Plan Year 2024 Qualified Health Plan Choice and Premiums in HealthCare.gov States: Methodology

Plan Data

This report includes data on individual market qualified health plans (QHPs) for Healthcare.gov Marketplaces. It excludes Small Business Health Options Program (SHOP) plans and stand-alone dental plans (SADPs). Except where otherwise noted, this report excludes catastrophic and child-only plans because they aren't available to all consumers. It also excludes PY14 Virginia QHPs covering morbid obesity treatment because these plans mirror others that don't cover morbid obesity and enrollment in these plans would only have included consumers seeking morbid obesity treatment.

Plan year 2024 (PY24) QHPs are those plans that are certified as of the beginning of October 2023. PY14–PY23 QHPs are those plans that were certified and available during some part of Open Enrollment for the applicable plan years. This includes plans that were decertified or suppressed from display on HealthCare.gov later in the PY, or suppressed at the beginning of Open Enrollment due to significant data errors.[1] The prior reports that the Assistant Secretary of Planning and Evaluation (ASPE) published generally used the data publicly available at the time of report generation and excluded plans decertified or suppressed after Open Enrollment.

The American Rescue Plan Act of 2021 (ARP) was signed into law on March 11, 2021. The ARP expanded eligibility for financial assistance to help pay for QHP coverage, beginning on April 1, 2021. The new law increased subsidies to lower consumer share of net premiums for most consumers who currently have a Marketplace health plan and expanded access to financial assistance for more consumers. In August 2022, the Inflation Reduction Act extended the increased subsidies established in the ARP.

This report assumes QHPs cover all zip codes in a county. For the two HealthCare.gov states that define rating areas using zip codes rather than counties (Alaska and Nebraska), this report uses the rating area that covers the most population based on Census Bureau data.[2]

Enrollment Data

This report uses HealthCare.gov enrollment data. Table 1 shows the cutoff dates used in collecting plan year enrollment data. These dates match previous final Open Enrollment report cutoff dates, except for PY14 and PY21 post-ARP (which uses data from the 2021 Special Enrollment Period that was made available on HealthCare.gov in response to the COVID-19 public health emergency).

Table 1: Plan Selection Cutoff Dates by Plan Year

Plan Year	Enrollment Selection Cutoff Date
2014	December 2014
2015	February 22, 2015
2016	February 1, 2016
2017	January 31, 2017
2018	December 23, 2017
2019	December 22, 2018
2020	December 21, 2019
2021 (*pre-ARP*)	December 21, 2020

[1] The 2024 QHP Landscape report includes data on certified plans of Community First Insurance Plans (HIOS Issuer ID 63251), which is not accepting new consumer enrollment at this time.

[2] U.S. Census Bureau, 2020 Census Demographic and Housing Characteristics File

Plan Year	Enrollment Selection Cutoff Date
2021 (*post-ARP*)	August 15, 2021
2022	January 15, 2022
2023	January 15, 2023

This report uses county-level plan selections to calculate state and national-level weighted averages. PY24 metrics use PY23 plan selection weights because PY24 plan selections will not be known until after the end of Open Enrollment.

This report uses the term "enrollees" to refer to individuals with non-canceled plan selections as of the cutoff date; the term doesn't refer to "effectuated enrollees" – individuals who selected plans and paid the premium necessary to effectuate coverage.

HealthCare.gov and State-based Exchange (SBE) Transitions

Except where otherwise noted, the metrics in this report include only states that use HealthCare.gov for a given plan year. Since states can transition between HealthCare.gov and State-based Exchanges with their own eligibility and enrollment platforms, one plan year's metrics may include different states than another plan year's metrics. All appendix table values are set equal to "N/A" for states that don't use HealthCare.gov in a given plan year.

Definitions

Issuer
This report identifies an issuer using its unique five-digit Health Insurance Oversight System (HIOS) issuer ID. In some cases, one parent company has multiple HIOS issuer IDs. An entity's HIOS ID is state-specific, such that a company offering plans through two different state Exchanges appears as two separate issuers.

Plan
This report identifies a plan using its unique 14-digit HIOS standard component ID, which is state and issuer specific. Each non-catastrophic standard plan ID has two cost sharing reduction (CSR) plan variations for American Indians and Alaska Natives, and silver plans have three additional income-based CSR plan variations. Unless otherwise specified, plan counts exclude CSR plan variations.

A plan's actuarial value (AV) determines its metal level (within an allowable de minimis range: bronze has a 60 percent AV, silver has a 70 percent AV, gold has an 80 percent AV, and platinum has a 90 percent AV). Not all states or counties have plans in every metal level; "N/A" indicates these scenarios. Beginning in PY18, certain bronze plans can have AVs that extend upwards to 65 percent. Although these bronze plans are sometimes labeled "expanded bronze," this report groups them in the standard bronze category.

Income-based CSRs are generally available to consumers with expected household incomes between 100%–250% of the Federal Poverty Level (FPL) who are eligible for premium tax credits, and who select a silver plan. The CSR plan variation AVs are higher than standard silver plan AVs because CSR plan variations have reduced copayments, coinsurance values, deductibles, or maximum out of pocket limits. The 73% AV silver plan variation is available to consumers who are eligible for advance payments of the premium tax credit (APTC) and have a household income greater than 200% of the FPL and less than or equal to 250% of the FPL. The 87% AV silver plan variation is available to APTC-eligible consumers with a household income greater than 150% of the FPL and less than or equal to 200% of the FPL. The 94% AV silver plan variation is available to APTC-eligible consumers with a household income greater than or equal to 100% and less than or equal to 150% of the FPL. More details are available at 45 CFR 155.305, 155.350, 156.135, and 156.420.

Typical Family of Four

This report defines a typical family of four as two 40 year-olds and two 0–14 year-old children, corresponding to one of the premium scenarios in the QHP landscape files. Previous ASPE reports used a 40 year-old, a 38 year-old, and two 0–14 year-old children.

Essential Health Benefits (EHB) Premium

QHPs must offer a comprehensive package of items and services, known as Essential Health Benefits (EHBs). QHPs can also offer benefits beyond EHBs, and QHPs report the premium percentage attributable to EHBs. Most QHPs have a percent of premium costs attributable to the EHB coverage of 100%; however, plans that cover benefits beyond EHBs have percents of premium costs attributable to EHB coverage that are smaller than 100%, reflecting the fact that some premiums pay for benefits beyond EHBs.

Second Lowest Cost Silver Plan (SLCSP)

The HealthCare.gov eligibility logic determines an enrollee's Advance Payments of the Premium Tax Credit (APTC) amount using the SLCSP, also called the benchmark plan. This report finds the SLCSP in each county by ranking all of the silver QHPs by their EHB premium amounts and finding the second-lowest value. The lowest value among this ranking is considered the Lowest Cost Silver Plan (LCSP). Enrollees' actual benchmark plans may vary based on their zip codes and plans' rating business rules. This report displays the premiums attributable to EHBs for all SLCSP metrics to align with the APTC methodology. Previous ASPE reports found the SLCSP using the EHB premium but displayed the total premium.

In some counties with three or more silver plans, the EHB premium amount for the two lowest-cost silver plans is exactly the same. For PY14–PY17, when this occurs, the SLCSP is the silver plan with the next highest premium relative to the tied lowest-cost silver plans. For PY18–PY24, when this occurs, the SLCSP premium equals the premium for the tied lowest-cost silver plans. This operational change resulted from an Internal Revenue Service (IRS) clarification regarding how to calculate APTC.[3]

For PY19–PY24, the SLCSP logic aligns with updated regulations at 26 CFR 1.36B-3(f)(3) and incorporates stand-alone dental plan (SADP) premiums for children less than 19 years-old; the PY19 ASPE report didn't incorporate this logic. When silver plans don't cover all pediatric dental EHB (Dental Check-Up for Children, Basic Dental Care – Child, Major Dental Care – Child), the logic adds the second-lowest-cost SADP EHB premium to the silver plan's EHB premium before ranking the silver plan EHB premiums and determining the SLCSP.

The SLCSP metrics for a typical family of four in this report use different logic depending on whether the SADP is age-rated or family tier-rated. If the SADP is age-rated, the logic uses two times the 0–14-year-old rate; if the SADP is family tier-rated, the logic uses the primary subscriber plus one dependent rate. In both cases, the logic multiplies the SADP rate by the EHB pediatric dental apportionment quantity. The logic excludes child-only SADPs because they aren't available to a family with adults.

Maximum APTC

The ARP established and the Inflation Reduction Act of 2022 (IRA) extended improvements in access to and affordability of health coverage through the Marketplace by expanding eligibility for APTC and increasing the generosity of premium tax credits to consumers who were previously eligible for APTC. Instead of no premium tax credits for individuals and families with household income of more than 400%, the new law made premium tax credits available to these families if they are otherwise eligible. Additionally, the law caps how much of a family's household income the family needs to pay towards their premiums at 8.5%, based on the cost of the

[3] See question 21 of the IRS Questions and Answers on Premium Tax Credits at: https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

benchmark plan. Table 2 shows the percent of annual household income that enrollees are required to spend toward SLCSP premiums before and after the passage of the ARP for PY21.

Table 2: Maximum Percent of Annual Household Income Paid Towards the SLCSP Premium

Income Bracket (by FPL)	% of Income (before ARP)	% of Income (after ARP)
100% - 133%	2.07%	0.0%
133% - 150%	3.10% - 4.14%	0.0%
150% - 200%	4.14% - 6.52%	0.0% - 2.0%
200% - 250%	6.52% - 8.33%	2.0% - 4.0%
250% - 300%	8.33% - 9.83%	4.0% - 6.0%
300% - 400%	9.83%	6.0% - 8.5%
Over 400%	100%	8.5%

Individuals with expected household incomes of 100%–400% of the FPL are generally APTC-eligible if they aren't otherwise eligible for minimum essential coverage. More detail is available at 45 CFR 155.305(f) and 26 CFR 1.36B. The maximum household APTC equals the APTC-eligible family members' benchmark plan premium minus the required household contribution, which is based on the household's expected income as a percent of FPL and an applicable percentage the IRS determines annually.[4] After-APTC benchmark premiums will differ slightly between any two years for identical family compositions and income amounts because of changes in the applicable percentages and FPL guidelines. The APTC methodology for a given plan year uses the FPL guidelines from the previous plan year (i.e., those that are available at the beginning of a plan year's Open Enrollment). Alaska and Hawaii's FPLs are higher than those for the 48 contiguous states; consequently, the Alaska and Hawaii maximum APTC amounts are higher for a given household income amount and benchmark plan premium.

If the required household contribution for a household with an income at or above the FPL is greater than the benchmark plan premium, the maximum APTC is $0 but the individuals are still considered APTC-eligible for the purposes of this report. For relevant metrics, this report uses the maximum APTC that enrollees can receive, including when the amount is $0. Enrollees will receive less than their maximum APTC if their maximum APTC is greater than their selected plan's EHB premium, or if they don't apply the maximum APTC amount and instead claim the credit when they file their federal income taxes. Enrollees can only apply APTC towards a plan's EHB premium. This report's maximum APTC calculation for a typical family of four with a household income of 325% of the FPL assumes all family members are APTC-eligible. However, in states where the household income to be eligible for Medicaid or Children's Health Insurance Program (CHIP) is higher than the income required to be APTC-eligible, the children could be Medicaid/CHIP-eligible and APTC-ineligible.

HealthCare.gov Enrollees

The HealthCare.gov enrollee maximum APTC and lowest cost plan (LCP) metrics include all enrollees who selected a non-catastrophic plan and have a non-missing county and zip code. This report includes tobacco users and calculates lowest cost plan premiums using tobacco rates when they exist. Previous ASPE reports excluded tobacco users from the maximum APTC and LCP metrics.

The HealthCare.gov enrollee metrics assume that families with multiple enrollment groups or policies maintain their selected grouping arrangement regardless of the selected plan. Calculations involving the lowest cost plan assume that all family members select the same plan and therefore consider that the plan be available to all

[4] The FPL guidelines for each year are available at https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references. The applicable percentages for PY24 are available at https://www.irs.gov/pub/irs-drop/rp-23-29.pdf.

household enrollment groups. The PY24 estimates hold all PY23 enrollee characteristics unchanged and calculate premiums using the PY23 age, family composition, and household income as a percent of the FPL. The metrics include bronze, silver, and gold lowest cost plan premiums and the lowest cost plan premium within an enrollee's chosen metal level. The latter considers the lowest cost plan within the metal level that corresponds to the enrollee's Open Enrollment plan selection, so it represents a mix of metal levels. The bronze, silver, and gold lowest cost plan metrics look only at the lowest cost plan in the given metal level, regardless of an enrollee's Open Enrollment plan selection.

For PY15–PY23, the HealthCare.gov enrollee maximum APTC metric uses the HealthCare.gov calculated maximum APTC amounts. For PY24, the report finds the county SLCSP and calculates an estimated maximum APTC using PY23 enrollment and eligibility data and PY24 plan data. In all plan years, the household maximum APTC is distributed among APTC-eligible enrollees using the relevant age rating curve and redistributed among QHP policies using the logic described in 45 CFR 155.340(f).

The HealthCare.gov enrollee LCP metrics do not consider plans' rating business rules. Since all medical QHPs are age-rated in HealthCare.gov states, rating business rules generally only affect premiums when the household contains more than three child enrollees (i.e., enrollees under the age of 21); in these cases, the three-child rating cap only applies if the children can enroll on the same policy. However, the PY24 SLCSP determinations do consider rating business rules because the determination includes both QHPs and SADPs, the latter of which can be family tier-rated plans with relationship-dependent rates.

The HealthCare.gov enrollee metrics include child-only medical plans and SADPs when they would be available to a given enrollment group. Previous ASPE reports didn't include child-only plans in any scenario.

This report calculates the policy-level lowest cost plan premium and distributes that premium amount among policy members based on each member's individual premium amount. As a result, APTC can lower the premiums of APTC-ineligible individuals who are on policies with APTC-eligible family members. When a policy includes more than 3 children such that some children aren't rated, this report distributes the total child rate among all child enrollees (e.g., if the policy includes 4 children, each with a rate of $100, the policy-level premium is $300 and each child's premium is $75).

Health Savings Account (HSA)-Eligible Plans

To contribute to an HSA, individuals must enroll in a high deductible health plan (HDHP) per 26 U.S.C. 223(c)(2).This report identifies PY17–PY24 HSA-eligible plans using the "HSA-Eligible" field issuers provide in their QHP data. CMS didn't verify this field's PY15–PY16 accuracy at the time of QHP data submission, so this report identifies PY15–PY16 has-eligible plans as those meeting the following conditions:

- The HSA-Eligible" field equals "Yes."
- The deductible value is greater than or equal to the plan year HDHP minimum deductible.
- The maximum out-of-pocket value is less than or equal to the plan year HDHP maximum out-of-pocket limit.[5]
- All benefit categories associated with the AV Calculator are subject to the deductible.

The HSA-eligible plan access metrics in this report exclude enrollees eligible for zero cost sharing and limited cost sharing variant CSRs because plan variations with these CSRs are generally not HDHPs. The HSA-eligible plan access metrics include all enrollees for bronze, gold, and platinum plans. Silver metal level HSA-eligible plan access metrics consider the enrollees' CSR eligibility; the standard silver HSA-access metrics include only CSR-ineligible enrollees, and the silver plan CSR variation HSA-access metrics include only those enrollees eligible for the associated CSR level. The total, metal level-agnostic metrics consider enrollees to have HSA-

[5] IRS Publication 969 for each tax year contains the minimum deductible and maximum out-of-pocket values.

eligible plan access if they have at least one non-silver HSA-eligible plan or an HSA-eligible silver plan or silver plan CSR variation that corresponds to their CSR eligibility available in their given county.

Median Individual Medical Deductible

The median individual medical deductible metric equals the average of the county-level median deductible in a given metal level or silver plan CSR variation, weighted by county-level enrollment. If a plan has an integrated medical and drug deductible, this metric uses the total individual deductible. If a plan has separate medical and drug deductibles, this metric uses the sum of the individual medical deductible and individual drug deductibles, unless the sum is greater than the QHP's maximum-out-of-pocket value (MOOP). In that case the MOOP is used. If the in-network deductible equals "Not Applicable," this metric uses the combined in/out-of-network deductible; if both the in-network and combined in/out-of-network deductibles equal "Not Applicable," this metric considers the deductible to be $0.

Plans with a Separate Drug Deductible

This report considers a plan to have a separate drug deductible if its "Medical & Drug Deductibles Integrated?" field equals "No" and it has a drug deductible greater than $0. If the in-network drug deductible equals "Not Applicable", this metric uses the combined in/out-of-network drug deductible; if both the in-network and combined in/out-of-network drug deductibles equal "Not Applicable," this metric considers the drug deductible to be $0.

Benefit Coverage Before the Deductible

A plan covers a benefit before the deductible if the benefit is not subject to a deductible. This report considers a benefit covered before the deductible if neither its copayment nor coinsurance use a cost sharing structure of "after the deductible," "with deductible" (for PY17–PY24), or "before deductible" (for PY14–PY16). In PY17, "with deductible" replaced the "before deductible" qualifier; in PY14–PY16, QHP certification instructions and guidance asked issuers to use "before deductible" only when the benefit was subject to a deductible.

Regardless of copayment or coinsurance values, this report also considers a benefit covered before the deductible if the benefit's associated deductible (either medical or drug) equals $0 or "Not Applicable".

Out of Pocket Cost

The out-of-pocket-cost (OOPC) of a plan is the estimated annual cost of that plan for a particular age group, gender, and utilization level of healthcare services. To calculate OOPC, Marketplace utilization data from the CMS External Data Gathering Environment (EDGE) is bucketed into age/sex groups and sorted by allowed cost.[6] These are then assigned deciles to further group into low, medium, and high utilization. For this report, the applicable age group is 35-44 year olds with medium utilization (translating to roughly 7 provider visits per year). For PY24, plan year 2021 EDGE data is used and trended forward. For PY23, plan year 2019 EDGE data was used and trended forward.

Estimated Total Yearly Cost

Estimated total yearly cost (ETYC) is a sum of the annual net premium for a plan and the OOPC of that plan. For this report, the enrollee scenario used to calculate ETYC assumed a "cost conscious" enrollee who would select the lowest ETYC plan available to them on HealthCare.gov. To calculate the weighted minimum ETYC, the minimum ETYC plan was found for each county and metal level and then the average ETYC across counties was determined, weighting each county's minimum ETYC plan by enrollment. The weighted minimum ETYC was calculated across genders, metal level, and different percents of the FPL. The resulting values were then averaged across genders to find an aggregate value to represent the typical 40-year-old enrollee at each metal level and each level of FPL.

[6] Consistent with 45 CFR 153.700, in states where HHS is operating the risk adjustment program, issuers must submit enrollment, claims, and encounter data for risk adjustment covered plans through EDGE servers. Issuers upload enrollee, pharmaceutical claim, medical claim, and supplemental diagnosis information from their systems to an issuer-owned and controlled EDGE server.

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