to another plan if similar pricing assumptions are used.

This paper addressed the design of a basic benefit package, while considering awareness of the needs of the target population and the values of the community providing the benefit plan. It also addressed legal requirements of the benefit design in order to secure additional funding from the Federal government through Medicaid program expansion by looking at actuarially equivalent or benchmark plans.

Designing a basic benefit package for a particular target population requires:

- Detailed knowledge of the specific population and their need of services,
- The community's values regarding how to frame the basic benefit package, and
- Awareness of the mandates and requirements imposed by the Federal government to gain additional financial assistance.

Traditional approaches to benefit design, such as the protection of assets, have to be weighed against the concept of access promotion. Benchmarking against federal mandates or other actuarially equivalent plans could help to determine feasibility of obtaining federal matching dollars.

This is one of a series of papers discussing issues related to universal health coverage for low-income uninsured Oregonians. This work is supported by a grant from the Health Resources and Services Administration. As more information is gathered, the papers will change. Views and ideas expressed within these papers are not intended to reflect those of any particular group, unless so noted, but are intended to inform and stimulate discussion and debate on critical health care coverage strategies. For the most recent revision, please visit the grant team's Web site: http://www.ohppr.org/hrsa/index_hrsa.htm, or call 503/418-1067 to request the paper in an alternate format.

¹ The American Academy of Actuaries (May 1993). "Standard Benefits in Health Care Reform—The Impact and Cost". Public Policy Monograph. Washington, DC.