

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201



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RE: Draft 2024 Actuarial Value Calculator Methodology

Introduction

Under the *Essential Health Benefits, Actuarial Value, and Accreditation final rule* (EHB Final Rule) that was published in the Federal Register at 78 FR 12834 on February 25, 2013, the Department of Health and Human Services (HHS) generally requires issuers of non-grandfathered health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (“Exchanges”) to use an Actuarial Value (AV) Calculator for the purposes of determining levels of coverage. Section 1302(d)(2)(A) of the Affordable Care Act (ACA) stipulates that AV be calculated based on the provision of essential health benefits (EHB) to a standard population. The statute groups health plans into four levels: bronze, with an AV of 60 percent; silver, with an AV of 70 percent; gold, with an AV of 80 percent; and platinum, with an AV of 90 percent.

In the final *Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2018* (Final 2018 Payment Notice) at 81 FR 94058 (December 22, 2016), we amended the *de minimis* range for bronze plans in certain circumstances. That is, a bronze health plan that either covers and pays for at least one major service, other than preventive services, before the deductible, or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), may have an allowable variation in AV for such plans of -4 percentage points and +5 percentage points. On April 18, 2017, the Centers for Medicare & Medicaid Services (CMS) published a final rule, *Patient Protection and Affordable Care Act; Market Stabilization* (Market Stabilization Final Rule; 82 FR 18346), that amended 45 CFR 156.140(c), which establishes the *de minimis* variation range for the AV level of coverage. The rule changed the allowable variation in the AV to +2/-4 percentage points, rather than +2/-2 percentage points for plans other than bronze plans meeting the criteria described above.¹

In the final *Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2023* (Final 2023 Payment Notice) released on April 28, 2022, we implemented changes to the allowable variation in AV *de minimis* ranges through amendments to 45 CFR 156.140(c), 45 CFR 156.200(b), and 45 CFR 156.400. Beginning in 2023, all individual and small group plans subject to the EHB package metal level requirements have an allowable

¹ Under § 156.400, the *de minimis* variation for an income-based silver cost-sharing reduction (CSR) plan variation meant a single percentage point. Bronze plans that don’t meet the expanded bronze plan design requirements defined in Final 2018 Payment Notice had an allowable variation of -4/+2 percentage points.

variation in AV of +2/-2 percentage points. However, expanded bronze plans retain the +5 upper limit of the allowable variation in AV from the Final 2018 Payment Notice, but are subject to the revised -2 lower limit established in the Final 2023 Payment Notice. Individual market silver qualified health plans (QHPs) have an allowable variation in AV of +2/0 percentage points, while all other individual market silver plans follow the +2/-2 variation in AV, and income-based silver Cost-Sharing Reduction (CSR) plan variations have an allowable variation in AV of +1/0 percentage points.

The AV Calculator represents an empirical estimate of the AV calculated in a manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population. This document is meant to detail the specific methodologies used in the AV calculation.

This document is revised from the 2023 AV Calculator Methodology to incorporate updates to the 2024 AV Calculator. The first part of this document provides background that includes an overview of the regulation that allows HHS to make updates to the AV Calculator as well as the updates that are incorporated into the draft 2024 AV Calculator. The second part of the document provides a detailed description of the development of the standard population and the AV Calculator methodology. The first section details the data and methods used in constructing the continuance tables that are used to calculate AV in combination with the user inputs. The second section describes the AV Calculator interface and the calculation of AV based on the interface and the continuance tables.

The draft 2024 AV Calculator is available for download. We note that the 2024 AV Calculator does not affect any 2023 plans, and will only be applicable for 2024 plans.

Comments

We will accept comments on the draft 2024 AV Calculator, as well as the draft 2024 AV Calculator User Guide and the draft 2024 AV Calculator Methodology until 5:00 p.m. (Eastern Time) on January 12, 2023. Comments must be submitted to PMPolicy@cms.hhs.gov with “Actuarial Value Calculator” in the subject line of the email.

Part I: Background

Regulatory Background

The 2014 AV Calculator Methodology, along with the 2014 AV Calculator and the 2014 AV Calculator User Guide, was originally incorporated by reference in the EHB Final Rule and comprises part of the final rule for determining AV at 45 CFR 156.135.² A revised version of the 2014 AV Calculator Methodology for 2015, along with the 2015 AV Calculator and 2015 AV Calculator User Guide, was released as part of the final *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015* (Final 2015 Payment Notice), published in the Federal Register at 79 FR 13744 (March 11, 2014). Under the Final 2015 Payment Notice, we also finalized provisions for updating the AV Calculator in future years at

² This document implements ACA § 1302(d) and 45 CFR 156.135.

45 CFR 156.135(g). HHS has been updating the AV Calculator, its Methodology, and its User Guide annually using these provisions since finalizing these provisions at 45 CFR 156.135(g).

In the final *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* (Final 2017 Payment Notice) that was published at 81 FR 12204 (March 8, 2016), we amended the provisions at 45 CFR 156.135(g) to allow for additional flexibility in our approach and options for updating of the AV Calculator in the future, to ensure our ability to keep the AV Calculator reflective of the current market. 45 CFR 156.135(g) states that HHS will update the AV Calculator annually for material changes that may include costs, plan designs, the standard population, developments in the function and operation of the AV Calculator and other actuarially relevant factors. In the preamble of the Final 2017 Payment Notice, we stated we will publicly release a draft version of the AV Calculator and the AV Calculator Methodology for comment before releasing the final AV Calculator. The draft 2024 AV Calculator, Methodology and User Guide were updated in accordance with 45 CFR 156.135(g).

In addition to the above regulatory requirements, we also finalized in the Final 2018 Payment Notice (81 FR at 94101) that HHS would use the dataset from masked enrollee-level External Data Gathering Environment (EDGE) server data³ to inform development of the AV Calculator and Methodology. We may use these masked enrollee claims data from issuers of risk adjustment covered plans⁴ in the individual and small group markets that are required to provide the EHBs to inform the calculation of AV for purposes of determining metal levels in the future.

In addition to the regulatory provisions at 45 CFR 156.135 and 156.140, additional guidance on AV is available in the [May 16, 2014 FAQs](#). Specifically, in Question 3, we clarify that issuers must always use an actuarially justifiable process when inputting their plan designs into the AV Calculator and that the AV Calculator is intended to establish a comparison tool and wasn't developed for pricing purposes.

Overview of the 2024 AV Calculator Considerations and Updates

This section provides an overview of the key changes made between the final 2023 AV Calculator and the draft 2024 AV Calculator and our consideration of updates.

Trend and Projection Factors

Like previous AV Calculators, we reviewed changes in medical and drug spending, year-over-year, from the year of claims data used (2018) to the plan year of the AV Calculator. In alignment with the 2023 AV Calculator, we trended spending forward from 2018 to 2021 at an annual rate of 5.40 percent for medical spending and 8.70 percent for drug spending. For 2021 to 2022, we applied a medical cost trend of 3.20 percent and a drug cost trend of 4.55 percent to account for the impact of the COVID-19 pandemic. We projected spending forward from 2022 to 2023 at an annual rate of 5.80 percent for medical spending and 8.70 percent for drug

³ 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.

⁴ See 45 CFR 153.20 for a definition of the term "risk adjustment covered plan".

spending. For the 2024 AV Calculator, we added a one-year projection factor of 5.40 percent for medical costs and 8.20 percent for drugs costs. To help ensure plan design stability for the non-grandfathered individual and small group market plans that are required to comply with AV, in selecting these projection factors, we also took into consideration the need to limit dramatic changes in AV. One of the conclusions of our review was that medical and drug spending is continuing to increase at different rates. As a result, we continued to use a higher trend factor for drug spending.

MOOP Limit

As we have done in previous years, we updated the annual limitation on cost sharing, also known as the maximum out-of-pocket (MOOP) limit, in the draft 2024 AV Calculator. Similar to prior years, this update was based on a projection, to enable the AV Calculator to comply with 45 CFR 156.130(a)(2). Since we may make the AV Calculator available prior to the finalization of the annual limitation on cost sharing for a given plan year, we use an estimated annual limitation on cost sharing in the AV Calculator.

For the draft 2024 AV Calculator, the MOOP limit and related functions have been set at \$9,450 for self-only coverage. Issuers that are required to meet AV standards must comply with the limit established in regulation. Issuers may not finalize plan designs that use this projected estimate used in the draft 2024 AV Calculator.

Copay Accrual Logic Change

In the draft 2024 AV Calculator, we made changes to the way that copays paid by an enrollee are counted toward the deductible, in order for the AV Calculator to be consistent with common practice among health plans. Specifically, stakeholders have noted that most health plans don't consider enrollee copays paid during the deductible phase for services that aren't subject to deductible to be spending that satisfies the deductible. In previous AV Calculators, copays paid by enrollees during the deductible phase for services that aren't subject to deductible did accumulate to the deductible. In the draft 2024 AV Calculator, these copays will no longer accrue to the deductible. The copays will still, however, be counted towards the MOOP. This change is expected to affect the AVs of plans with copays for services that aren't subject to the deductible.

Algorithm Update

In addition to the trend factors, MOOP limit, and copay accrual logic change, we updated the algorithm to more accurately calculate spending during the deductible phase for plans with separate deductibles and a combined MOOP. This update involves changing how the calculator handles plan designs that imply that an enrollee would meet the MOOP before reaching the deductible. This can occur for plan designs where little spending counts toward the deductible. In these cases, the algorithm determines a new value for the deductible that's consistent with the enrollee reaching the deductible before the MOOP and uses this adjusted deductible to compute the start of the coinsurance range. The update in the draft 2024 AV calculator involves a special case of these plan designs where the algorithm finds that no enrollee spending below a deductible value counts towards reaching the deductible. In the course of

calculating the plan AV, the algorithm may find that above a certain threshold value, a small share of spending counts towards the deductible, while below this value, no spending counts towards the deductible. If the algorithm determines deductibles above this value would result in the enrollee being unable to satisfy the deductible before reaching the MOOP, then the algorithm will use this threshold value in place of the deductible.

Output Message Update

To align with the requirement of a narrower *de minimis* range of +2/0 percentage points for individual market silver QHPs established in the Final 2023 Payment Notice, the draft 2024 AV Calculator includes the message “*Individual Silver QHPs must meet a [0, +2] percent de minimis range.*” in the Status/Error Messages field if the user selects “Silver” as the desired metal level and the AV output falls within the range of 68% and 70%. The draft 2024 AV Calculator doesn’t otherwise flag or return an error for individual market silver QHPs that don’t meet this requirement. It is the responsibility of the issuer to ensure that their individual silver QHPs meet the *de minimis* requirement under this policy.

Additionally, the draft 2024 AV Calculator includes a new warning message in rare cases where the AV can’t be computed because the algorithm doesn’t converge. AV output will be suppressed and the user will receive the following message: “[*Algorithm*][*Medical algorithm*][*Rx algorithm*] failed to converge”. For detailed instructions on how to handle these cases, please refer to the AV Calculator User Guide.

Consideration of Additional Updates Not Made in the AV Calculator

We considered a variety of other updates to the operation and function of the AV Calculator:

- Similar to previous years, we analyzed the most recently available enrollee-level EDGE claims data to assess relative differences in demographic and spending patterns in the EDGE data compared to the data in the draft 2024 AV Calculator. We want to ensure as much plan design stability as possible for the non-grandfathered individual and small group market plans that are required to comply with AV requirements. As such, we aren’t using EDGE data to generate continuance tables at this time, although we will continue to investigate how we can use this data to inform our work on building and trending the continuance tables in future AV Calculators.
- We considered adding additional benefit categories to the AV Calculator to allow users to input the benefit-specific cost sharing with respect to urgent care, ambulance services, and durable medical equipment. From our analyses, we found that the spending and utilization of these services in the current data would have relatively minimal impact on the AVs. We decided not to add these categories in the draft 2024 AV Calculator, but we will continue to monitor the utilization trends of these services.
- We explored producing a single continuance table from which metal level-specific AVs can be derived. We will continue to investigate potential methods for creating a single continuance table AV Calculator in future updates.
- We also considered expanding the number of drug tiers available, such as splitting

the current generics drug tier into preferred generics and non-preferred generics categories as the five-tier formulary design is more common. However, due to data limitations, we aren't expanding the number of drug tiers at this time. The definitions of the drug tiers used in the AV Calculator are discussed in the AV Calculator User Guide. We remind AV Calculator users that issuers must always use an actuarially justifiable process when inputting their plan designs into the AV Calculator.

- We further considered changes to allow cost-sharing for Mental/Behavioral Health and Substance Use Disorder Outpatient Services (MH/SUD) to begin after a set number of visits and to allow MH/SUD deductible or coinsurance to begin after a set number of copays. This update would allow the AV Calculator to accommodate more plan designs. However, due to the complexity of this change and the potential confusion for plans regarding MH/SUD parity requirements, the draft 2024 AV Calculator won't incorporate this change at this time.

Part II: AV Calculator's Methodology and Operation

Data Sources and Methods

This section describes the data and methods used to create the building blocks of the AV Calculator, including the development of the standard population. The inputs for AV calculation are information on utilization, cost sharing, and total costs for health services for a standard population of health plan enrollees resembling those that are likely to be covered by individual and small group market health insurance in 2024. This information is used to create a series of continuance tables that describe the distribution of claims spending for a population of health insurance users that we refer to as the standard population. The standard population is the basis for these continuance tables from a utilization perspective.

Because spending is affected by plan design through induced demand, the claims data are used to develop four sets of continuance tables, based on bronze, silver, gold and platinum plan designs. The AV Calculator estimates the AV of a plan design based on the aggregated data contained in the four sets of continuance tables representing each plan's metal level.

The remainder of this document outlines the process for creating and using each of these components in turn. The first section describes the large national claims database that's used as the basis to develop the standard population. In addition, preliminary adjustments to that database are described in the first section. The second section explains the process for adjusting and supplementing the claims data in the national database to better estimate the individual and small group markets in 2024 to develop the standard population. Finally, the last section describes the methodology for using the claims database to develop the continuance tables.

National Database

To provide information on utilization and cost sharing for a standard population of enrollees, HHS began with claims data from the Health Intelligence Company, LLC (HIC) database for calendar year 2018. This commercial database, which is the same source used for prior years' AV Calculators, includes detailed enrollment and claims information for members of several

regional insurers. It incorporates both individual and small group market data and includes many plans that are required to comply with EHB. The draft 2024 AV Calculator relies on both individual and small group claims data to reflect the plans that are required to comply with AV requirements. As described below, several adjustments were made to these data to more closely represent the expected population of individual and small group market enrollees.

Since descriptions of the plan benefit design characteristics weren't included in the database, cost-sharing variables, including copays, coinsurance, and deductibles from the claims data were used to infer the member and plan shares of the total spending that's reflected in the database, as described below. The data contain spending, demographic, and enrollment information at the member level, including age, sex, and family structure, presence of a preexisting condition, enrollment length, spending, and number of claims. Enrollees are grouped into Product Client Contracts (PCCs) defined by plan type (for example, Preferred Provider Organization (PPO)) and benefit design for a given contract or plan group. The draft 2024 AV Calculator treats each PCC as a separate health plan, since each PCC represents a uniform benefit structure under a contract or plan group. However, in practice, a regional health plan may operate multiple PCCs. All cost data in the database are projected forward to 2024.

Spending and claims information is provided in the database both for total services and for each of the following medical and drug service categories:

- Emergency Room (ER) Services
- All Inpatient (IP) Hospital Services (including Mental Health and Substance Use Disorder Services)
- Primary Care (PCP) Visit to Treat an Injury or Illness (excluding Preventive Well Baby, Preventive, and X-rays⁵)
- Specialist Visit
- Mental/Behavioral Health and Substance Use Disorder Outpatient Services
- Imaging (for example, CT/PET Scans, MRIs)
- Speech Therapy
- Occupational and Physical Therapy
- Preventive Care/Screening/Immunization
- Laboratory Outpatient and Professional Services
- X-rays and Diagnostic Imaging
- Skilled Nursing Facility (SNF)
- Outpatient Facility Fee (for example, Ambulatory Surgery Center)
- Outpatient Surgery Physician/Surgical Services⁶
- Drug Categories

⁵ Depending on the plan design, the AV Calculator may apply the same or separate cost sharing to primary care visits and X-rays associated with primary care visits. The AV Calculator may also apply the same or separate cost sharing to specialist visits and X-rays associated with specialist visits. See the section below on calculating AV for further information.

⁶ Currently, the level of aggregation within the national claims database doesn't allow for the explicit distinction of surgical services from other outpatient professional claims. While provisional outpatient surgery claims are the main component by cost and utilization of the Outpatient Surgery Physician/Surgical Services category, the category currently includes other outpatient professional claims not otherwise classified.

- Generics
- Preferred Brand Drugs
- Non-Preferred Brand Drugs
- Specialty Drugs (High Cost)

With the exception of preventive care, the claims database defines which services fall into each category. In addition, the database provides a breakdown of whether a service and associated cost is considered part of Outpatient Surgery Physician/Surgical Services or Outpatient Facility Fees for the following five service categories: Mental Health and Substance Use Disorder, Advanced Imaging, Speech Therapy, and Occupational and Physical Therapy, Diagnostic Laboratory, and Unclassified (medical). For this reason, Mental Health and Substance Use Disorder, Advanced Imaging, Speech Therapy, Occupational and Physical Therapy, and Diagnostic Laboratory will be referred to throughout this text as the five benefits with both facility and professional components. In the development of the continuance tables based on the standard population, we relied on this aspect of the database to account for separate copays and cost-sharing payments applying to the professional and facility components of services.

Preventive care is defined, and claims are categorized, using the CPT code list that's translated and modified from the US Preventive Services Task Force recommended preventive services list. The services defined as preventive care correspond to the preventive services covered without cost sharing under section 2713 of the Public Health Service Act.

To prepare the data for use in the continuance tables, several enrollment restrictions are applied to ensure that the data accurately represent utilization experience for enrollees. The full data include 49,820,016 enrollees and 1,003,208 individual or small group plans. In the absence of metal level information directly from the plans that submitted data to this commercial database, the plan metal levels are inferred from the spending data to aid in the construction of the continuance tables. Metal level imputation is handled separately for individual and small group plans in the claims data.

To ensure that the metal level imputation procedure can be applied effectively, individual and small group plans with utilization data that are likely incomplete are excluded. To be included, individuals must have an age between zero and sixty-four and a specified sex. Individuals must also be located in a U.S. state, or Washington, D.C. At the plan level, the plan must have total allowed spending greater than \$0. Plans must also be a Preferred Provider Organization (PPO), Point of Service (POS), Health Maintenance Organization (HMO), or Exclusive Provider Organization (EPO) plan to reflect frequent types of plans that are available in the AV-compliant markets; must have at least one member with prescription drug coverage; and must have enrollment in both January and December of the plan year, with at least 50 percent of those enrolled in the plan year enrolled in December to ensure data quality. Additionally, individual market plans must have at least 50 members and, if the plan has over 1,000 members, it must have at least one member with a maternity claim, while small group plans must have 60 or fewer subscribers and more than 10 members.⁷

⁷ In the 2020 AV Calculator and previous calculators, the AV calculator required small group plans to have 100 or fewer employees. This limitation was applied in anticipation of the small group market definition expanding to

Because the database doesn't include plan level information on which plans are subject to the ACA market reforms, individual plans must also meet another set of requirements designed to identify plans that are subject to the ACA market reforms, as opposed to grandfathered or transitional plans. For these purposes, a plan is identified as subject to the ACA market reforms if it meets at least one of the following conditions: 1) the plan has at least 2.50 percent single new subscribers in 2014 or later, or a new subscriber in 2015 or later; 2) more than 20 percent of the plan's current members were enrolled in individual market plans meeting the previous condition or in group market plans in the previous year; 3) the plan's primary state is a state which didn't allow transitional plans in 2018.⁸ These requirements shrink the individual market population in the dataset to 4,168,675 enrollees in 1,801 plans. Because most employer plans offered prior to the obligation to cover EHBs provided substantial coverage of EHBs, these requirements apply only to individual plans and not to the small group market.

Methodological differences in the metal level imputation procedure between individual and small group plans require small group plans to meet additional exclusion criteria. Plans with imputed coinsurance rates that fall outside the range of 0-100 percent are dropped as are plans without an imputed deductible. Plans must also have at least one member with over \$5,000 of allowed spending. After these plan level restrictions, the small group market population in the database consists of 4,171,567 enrollees and 116,449 plans.

Finally, the database is subject to one final enrollee level restriction; enrollees with fewer than 4 months of enrollment in 2018 were excluded.⁹ The resulting database, consisting of 7,350,085 enrollees and 118,250 plans, is used to construct the continuance tables, subject to the additional adjustments identified in the next two sections of this document.

The claims costs incorporated into the continuance tables in the draft 2024 AV Calculator are projected forward from 2018 to 2021 at an annual rate of 5.40 percent for medical spending and 8.70 percent for drug spending, from 2021 to 2022 at 3.20 percent for medical spending and 4.55 percent for drug spending, from 2022 to 2023 at 5.80 percent for medical spending and 8.70 percent for drug spending, and from 2023 to 2024 at 5.40 percent for medical spending and 8.20 percent for drug spending.

employers with 1 to 100 employees. However, most states have taken advantage of the flexibility to keep the definition at 1 to 50 employees. The final 2022 AV Calculator sets a maximum plan size at 60 subscribers, rather than 50, to account for employee turnover during the year. Starting with the final 2023 AV Calculator, a minimum plan size of 10 members was also set because we aren't able to accurately impute plan design parameters and metal level for smaller plans.

⁸ Because the data doesn't directly include plan level information, the concept of a primary state is used to link a plan to a state. By linking plans to states, we can incorporate state level policies to help identify plans subject to the ACA market reforms. A plan has a primary state if in either 2015, 2016, or 2017, 90 percent of plan members came from one state. In the unlikely event a plan has different primary states across those years, the 2017 primary state dominates.

⁹ We note that the treatment of newborns in the claims data isn't different from the treatment of any other age group and the standard population data is reweighted to fit the expected age distribution.

Standard Population Development

The claims data, excluding the populations and plans noted above, provided the raw material for developing a standard population based on the expected enrollment in individual and small group market plans in 2024. While the use of post-ACA 2018 individual and small group market data removed the need to augment the data to the degree required in earlier versions of the AV Calculator, utilization and spending in the data required some adjustment to represent utilization and spending in the population expected to participate in the individual and small group markets in 2024.¹⁰ The data are therefore weighted to match the expected 2024 age, sex, market-type, and plan-type distribution, adjusted for length of enrollment.

Demographic Distribution: Expected market participation for each sex/age group was estimated as a blend of both a predicted individual demographic distribution, and observed 2018 small group distribution.¹¹ The individual demographic distribution for the draft 2024 AV Calculator, as in all previous versions, was predicted by an HHS-developed model called the ACA Health Insurance Model (ACAHiM). ACAHiM is an analytical framework that simulates the structure of the markets for insurance coverage that are required to comply with the ACA market reforms after the implementation of a new policy, projecting enrollment, spending, and premiums across and within these markets. The model estimates market enrollment in a manner that incorporates the effects of policy choices and accounts for the behavior of individuals and employers. The model was developed with reference to existing models such as those of the Congressional Budget Office and the CMS Office of the Actuary, to characterize medical expenditures and enrollment choices across the Exchanges. ACAHiM is used in creating the demographic distribution of the standard population for the AV calculator because it generates predictions of market enrollment and demographics for future plan years, as opposed to relying on older demographic distributions directly from the claims data. For the draft 2024 AV Calculator, the small group demographic distribution is based on the observed 2018 small group market distribution from EDGE data. The individual market and small group market use the same demographic distribution weights in the draft 2024 AV Calculator.

Length of Enrollment: To represent the full population of enrollees, including those with less than one full year of enrollment, we annualized claims for enrollees with less than full year enrollment based on age, gender and risk quartile. To annualize the claims, for each age, gender and risk quartile group, we calculated a claim annualization factor for each length of enrollment. This factor is equal to the average total spending of full year enrollees divided by the average total spending of full year enrollees at that length of enrollment. For example, the spending of a 25-year-old female enrollee in the second risk quartile with four months of enrollment is multiplied by a factor calculated using the spending of full-year 25-year-old female enrollees in the second risk quartile, where the factor is equal to the average total spending in the full year divided by average total spending during the first four months of enrollment. This process isn't used to annualize IP, ER, or SNF claims, as such claims don't represent utilization that's

¹⁰ AV Calculators prior to the 2018 AV Calculator included augmentation for individuals previously enrolled in high risk pools (HRPs) and Pre-existing Condition Insurance Plans (PCIP). As those individuals are now represented in individual market-enrollment, the draft 2024 AV Calculator, like the 2018-2023 AV Calculators, doesn't include similar adjustments.

¹¹ The demographic distribution is based on the following age groups: 0 to 6 year-olds, 7 to 18 year-olds, 19 to 25 year-olds, 26 to 40 year-olds, 41 to 54 year-olds, and 55 to 64 year-olds.

expected to recur on a regular basis. The four-month cutoff was chosen after analysis of risk score characteristics and consultation with other data sources indicated that enrollees with four to eleven months of enrollment had comparable characteristics to those with full year enrollment. Enrollees with less than four months of enrollment had substantially lower risk scores, indicating the data don't contain enough information to adequately annualize their spending. The average number of months of enrollment in the claims data was more than 9 months.

Cap on Spending: Since the AV Calculator is designed to predict AVs based on a standard population, we implemented a cap on enrollee spending at the 99.90th percentile of annual allowed amounts for all enrollees in the claims data to reduce the distortion created by outliers with very high spending. This cap was selected to prevent outlier claims from overly influencing the AV.

Varied Use of HMOs by Market: To make the standard population representative of the plan type distribution anticipated for the 2024 market, we classified plans as either HMO/EPO or PPO/POS and then combined the groups using market-specific weights. In the individual market, HMO/EPO claims are weighted 70% and PPO/POS claims 30%. In the small group market, HMO/EPO claims are weighted 40% and PPO/POS claims are weighted 60%. Prior to the final 2021 AV Calculator, earlier versions applied a single set of weights to claims by plan type. All versions of the AV Calculator since the final 2021 version use the adjusted weighting method to better reflect the different shares of plan types by market.

Constructing Continuance Tables

Continuance tables summarize the claims experience and utilization of the standard population and are therefore the key input to calculating AV. Specifically, a continuance table describes the distribution of claims spending for a population of health insurance users in plans with a particular benefit structure. The set of continuance tables underlying the AV Calculator reflects the standard population developed by the Secretary of HHS to implement section 1302(d) of the ACA. The continuance tables themselves, as a representation of the standard population and not the standard population itself, are a component of the rules for determining AV under the [EHB Final Rule](#). The continuance tables were updated in accordance with 45 CFR 156.135(g) to reflect the standard population and the plan designs and costs projected in the 2024 market.

The continuance tables rank enrollees by allowed total charges (after any provider discounts but before any member cost sharing) and group them by ranges of spending. These ranges of spending define the rows of the continuance table. The data are then used to calculate the cumulative average cost in the range for all enrollees and the average cost for all enrollees whose total spending falls within the range. For each service type listed above, the columns of the continuance table display the average cost of spending on that service type that's attributed to cumulative enrollees in each range and the average frequency of the service type per enrollee.

To construct the continuance tables from the underlying utilization data, enrollees are separated into groups based on common plan enrollment, and each group is assigned to a metal level based on the plan characteristics. Separate continuance tables are created based on the utilization of enrollees in the same metal level, sex, and age bracket.

The continuance tables for each metal level are based on utilization data from enrollees in the claims database with the same imputed metal level. This metal level imputation is performed separately for small group and individual market plans.

For small group plans, estimated AVs are calculated for each plan, and plans are assigned to a metal level such that the estimated AV is within +/- 5 percentage points of the target AV for each metal level, with the exception of the bronze continuance table, which is based on all plans with estimated AVs below 65 percent, and platinum, which is based on all plans with estimated AVs above 85 percent. The estimated AV calculation is described below.

For small group market plans that meet all the requirements detailed in the national database section above, the plan deductible is imputed as the 90th percentile of positive deductibles that are at least \$250 lower than the amount of total spending for all enrollees within a PCC, and plan MOOP is imputed as the 90th percentile of enrollee spending above \$1,000 over all enrollees within a PCC. The coinsurance rate is estimated by examining the coinsurance variable on claims for plan members with spending between the deductible and the MOOP. Spending data are also used to impute copays for several services including IP services, ER services, PCP office visits, specialist office visits, and four levels of prescription drugs: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty high-cost drugs.

To estimate AV for each small group plan, the realized AV of the imputed benefit characteristics is calculated for groups of enrollees by spending bucket; the spending buckets are \$0 to \$250, \$250 to \$500, \$500 to \$1,500, \$1,500 to \$5,000, \$5,000 to \$15,000, \$15,000 to \$25,000, and \$25,000 and over. Nonlinear least squares regressions, a statistical technique, is used to develop the model estimating AV based on the imputed cost shares in each of the spending buckets.

Individual market plans in the national claims database are assigned to a metal level using a different process. Aggregated plan-level risk adjustment data from 2018 is used to construct a model that relates plan metal level to plan empirical AV, average allowed spending per member per month, and percent of members with at least one HCC. Here, CSR plan variants are included in their AVC-equivalent metal levels since there is no CSR indicator in the claims database. This model uses a multinomial logistic regression to estimate the probability that a given plan belongs to each metal level. Once this model is tested and estimated on the risk adjustment data, it is then applied to the individual market plan data, where the observed plan characteristics mentioned previously are used to predict the probability the plan is in each metal level. The plan is then assigned to the metal level with the highest predicted probability.

The utilization data are then used to create continuance tables for each sex/age group and each metal level. The continuance tables for each metal level are based on utilization of enrollees in plans with the respective metal level AV. To produce a single continuance table for each metal level, each of the separate continuance tables representing age/sex groups for a given metal level are assembled into a single metal-level-specific continuance table, with each sex/age-group cell weighted by expected individual market participation in the corresponding metal level for enrollees with those characteristics as discussed above. These continuance tables consist of \$100 spending buckets from \$0 to \$15,000 and \$5,000 spending buckets from \$15,000 to \$50,000. The next bucket begins at \$100,000 and increases by \$100,000 increments up to \$500,000,

followed by a \$1,000,000 bucket, a \$2,000,000 bucket, and finally an “Unlimited” row, which encompasses all spending.

Separate continuance tables for medical services and prescription drugs underlie the AV Calculator to accommodate the input of benefit structures with separate deductibles for these types of spending. To estimate costs for a plan with a separate drug benefit, the continuance table must include only non-drug claims to determine AV for the medical portion of the plan. To produce a single AV for this type of plan, the plan-covered spending on drugs and medical services are added together and divided by total spending.

Finally, because the claims data doesn’t include metal level or label whether the plan meets the ACA requirements for a CSR plan variation, we must impute a metal level from the claims; this imputation classifies many CSR variant enrollees as platinum, rather than silver. As there are very few actual platinum enrollees, the platinum continuance table consists largely of CSR variant enrollees, who may resemble silver enrollees more than actual platinum enrollees.

The AV Calculator Interface

This section describes the AV Calculator interface and how inputs into the AV Calculator are used to determine AV. The inputs for the AV Calculator were based on the 10 broad categories of EHB and determined through a combination of consultation with actuarial experts and testing the magnitude of the effect of parameters on the calculated AV as well as comments received. The AV Calculator is designed to produce a summarized AV that’s displayed to the nearest hundredth of a percentage point based on the continuance tables described above and the cost sharing inputs described below.

Similar to previous years, the draft 2024 AV Calculator remains unlocked. This allows users to view the source code for the AV Calculator algorithm. We note that the workbook structure is also unlocked so that users may make copies of output tabs. However, users shouldn’t move or copy the original “AV Calculator” tab either whole or in part, as doing so will result in calculation errors for subsequent runs. This functionality should only be used after reviewing the relevant instructions contained in the draft 2024 AV Calculator User Guide. Additionally, users shouldn’t reveal hidden rows in the “AV Calculator” tab. Doing so invalidates the AV estimates produced by the AV Calculator due to the potential introduction of calculation errors. Furthermore, auto-filling rows may also impair the function of the calculator and result in runtime errors.

Plan Benefit Features Allowed as Inputs

Plan design structures are characterized by cost-sharing features that determine the division of expenses between the plan and the insured. The ratio of the share of total allowed costs paid by the plan relative to the total allowed costs of covered services is the AV of the plan. No summary calculator could capture every single potential plan variation, nor are they necessary for an accurate calculation of AV. However, empirically, the vast majority of the variation between the AVs of health plans is captured by a finite number of variables, and the AV Calculator focuses on accurately determining plan AVs based on this set of key plan characteristics. Therefore, the AV Calculator includes only these key characteristics that have a significant effect on AV.

The user inputs a combination of metal level and cost-sharing features, and the AV Calculator uses these inputs and the continuance tables to produce an AV for the health plan. The metal level input allows the AV Calculator to account for induced demand by using the set of continuance tables for that specified metal level. This step is necessary to take into account the differences in utilization that are based on generosity of the health plan (such as utilization due to induced demand).

Deductibles, general rates for coinsurance, and MOOPs generally have a significant effect on utilization and the share of plan-covered expenses. The AV Calculator allows the user to specify either an integrated deductible that applies to both medical and drug expenses or separate deductibles for each type of spending.¹² Similarly, if a plan design has separate medical and drug MOOP spending limits, the user may specify either an integrated MOOP or separate MOOPs for medical and drug spending. The user may also specify different coinsurance rates for medical and drug spending.

The AV Calculator allows the user to specify coinsurance rates and copays for the medical services listed on page 7 of this document, along with the deductible, general coinsurance, and MOOP. In addition, the AV Calculator allows the user to specify whether services are subject to deductible or subject to coinsurance, and whether any copays apply only after the deductible is met.

The AV Calculator doesn't allow the user to subject recommended preventive care to a copay or deductible because the ACA directs that these services be covered by the plan at 100 percent.¹³

The AV Calculator also allows users to specify other plan details. For IP and SNF services, the default option is that copays and coinsurance costs apply per stay, but these may be applied at the per day level instead by choosing the corresponding options. If IP copay costs are applied at the per day level, the user may specify that these copays only apply for a set number of days chosen by the user, ranging from the first one to ten days in the hospital. However, due to data limitations, the option to limit the number of days to which the copay applies imposes a limit to the number of days a copay applies per year and not number of days per stay. For example, if the user selects to apply costs at the per day level and limits the copay per day to one day only, an enrollee with two distinct hospital stays within a year would pay the copay only once. Users may also specify that cost sharing for PCP visits only applies after a set number of visits chosen by the user, ranging from one to ten visits. Alternatively, users may specify that the deductible or coinsurance doesn't apply to primary care services until after a set number of visits, ranging from one to ten visits; during this initial set of visits, the enrollee pays a per-visit PCP copay. Users

¹² Given how the AV Calculator tallies spending relative to the deductible, similar plans with separate or combined deductibles imply different cost-sharing schemes. For example, a plan with a \$1000 medical deductible, a \$0 drug deductible, and a \$10 copay for generic drugs will have slightly different cost sharing than a plan with a \$1000 combined deductible and a \$10 copay for generic drugs. In the case of a separate drug deductibles, the \$10 drug copay won't be credited toward the medical deductible. In the case of the combined deductibles, depending on the exact plan design, the \$10 drug copay could move medical spending into the coinsurance range more quickly.

¹³ For the purposes of the AV Calculator, preventive care means the services are required to be covered without cost sharing under Section 2713 of the Public Health Service Act and its implementing regulations. See 45 CFR 147.130.

may specify cost sharing for four levels of prescription drugs: generics,¹⁴ preferred brand drugs, non-preferred brand drugs, and specialty high-cost drugs. Additionally, the user may specify that, for specialty level drugs, the enrollee pays the lesser of either the specialty drug coinsurance or a set dollar limit chosen by the user. The AV Calculator also incorporates health savings accounts (HSAs) and health reimbursement arrangements (HRAs) that are integrated with group health plans if the amounts in the HSAs and HRAs may only be used for cost sharing; to use this option for HSAs, the user must include an annual amount contributed by the employer or, in the case of HRAs, the amount first made available (sometimes referred to in this document as “HRA contributions”).

The AV Calculator produces estimates of AV based only on in-network utilization and allows the user to specify only in-network cost-sharing parameters. This is consistent with § 156.135(b)(4).

The AV Calculator can accommodate plans utilizing a multi-tiered network with up to two tiers. Users may input separate cost-sharing parameters—such as deductibles, coinsurance rates, MOOPs, and schedules for service-specific copays and coinsurance—and specify the share of utilization that occurs within each. The resulting AV is a utilization-weighted blend of the AV for the two levels.

¹⁴ From a technical perspective, it is important to note that the generic drug category in the claims database includes maintenance drugs. To address the fact that not all maintenance drugs are generics and that some of those drugs are high cost, the definition of the generic drug category only includes maintenance drugs that cost less than \$50 per prescription. The remaining maintenance drug claims are split between preferred brand and non-preferred brand drugs.

Calculating AV

AV is the anticipated covered medical spending for EHB coverage (as defined in § 156.110(a)) paid by a health plan for a standard population, computed in accordance with the plan's cost sharing, and divided by the total anticipated allowed charges for EHB coverage provided to a standard population. It is reflected as a percentage and can be thought of as the share of the total expenditures for EHB that can be expected to be covered by the plan. The denominator of this calculation is the average allowed cost of all services for the standard population in the year for a specified metal level; the numerator is the share of average allowed cost covered by the plan, using the cost-sharing parameters specified.

The remainder of this section describes the nine steps in the calculation of AV for the various plan structures that may be specified by the user:

- Step 1: Set the metal level (by identifying the continuance tables on which the calculation will be based)
- Step 2: Calculate average expenses over all enrollees (by identifying the denominator of the AV calculation, the average cost over all enrollees for a plan of the specified metal level)
- Step 3: Calculate expenses covered by employer contributions to HSAs and HRAs, if applicable
- Step 4: Calculate plan-covered expenses for spending before the deductible is met
- Step 5: Determine applicable enrollee spending level for MOOP
- Step 6: Calculate plan-covered expenses for spending between the deductible and the MOOP (in the coinsurance range)
- Step 7: Calculate plan-covered expenses for spending above the MOOP
- Step 8: Apply tiered network, if applicable (to calculate AV in Tier 2)
- Step 9: Calculate AV and corresponding metal level (to assign AV and metal level)

Before proceeding with the above calculation, the AV Calculator checks that the user has specified the necessary deductibles, coinsurance, and MOOPs consistent with the choice of integrated or separate deductibles and MOOPs for medical and drug expenses. The draft 2024 AV Calculator also checks that the deductible is less than or equal to the MOOP and that the MOOP (or sum of the MOOPs, for plans with separate medical and drug MOOPs) is less than \$9,450 for self-only coverage.¹⁵

Additionally, if the effective coinsurance (the coinsurance after adjusting the level of plan covered spending to account for copays) based on user inputs is 100 percent, the MOOP and deductible are set equal to each other for AV calculations.

¹⁵ Each year's draft AV Calculator uses an estimated MOOP limit. Plan designs mustn't exceed the annual MOOP limit that's established in the *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year*.

If the user's chosen inputs for deductible and MOOP aren't exactly equal to the spending thresholds used in constructing the continuance table, the values are pro-rated using linear interpolation. For instance, if a user enters a \$150 deductible, then the AV Calculator estimates the amount of spending below the deductible by interpolating between the average cost per enrollee that occurs below the \$100 threshold on the continuance table and the average cost per enrollee that occurs below the \$200 threshold on the continuance table. In this case, if the average cost per enrollee at the \$100 threshold was \$85 and the average cost per enrollee at the \$200 threshold was \$185, the interpolated average cost per enrollee would be \$135 (halfway between \$85 and \$185).

Step 1: Set Metal Level

The user enters the desired metal level for the calculation, and the AV Calculator selects the corresponding continuance tables for use in all remaining steps of the calculation.

Step 2: Calculate Average Expenses Over All Enrollees

The denominator of the AV calculation is the average cost over all enrollees for a plan of the specified metal level, found in the final row of the corresponding continuance table in the column for average cost.

Step 3: Calculate Expenses Covered by Employer Contributions to HSA and HRA, if Applicable

Section 156.135(c) provides that, for plans other than those in the individual market that at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost sharing, annual employer contributions to HSAs or amounts newly made available under such HRAs for the current year are counted towards the total anticipated medical spending of the standard population that's paid by the health plan. When the HSA or HRA Employer Contribution box is checked and the entered annual contribution amount is positive, because the value of a contribution to this type of HSA or HRA can affect expected utilization, the AV Calculator treats the actuarial average spending of the employer contributions as covered "first-dollar" spending for covered EHB services, as if the annual contribution amount is applied at the very beginning of an enrollee's spending in a benefit year.

Specifically, the AV Calculator uses the continuance table for combined expenses to identify the average cost per enrollee at the annual HSA or HRA contribution amount. If the annual contribution amount falls between two spending thresholds in the continuance table, this amount is pro-rated as described in the previous section. The pro-rated amount is plan-covered expenses and is included in the numerator. Next, the AV Calculator identifies any plan-covered benefits obtained in the deductible stage and subtracts them from the numerator, to avoid double-counting when these benefits are included in the numerator during the regular benefit calculation steps described in Step 4: Calculate Plan-Covered Expenses for Spending Before the Deductible is Met below. At the conclusion of these steps, plan-covered expenses in the numerator include average costs at the annual HSA or HRA contribution amount less any plan-covered expenses in the deductible stage below the HSA or HRA contribution amount.

Step 4: Calculate Plan-Covered Expenses for Spending Before the Deductible is Met

The AV Calculator next computes any plan-covered expenses for spending before the deductible is met for each benefit type and includes these expenses in the numerator. The computation process identifies the relevant deductible for each benefit type, which depends on whether the plan includes separate medical and drug deductibles or a combined deductible. For plans with a combined (“integrated”) deductible, the relevant deductible is always the combined deductible. For plans with separate medical and drug deductibles, the relevant deductible is the medical deductible for medical services and the drug deductible for drug services.

The following terms are used throughout the subsequent discussion of calculating plan-covered expenses during the deductible range:

- The adjusted deductible is the deductible divided by the percentage of spending below the deductible that satisfies the deductible. This excludes spending on copays regardless of whether the relevant service is subject or not subject to the deductible. This calculation is iterative to ensure that the adjusted deductible remains consistent with the percentage of spending below the deductible that satisfies the deductible.¹⁶ The iteration process also ensures that enrollee spending when the deductible is met doesn’t exceed the MOOP.
- The average cost of a benefit during the deductible range (hereafter in this section simply referred to as “average cost of a benefit,”) is the average cost of that benefit listed in the row of the continuance table corresponding to spending at the relevant adjusted deductible (which may be pro-rated, if necessary).
- The per-service cost of a benefit is the average cost of a benefit as described above divided by the benefit type frequency.
- Special cost sharing is defined as any cost sharing for a service type other than subjecting that service to the deductible and the general coinsurance rate without including a special coinsurance rate or copay.

The process for calculating plan-covered expenses and enrollee-covered expenses below the deductible for a given benefit type depends on whether the benefit type is subject to the deductible or to a copay as follows:

- If the benefit type is subject to neither the deductible nor a copay, the plan covers all spending on that benefit type below the relevant deductible. The AV Calculator identifies the average cost of that benefit, all of which is included in plan covered expenses. There is no enrollee-covered expense associated with this benefit type.¹⁷
- If the benefit type is subject to copay but not the deductible, the plan covers all spending on that benefit type below the deductible, less enrollee copays. The AV Calculator subtracts the copay for the benefit type from the per-service cost to

¹⁶ The iterative calculation of the adjusted deductible was added in the 2018 AV Calculator and further modified in the 2024 AV Calculator. Please note that any attempts to reproduce AV without the iterative calculation may differ from the AV calculated by the AV Calculator.

¹⁷ Before the deductible is met, services may not be subject to a coinsurance rate. Therefore, if a plan has benefits with only coinsurance and no deductible or copay, the AV Calculator assumes that there is no enrollee-covered expense associated with this benefit type before the deductible is met. To help AV Calculator users understand the AV Calculator’s operation in these cases, the AV Calculator’s Additional Notes field will indicate if a service has no enrollee cost sharing in the deductible range.

produce plan-covered expenses per service for this benefit type. The AV Calculator multiplies this result by the benefit type frequency to produce total plan-covered expenses for the benefit type. In the draft 2024 AV Calculator, the cost of the copays applies only to the point at which the enrollee reaches the MOOP, but not the point at which the enrollee reaches the deductible. To track enrollee out-of-pocket costs, the copay is multiplied by the benefit-type frequency to determine enrollee spending.

- If the benefit type is subject to the deductible and not subject to a copay, or subject to the copays applying only after deductible, the plan covers no spending on that benefit type below the relevant deductible. The average cost of the benefit is applied to the enrollee-covered expenses. If the benefit is subject to copays applying only after the deductible, then copays aren't considered until after the deductible range. The AV Calculator will return an error if the benefit applies the copay only after deductible and the deductible isn't checked for the benefit.
- If the benefit type is subject to the deductible and the user has entered a copay rate applying during the deductible, the plan covers no spending on that benefit type below the relevant deductible. The difference between the per-service cost of a benefit and the copay amount multiplied by the frequency of the service applies towards enrollee covered expenses for the deductible. The cost of the copays applies only to the point at which the enrollee reaches the MOOP, but not the point at which the enrollee reaches the deductible. Compared to plans with no copay during the deductible, this increases the total amount of per member spending required before the deductible is met.¹⁸

Some claims are composed of multiple components, each with separate inputs for cost sharing in the AV Calculator. The assignment of special cost sharing to claims with multiple components is as follows:

- If the benefit type is one of the five benefit types with both facility and professional components, then the cost sharing depends on the combination of cost sharing entered both for that service type, and for the outpatient facility and professional service types. If special cost sharing is entered for the service type and for one or both of outpatient facility and professional services, or if special cost sharing is entered for only the service type, the cost sharing associated with the service type is used. If special cost sharing isn't entered for the service type and is entered for one or both of outpatient facility and professional services, the cost sharing associated with outpatient services is used. For example, if Speech Therapy is subject to the deductible, is subject to coinsurance, and has no special coinsurance rate; and Outpatient Facility is subject to the deductible and has a specific 60 percent coinsurance rate; the Outpatient Facility component of a Speech Therapy claim will be subject to a 60 percent coinsurance. The AV Calculator's Additional Notes field will indicate if the service-level cost sharing overrides the outpatient cost-sharing input in a particular AV calculation.
- If the benefit type is a PCP or specialist visit, then the cost sharing that applies to

¹⁸ At this time, subjecting drugs to a copay in the deductible range and a special coinsurance rate in the coinsurance range isn't supported by the AV Calculator. Plans may apply both a copay and the general coinsurance rate to prescription drugs by entering a copay and selecting the Subject to Coinsurance option.

any X-ray service provided as part of the visit depends on the cost sharing entered for PCP and/or specialist visits and X-rays. If special cost sharing is entered for one or both of PCP and specialist visits and for X-rays, or if special cost sharing is entered for only X-rays, the cost sharing associated with X-rays is used. If special cost sharing isn't entered for X-rays and is entered for one or both of PCP and specialist visits, the cost sharing associated with primary care and/or specialist visits is used. For example, if PCP office visits aren't subject to the deductible and are subject to a \$20 copay, but X-rays are subject to the deductible and general coinsurance, a PCP office visit that includes an X-ray will be split into two services: a PCP office visit and an X-ray and the primary care cost sharing will apply to both. The AV Calculator's Additional Notes field will indicate if the office visit cost sharing overrides the X-ray cost-sharing input in a particular AV calculation.

The AV Calculator also supports three specific variations on the general deductible process described above:

- If the user limits IP copays to a set number of days, the AV Calculator compares the IP frequency at the adjusted deductible amount to the set number of days. If the IP frequency is less than or equal to the set number of days, the calculation proceeds normally. However, if the IP frequency is greater than the set number of days, the AV calculator multiplies the set number of days by the copay and subtracts the resulting total copay spending from the average cost of the benefit to compute plan-covered spending.
- If the user selects the option restricting primary care cost sharing to care after a set number of visits, the AV Calculator first determines whether the primary care frequency at the adjusted deductible amount exceeds the set number of visits. If the frequency is less than or equal to the set number of visits, the copay doesn't apply and the plan covered spending equals the full value of average cost for that service. However, if the frequency is greater than the set number of visits, the AV Calculator subtracts the set number of visits from the frequency and multiplies the result by the copay to obtain total enrollee copay spending. The AV Calculator then subtracts total enrollee copay spending from the average cost for that service to compute total plan-covered spending.
- If the user specifies that the primary care deductible and/or coinsurance applies only after a set number of visits with copays, the AV Calculator compares the set number of copay visits to the frequency of visits when total average spending is equal to the deductible. If the frequency of visits is less than or equal to the set number of copay visits, then the AV Calculator treats this service as if it was subject to a copay but not the deductible. However, if the frequency of visits exceeds the set number of copay visits, the AV Calculator computes total plan-covered spending at the deductible by multiplying the per-service cost by the set number of copay visits and subtracting from the result the set number of copay visits multiplied by the copay amount.

At the conclusion of these steps, plan-covered expenses in the numerator include all plan covered expenses for spending up to the amount corresponding to the adjusted deductible. For plans with separate deductibles and a combined MOOP, the AV Calculator also tracks the average cost per

enrollee at the amount of the deductible, which is used in later steps. This is the average cost per enrollee at a level of spending equal to the deductible, listed in the corresponding row of the medical or drug continuance table.

The AV Calculator contains special code for handling cases where the plan design implies that an enrollee would meet the MOOP before reaching the deductible. For integrated deductible plans and separate deductible/separate MOOP plans, the deductible will be ignored and the enrollee will be assumed to incur medical expenses until they reach their MOOP. For separate deductible/combined MOOP plans, the deductible will instead be replaced with the highest value that's consistent with the enrollee reaching the deductible before the MOOP. This logic differs from that of other plan structures because only one deductible might cause this issue and the average enrollee will still incur a mix of medical and drug expenses, both of which will count towards the combined MOOP.

An edge case of this problem for separate deductible/combined MOOP plans occurs when the algorithm, through the course of its deductible logic iteration, finds that no spending below a certain deductible value counts towards the deductible. In this case, if the algorithm determines deductibles above this value would result in the enrollee being unable to satisfy the deductible before reaching the MOOP, then the algorithm will use this threshold value in place of the deductible.

Step 5: Determine Applicable Enrollee Spending Level for MOOP

To identify the spending level at which an enrollee will reach the MOOP, the AV Calculator considers both enrollee expenses during the deductible phase and enrollee expenses during the coinsurance phase. To account for enrollee spending below the deductible that doesn't count towards the deductible, the AV Calculator determines a modified MOOP. For each benefit with a copay in the deductible phase, the AV Calculator multiplies the copay by the average frequency at the adjusted deductible for the benefit type. The calculator then sums the enrollee copay expenses across all benefits and divides this sum by the sum of total average spending at the adjusted deductible across all benefits. This percentage is multiplied by the average cost per enrollee at the adjusted deductible, and the result is subtracted from the MOOP to obtain the amount that an enrollee would have to pay in the coinsurance range for the remaining service types before reaching the MOOP limit. The resulting "modified MOOP" represents the amount that an enrollee would have to pay in the coinsurance range for all remaining service types before reaching the MOOP limit. If the plan has separate MOOPs for medical and drug spending, the AV Calculator carries out the above steps separately for medical and drug benefit types and their corresponding MOOPs, producing a modified MOOP for medical spending and a modified MOOP for drug spending.

Next, the AV Calculator computes the spending level at which the modified MOOP will apply. For this calculation, the AV Calculator utilizes an iterative process that involves both the effective and realized coinsurance rate. In the AV Calculator, all coinsurance rates are expressed as the percentage of spending the plan pays. The effective coinsurance rate is the percentage of costs borne by the plan for services subject to coinsurance, accounting for copays. The initial effective coinsurance rate is calculated using the overall average mix of spending on service types. In contrast, the realized coinsurance rate is the coinsurance rate the enrollee receives

during the coinsurance range, which accounts for different mixes of spending on service types at different levels of total spending.¹⁹

To find the point at which the MOOP is reached during the first iteration of this calculation, the AV Calculator first subtracts the deductible from the modified MOOP and divides the resulting value by one minus the effective coinsurance rate. For future iterations, the calculator uses the realized coinsurance rate from the previous iteration as the effective coinsurance rate. The AV Calculator then adds the adjusted deductible to this value to calculate the total amount of spending at which out-of-pocket costs paid by the enrollee reach the modified MOOP. For plans with separate MOOPs, the AV Calculator performs this process separately for medical and drug benefits and their corresponding deductibles, modified MOOPs, and continuance tables to obtain separate average cost estimates for medical and drug spending at the relevant modified MOOP.

For plans with separate deductibles and a combined MOOP, the calculation is similar. However, the medical and drug deductibles are combined into a single equivalent combined deductible and the adjusted medical and drug deductibles are combined into a single equivalent combined adjusted deductible. Both the equivalent combined deductible and the equivalent combined adjusted deductible are calculated by finding the average cost associated with their rows in the separate medical and drug continuance table, then adding these costs together, then looking up this value in the “Max’d” row of the combined continuance. The row value that corresponds to this “Max’d” value is considered the equivalent combined value.

Step 6: Calculate Plan-Covered Expenses for Spending Between the Deductible and the MOOP

To calculate expenses covered by the plan in the coinsurance range (that is, the plan’s spending for services when spending is between the amount corresponding to the adjusted deductible and the amount corresponding to the modified MOOP), the AV Calculator examines each of the medical and drug benefits listed in the AV Calculator to determine plan-covered spending during the coinsurance range. The computation for each benefit type depends on the coinsurance and copay requirements applying to that type. The narrower the range between the deductible and the MOOP, as in the case with some bronze plans, the smaller the role this computation plays in the overall AV of the plan.

The AV Calculator computes plan-covered expenses for all benefits as follows:

- For each benefit type that’s subject to coinsurance, the AV Calculator identifies the applicable coinsurance rate, either a service-specific rate or the general rate, for that benefit. The AV Calculator then subtracts the average cost of that benefit corresponding to spending at the deductible from the average cost of that benefit corresponding to spending at the modified MOOP to obtain the average costs for

¹⁹ The coinsurance for the five benefits with facility and professional components as well as X-rays associated with primary care visits is determined by a similar method to the one applied for costs under the deductible. For the five benefits with facility and professional components, their cost sharing is overridden by the outpatient facility and professional cost sharing if and only if the services don’t have special cost sharing entered and the corresponding outpatient component does have special cost sharing applied. For X-rays associated with primary care and specialist visits, the primary care visit cost sharing applies if and only if the primary care is subject to special cost sharing, while X-rays aren’t subject to special cost sharing.

that benefit that are attributed to spending in the range between the deductible and the modified MOOP. Multiplying this average cost by the benefit's coinsurance rate produces plan-covered expenses for this benefit in the range, which are included in the numerator.²⁰

- For each benefit type that isn't subject to the deductible or coinsurance, but is subject to copay, the AV Calculator divides average cost at the deductible for that benefit by the frequency for that benefit type to estimate the per-service cost at the deductible. The AV Calculator then subtracts the benefit copay from the per-service cost and multiplies the result by the benefit frequency to produce plan-covered spending for the benefit corresponding to spending at the deductible. Next, the AV Calculator follows a similar process to calculate plan-covered spending for the benefit corresponding to spending at the modified MOOP. Finally, the AV Calculator subtracts plan-covered spending at the deductible from plan-covered spending at the modified MOOP and adds the resulting value to the total plan-covered spending. The AV Calculator may use one of several variations on this process to compute plan-covered spending, depending on whether the user selects options that affect how the AV Calculator applies copays or general cost-sharing requirements. In this instance, the AV Calculator computes plan-covered spending at the deductible level based on the average spending and frequency for each benefit type at the deductible level, and it follows an analogous process to compute plan-covered spending at the modified MOOP level.

The AV Calculator supports two specific variations on the calculation of expenses between the deductible and MOOP:

- For specialty high-cost drugs, if they are subject to the plan coinsurance rate and if the user selects the option to limit the amount of enrollee cost sharing on those drugs, the AV Calculator follows a process analogous to that described above to determine whether the enrollee cost-sharing amount for spending between the deductible and the modified MOOP exceeds the specialty-drug spending limit. If the enrollee cost-sharing amount is less than or equal to the specialty-drug spending limit, the AV Calculator treats the benefit as subject to plan coinsurance and incorporates it into the numerator using the process described below. However, if the enrollee cost-sharing amount exceeds the specialty-drug spending limit, the AV Calculator computes plan-covered spending by subtracting the spending limit from the average cost for that benefit between the deductible and the modified MOOP.
- For primary care, if the benefit is subject to plan or benefit-specific coinsurance and if the user selects the option to begin cost sharing after a set number of visits,

²⁰ If specialty high-cost drugs are subject to coinsurance at a coinsurance rate different from the overall plan coinsurance rate and if the user selects the option to limit the amount of enrollee cost sharing on specialty high-cost drugs, the AV Calculator compares this specialty drug spending limit to the enrollee cost-sharing amount under the specialty drug coinsurance rate. To compute this latter value, the AV Calculator multiplies the average cost for the benefit in the range between the deductible and the MOOP by one minus the specialty-drug coinsurance rate. If the enrollee cost-sharing amount is less than or equal to the specialty-drug spending limit, the calculation proceeds as described above. However, if the enrollee cost-sharing amount exceeds the specialty-drug spending limit, the AV Calculator computes plan covered spending in the range between the deductible and the modified MOOP by subtracting the specialty-drug spending limit from the average cost of the specialty drug benefit in this range.

the AV Calculator compares the set number of visits to the frequency for primary care at the modified MOOP. If the set number of visits is less than or equal to the frequency at the modified MOOP, then plan-covered spending equals the difference between the average cost of services at the modified MOOP and the average cost of services at the deductible. However, if the set number of visits is greater than the frequency at the modified MOOP, the AV Calculator computes the enrollee cost-sharing amount by subtracting the set number of visits from the frequency and multiplying the result by the coinsurance rate. The AV Calculator then computes plan-covered spending by subtracting the enrollee cost-sharing amount from the difference between the average cost of services at the modified MOOP and the average cost of services at the deductible.²¹

For the five benefits with facility and professional components and X-rays associated with PCP or specialist visits, the AV Calculator determines the applicable cost sharing for expenses between the deductible and the MOOP in the same way it determines the applicable cost sharing for the deductible. For the five benefits, if that benefit has special cost sharing it applies to claims with both components.

At the completion of these steps, the numerator includes plan-covered expenses in the range of spending between the MOOP and deductible for all services. The AV Calculator calculates the realized coinsurance rate here and compares it to the effective coinsurance rate used in step 5. If they are equal, the calculator moves on to step 7. If they aren't equal, the calculator repeats steps 5 and 6, this time with the recently calculated realized coinsurance rate as the effective coinsurance rate in step 5.

Step 7: Calculate Plan-Covered Expenses for Spending Above the MOOP

The plan covers all expenses for spending on covered benefits above the MOOP. To calculate the amount of this spending, the AV Calculator computes the difference between average cost over all enrollees and average cost at the modified MOOP, and includes the full amount in the numerator. If the plan has separate MOOPs for medical and drug spending, the AV Calculator computes the difference between the average cost for medical benefits over all enrollees and the average cost for medical benefits at the modified medical MOOP and performs a corresponding calculation for drug benefits; the full amount for both benefit types is included in the numerator. At the conclusion of this step, the numerator includes plan-covered expenses over the full range of spending.

Step 8: Apply Tiered Network, if Applicable

If the plan is a blended network plan, the AV Calculator first performs all steps above using the

²¹ The AV Calculator follows a similar process if primary care services are subject to coinsurance and the user specifies that cost sharing only applies after a set number of visits with copays. If the set number of copay visits is less than or equal to the frequency for primary care at the modified MOOP, the AV Calculator computes plan-covered spending in this range using the process described above but subtracting the copay amount multiplied by the frequency for primary care at the modified MOOP. Similarly, if the set number of copay visits exceeds the frequency at the modified MOOP, the AV Calculator computes plan-covered spending in this range as described above by subtracting the copay amount multiplied by the copay visit limit.

deductible, coinsurance rate, MOOP and benefit-specific deductible, coinsurance, and copay requirements entered for Tier 1, and then multiplies the numerator calculated in step 7 by the portion of total claims costs specified by the user as anticipated to be used in Tier 1. The result becomes the preliminary numerator. The AV Calculator then repeats steps 3 through 7, utilizing the information about the deductible, coinsurance rate, MOOP and benefit-specific deductible, coinsurance, and copay requirements contained in the Tier 2 columns of the AV Calculator to calculate a secondary numerator. This secondary numerator is then multiplied by the portion of total claims cost specified by the user to reflect utilization of the Tier 2 network. Once this process is complete, the AV Calculator adds the preliminary and secondary numerators to produce the new final numerator.

Step 9: Calculate AV and Corresponding Metal Level

In the final step, the AV Calculator computes the final AV amount, classifies the plan by metal level, and determines whether the metal level matches the desired metal level input by the user.

The AV Calculator compares the observed metal level to the user's desired metal level. If the desired metal level matches the observed metal level, the AV Calculator outputs the AV, metal level, and the message, "Calculation Successful." If the plan doesn't match the desired metal level, the AV Calculator provides the user the option to reset the "Desired Metal Tier" parameter to the observed metal level and rerun the AV calculation. If the user declines, the AV Calculator outputs the AV, the metal level, and the message, "Calculation resolved without matching metal tiers." To compute the AV, the AV Calculator divides the numerator by the denominator. If the AV is outside of the ranges corresponding to each metal level, the AV Calculator outputs the AV and the message "Error: Result is outside of [-y, +x] percent de minimis variation.", with x and y representing the upper- and lower-bounds respectively of the de minimis range for the specified "Desired Metal Tier" parameter.

Additionally, users may select the option to determine whether the plan design satisfies the ACA CSR plan variation requirements or the expanded bronze plan AV de minimis range in accordance with 45 CFR 156.140(c). CSR requirements are available to eligible enrollees with household incomes below 250 percent of the Federal Poverty Level (FPL) under section 1402(a) through (c) of the ACA. Under the regulations implementing section 1402, issuers of qualified health plans must provide plan variations to eligible lower-income enrollees, who have enrolled in silver qualified health plans in the individual market through the Exchange.²² These plan variations must have reduced cost sharing and meet specified AV levels depending on the enrollee's household income. To use the AV Calculator to verify the AV of a plan variation, users should select the indicator that the plan meets the CSR standard, and select the intended type of CSR plan. The below table provides information on which metal level should be chosen to align with the expected utilization for each plan variation. Please note that the metal level continuance tables indicated below should be used regardless of any error message prompting the use of a different continuance table.

²² 45 CFR 156.420.

Household Income	Silver Plan Variation AV	Desired Metal Tier
100-150% of FPL	Plan Variation 94%	Platinum
150-200% of FPL	Plan Variation 87%	Gold
200-250% of FPL	Plan Variation 73%	Silver

After the other information has been entered, and the AV is calculated, the AV Calculator will produce an additional output message, which describes whether the plan satisfies the AV requirements for enrollees at a particular percentage of FPL.

Similarly, in accordance with 45 CFR 156.140(c), the draft 2024 AV Calculator allows the user to calculate AV for bronze plans that meet certain requirements, and therefore would be allowed to utilize an expanded bronze plan *de minimis* range. The requirements for using the expanded bronze plan *de minimis* range require that the bronze plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2). For the bronze plans that meet either of these requirements, the allowable variation in AV for such plans is +5/-2 points.²³ The draft 2024 AV Calculator doesn't check the plans for compliance with the requirements to use the expanded bronze plan *de minimis* range. To run an expanded bronze plan in the AV Calculator, the user should check the box entitled *Indicate if Plan Meets CSR or Expanded Bronze AV Standard* and then select the radio button entitled *Expanded Bronze (58%-65%)*. This process will automatically update the *Desired Metal Tier* to Bronze. If an expanded bronze plan is incorrectly run without *Bronze* selected as the *Desired Metal Tier*, the user will receive the following output messages "Calculation resolved without matching metal tiers" or "Error: Result is outside of de minimis variation for Expanded Bronze" to indicate that the AV calculation isn't successful. An expanded bronze plan AV calculation is successful in the AV Calculator when the user receives the output message "Expanded Bronze Standard (58% to 65%), Calculation Successful". It is the responsibility of the bronze plan issuer to ensure that its bronze plan meets the requirements under this policy at 45 CFR 156.140(c) if the issuer uses that expanded bronze plan *de minimis* range in the AV Calculator.

Disclaimer: The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

²³ For information on the expanded bronze plan policy at 45 CFR 156.140(c), please refer to the Final 2018 Payment Notice and the Market Stabilization Final Rule and Final 2023 Payment Notice.