

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Patient Protection and Affordable Care Act; Actuarial Value Calculator Methodology
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

This document is incorporated by reference into the Notice of Proposed Rulemaking, *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation*, published in the Federal Register at 77 Fed. Reg. _____ (Nov. ____, 2012) and comprises part of the proposed rule for determining actuarial value proposed as 45 C.F.R. § 156.135.

Introduction:

In the Essential Health Benefits, Actuarial Value, and Accreditation Notice of Proposed Rulemaking published in the Federal Register, HHS proposes the use of an AV Calculator to determine levels of coverage for non-grandfathered health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges). Section 1302(d)(2)(A) of the Affordable Care Act stipulates that AV be calculated based on the provision of essential health benefits (EHBs) to a standard population. The statute groups health plans into four tiers: bronze, with an AV of 60%; silver, with an AV of 70%; gold, with an AV of 80%; and platinum, with an AV of 90%. The Notice of Proposed Rulemaking proposes that a de minimis variation of +/- 2% of AV is allowed for each tier.

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. Although producing an exact calculation of a very complex interaction of use of health care services is not possible in a tool that is publicly available and able to accommodate the majority of plans, the results provided by this AV Calculator are well within the de minimis range and ensure compliance with the Affordable Care Act and proposed regulatory AV standards.

This incorporated piece of the proposed rule provides a detailed description of the development of the standard population and AV Calculator methodology. The following 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 final section describes the AV Calculator interface and the calculation of actuarial value.

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 likely to be covered by individual and small group market health insurance in 2014. 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 are proposing 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 is used to develop four sets of continuance tables, based on bronze, silver, gold and platinum plan designs.

The AV Calculator estimates the actuarial value of a plan design based on the aggregated data contained in the four sets of continuance tables representing each plan's benefit structure.

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 was 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 2014 to develop the standard population. The third section describes the methodology for using the claims database to develop the continuance tables. Finally, the last section details the process for accounting for spending and utilization of certain essential health benefits (EHB) that are poorly represented in the database.

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 2010. This commercial database includes detailed enrollment and claims information for individuals who are members of several regional insurers and covers over 54 million individuals enrolled in individual and group health plans. A database including enrollees in small group plans is desirable because 83 percent¹ of small group plans do not offer multiple choices of plans, reducing selection bias between plans. Including claims in the small group market permits the continuance tables to be based on induced demand assumptions that reflect plan design options that will be available in 2014, particularly the bronze and silver options that are described in § 156.140 of this proposed rule. In addition, large group health plans tend to have gold and platinum level benefit generosity, and data on these plans offer information about gold and platinum plan design options.

Since descriptions of the plan benefit design characteristics were not included in the database, cost sharing variables, including copayments, coinsurance and deductibles, from the claims data were used to infer the member and plan shares of the total spending that is reflected in the database, as described below.² The data contains spending, demographic and enrollment information at the member level, including age, sex, family structure, presence of a pre-existing condition, enrollment, spending, and number of claims. Enrollees are grouped into Product Client Contracts (PCCs) defined by plan type (e.g., PPO, HMO, indemnity, etc.) and benefit design for a given contract or plan group. The 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 trended forward to 2014.

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 Services

¹ <http://ehbs.kff.org/pdf/2012/8345.pdf> (Table 4.1)

² The AV Calculator does not incorporate information from individual plans because these data could not be used to infer plan design.

- All Inpatient Hospital Services (including mental health and substance use disorder services)
- Primary Care Visit to Treat an Injury or Illness (exc. Preventive Well Baby, Preventive, and X-rays)
- Specialist Visit
- Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services
- Imaging (CT/PET Scans, MRIs)
- Rehabilitative Speech Therapy
- Rehabilitative Occupational and Rehabilitative Physical Therapy
- Preventive Care/Screening/Immunization
- Laboratory Outpatient and Professional Services
- X-rays and Diagnostic Imaging
- Skilled Nursing Facility
- Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
- Outpatient Surgery Physician/Surgical Services
- Drug Categories
 - Generics
 - Preferred Brand Drugs
 - Non-Preferred Brand Drugs
 - Specialty High-Cost Drugs

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 service categories: Mental Health and Substance Use Disorder, Advanced Imaging, Rehabilitative Speech Therapy, Occupational and Physical Therapy, Diagnostic Laboratory, and Unclassified (medical). In the development of the continuance tables based on the standard population, we relied on this aspect of the database to account for separate copayments 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 from the US Preventive Services Task Force. The services defined as preventive care correspond to the preventive services covered without cost sharing under section 2713 of the Affordable Care Act.

To prepare the data for use in the continuance tables, several enrollment restrictions are applied to ensure that the data represent a full year of utilization experience for enrollees. The full data include 39,184,536 enrollees and 767,517 PPO/POS (Point of Service) plans. Restricting to group PPO/POS with drug coverage and at least 50 enrollees brings the count down to 15,243,652 enrollees and 61,647 plans. In the absence of plan benefit design information directly from the plans that submitted data to this commercial database, the cost-sharing parameters that apply to individuals are inferred from the spending data to aid in the construction of the continuance tables. To ensure that the imputation procedure can be applied effectively, plans

with utilization data that are likely incomplete are excluded. Specifically, to be included, plans with more than 50 members must be PPO/POS plans with positive drug enrollment in at least one month, and plans with over 1,000 members must additionally have at least one claim with a maternity DRG. Moreover, all plans must have at least one member with over \$5,000 in spending. For plans that meet these requirements, the 90th percentile of positive deductibles that are at least \$250 lower than the amount of total spending for all enrollees within a PCC is set as the plan deductible, and the 90th percentile of beneficiary spending above \$1,000 over all enrollees within a PCC is set as the plan maximum out-of-pocket (MOOP) limit. 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 copayments for several services including in-patient (IP) services, emergency room (ER) services, primary care office visits, specialist office visits, and five tiers of prescription drugs: generics, preferred brand drugs, non-preferred brand drugs, specialty high-cost drugs (defined as drugs costing more than \$500 per dose or with greater than \$100 copayment), and maintenance drugs for chronic conditions.

To prepare the data for use in the continuance tables, additional restrictions are made to exclude implausible plan designs. Plans with zero spending for all enrollees and plans with imputed coinsurance rates that fall outside the range of 0-100% are dropped. Additionally, plan-demographic group combinations with negative realized actuarial value are dropped. Enrollees with unspecified sex are also excluded. The resulting database consisting of 12,553,043 enrollees and 46,359 plans was used to construct the continuance tables, subject to the additional adjustments identified in the next two sections of this document.

Standard Population Development and Adjustment from Primary Claims Data

The claims data, excluding the populations and plans noted above, provide the raw material for developing a standard population based on the expected enrollment in individual plans for the years 2014 and beyond. Utilization and spending in this data do not necessarily represent utilization and spending in the population expected to participate in the individual and small group markets in 2014. Further adjustment is therefore necessary to reflect the expected enrollment in plans required to use the AV Calculator in 2014.

We anticipate that the standard population should be composed of the following:

Newly insured individuals: Most currently uninsured individuals will be eligible to enroll in the individual or small group markets beginning in 2014. Because the data in the commercial database represent a population insured under group policies with guaranteed issue, utilization in this group is likely to adequately represent utilization among the newly insured. However, it is possible that there is pent-up demand for health services in this group due to their prior lack of insurance. The AV Calculator is intended for multiple years of use and pent-up demand (to whatever extent it occurs) is likely to greatly diminish over time. The continuance tables therefore do not incorporate any adjustment for additional utilization due to pent-up demand in this group.

Individuals in the status quo individual market: After January 1, 2014, utilization in the group of enrollees in the individual market is likely to be comparable to enrollees in the database, so no adjustments in addition to those noted above are incorporated to account for this group.

Individuals in the small group market: The database consists of individuals with group coverage, and we expect the 2014 small group population to be very similar to the current group market enrollees. Therefore, no adjustments in addition to those noted above are incorporated to account for this group.

Individuals moving out of employer coverage: If individuals move from employer coverage to the individual market, their utilization is likely to be comparable to enrollees in the database, so there is no adjustment in addition to those noted above to account for this group.

Individuals with Medicaid eligibility for part of the year: During the course of a year, some individuals enrolled in Medicaid will become ineligible due to income and will enroll in the individual or small group markets. Utilization in this group is likely to be similar to that among enrollees in the group market because the ability to move up out of Medicaid income levels and into employment likely indicates better health status than that of the average Medicaid beneficiary. Therefore, no adjustments are incorporated to account for this group.

High risk individuals: As of December 2011 (the most recent date for which data with detailed demographic information on enrollees is available), about 220,000 people were enrolled in state high risk pools (HRPs), and about 49,000 were enrolled in the federally-administered or state-administered Pre-existing Condition Insurance Plans (PCIP).³ Average spending for individuals in both the HRPs and the PCIP is substantially higher than spending for enrollees in the claims database. Individuals in state high-risk pools have average spending of about \$10,900 per year, based on 2010 annual state high-risk pool expenses reported by the National Conference of State Legislatures (NCSL)⁴ and most have annual spending that consistently exceeds their plan's MOOP. Based on data from the federally-administered and state-run PCIP programs, individuals in PCIP have average spending of about \$28,000 per year, and many of these individuals are past the MOOP. While states have the flexibility to keep high risk pools open beyond 2014, the continuance tables include adjustments to the existing utilization data to account for both of these populations as described in the following section.

Constructing Continuance Tables

Continuance tables summarize the claims experience and utilization of the standard population and are therefore the key input to calculating actuarial value. Specifically, a continuance table describes the distribution of claims spending for a population of health insurance users who face a particular benefit structure. The set of continuance tables underlying the AV Calculator reflect the standard population developed by the Secretary to implement section 1302(d) of the Affordable Care Act. 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 actuarial value under the proposed rule. Therefore, they are available for public notice and comment at <http://cciio.cms.gov/resources/regulations/index.html#pm> and are incorporated by reference into the proposed rule.

³ The December 2011 PCIP enrollment data by state is available on the Healthcare.gov website: <http://www.healthcare.gov/news/factsheets/2012/09/pcip09142012a.html>.

⁴ NCSL annual spending data by state is available on the organization's website: <http://www.ncsl.org/issues-research/health/high-risk-pools-for-health-coverage.aspx>.

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 number of enrollees with total spending falling within each range, 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 is 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, sex, and age bracket, and each group is assigned to a metal level based on the estimated actuarial value of the plan. Separate continuance tables are created based on the utilization of enrollees in the same metal tier, sex, and age bracket.

Because continuance tables are constructed for a plan designs with similar actuarial values, the tables must account for changes in utilization induced by plan design. To account for this induced demand, each continuance table reflects utilization of individuals from the claims database in plans with actuarial values in each of the four metal tiers. That is, each plan in the database is assigned an actuarial value based on the service utilization and plan payments for enrollee groups in that plan, and enrollees are grouped by these values into the metal tiers. The continuance tables for each metal tier are based on utilization data from enrollees in the claims database with estimated actuarial values within +/- 5% of the target actuarial value for each metal tier.

To estimate actuarial value for each plan, the realized actuarial value of the imputed benefit characteristics is calculated for groups of enrollees by age, sex, and spending bracket; the spending brackets 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, are used to develop models estimating actuarial value based on the imputed cost shares in each of the spending brackets.

The utilization data are then used to create continuance tables for each sex/age group and each metal tier. Only utilization data from enrollees with at least 12 months of enrollment or newborns are used in the continuance tables in order to represent a consumer's view of what cost-sharing to expect in a full 12 months of eligibility. The continuance tables for bronze and silver plans are based on utilization of enrollees in PPO/POS plans with between 50 and 250 enrollees with estimated actuarial values in the bronze and silver range.⁵ Utilization data from all group plans with more than 50 enrollees and estimated actuarial values in the gold and platinum range is used to construct continuance tables for gold and platinum plans.

To produce a single continuance table for each metal tier, each of the separate continuance tables representing age/sex groups for a given metal tier are assembled into a single metal-level-

⁵ Because the bronze and silver tables use only enrollees in plans with between 50 and 250 enrollees, the overall means are distorted due to random observations of extreme spending above the 99th percentile. To account for this distortion, enrollees above \$45,000 in total allowed spending were combined between the two continuance tables, with the average proportion and utilization rates being applied for all buckets above \$45,000 for both bronze and silver tables. A further ad hoc adjustment of reducing bronze spending by 4% for all enrollees below the \$45,000 cut-off rate is made to emulate the difference in mean spending observed in the full empirical BHI distributions.

specific continuance table, with each sex/age-group cell weighted by expected individual market participation in the corresponding metal tier for enrollees with those characteristics.⁶ Expected market participation for each sex/age group is estimated by a model developed by HHS to predict 2014 insurance enrollment. This model utilizes 2007-2011 data from the Census Current Population Survey⁷ and a series of decision rules to predict individuals' behavior in the 2014 health insurance marketplace. The model uses variables such as size of Advanced Premium Tax Credits, estimates about the offer of employer-sponsored insurance (ESI), and eligibility for Medicaid to predict whether individuals enroll in an Exchange plan, ESI, Medicaid, or another source of coverage or whether they remain uninsured. For a continuance table representing a particular metal tier, the HHS model predicts the share that each age/sex group represents of the full enrollee population at that metal tier.

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 actuarial value 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.

Because enrollees in the current group market do not fully represent the population expected to enroll in the individual and small group markets in 2014 (including the Exchanges), the continuance tables are adjusted to include spending by enrollees in both the federal and state-administered PCIP and the state HRPs. As explained above, PCIP and HRP enrollees generally have spending far above the individual market average, and most exceed the MOOP; however we do not have claims for this population. To adjust for the presence of these individuals, first the incremental spending for all PCIP enrollees is averaged across all market enrollees, including PCIP, by dividing the increment of expected spending for all PCIP members above the expected spending for the standard population by the expected individual market population in 2014. An analogous calculation is made for HRP enrollees. Second, both of these per-member-per-year amounts are added to the average-cost-per-member column in the final row of each combined continuance table, which represents the average cost over all enrollees. This step adjusts the continuance tables to reflect that spending by PCIP and HRP enrollees is expected to increase average total spending for enrollees that are reflected in the standard population and the continuance tables. Third, a weighted portion of the per-member-per-year costs for PCIP and HRP enrollees is added to the average-cost-per-enrollee column of each row of the continuance table. The weight for each row is chosen so that the median of the distribution of medical spending for PCIP and HRP enrollees is equal to that of ER spending, and the median of drug spending is equal to that of generic drug spending. For the combined medical and drug continuance tables, the weight of each row is chosen so that the median of the combined distribution for PCIP and HRP enrollees is equal to that of ER spending. ER spending was chosen for this process because the distribution of ER spending in the claims database was the most closely aligned of all spending types to the observed distribution of spending among

⁶ We expect that small group participation is similar to individual market participation in terms of age and sex distribution.

⁷ For more information on this survey, see <http://www.census.gov/cps/>.

PCIP/HRP enrollees. This step spreads spending for PCIP and HRP enrollees across the distribution of enrollee spending in accordance with observed distributions of spending for high-risk enrollees relative to MOOP.

Essential Health Benefits Generally Not Represented in Current Policies

Certain EHB that must be covered under the proposed definition of EHB in this proposed rule are relatively uncommon among the insured population reflected in the 2010 claims database that was used to develop the standard population and the continuance tables. These EHB services include pediatric oral and vision, and habilitative services. The continuance tables incorporate a number of assumptions and additional data sources to ensure the AV Calculator will account for these benefits.

Pediatric oral services must be covered by all EHB- benchmark plans. The continuance tables incorporate assumed utilization of pediatric dental visits based on estimates from an analysis performed for the National Association of Dental Plans. Spending for these services is incorporated into the continuance tables using a similar method to that described above for incorporating PCIP and HRP spending. First, the per-member-per-year spending is added to the average-cost-per-member column in the final row of each combined continuance table, which represents the average cost over all enrollees. This accounts for the increase in average per-member spending for these services. Next, a weighted portion of the per-member-per-year cost is added to the average-cost-per-enrollee column of each row of the continuance table, with the weight proportional to the ratio of the spending limit for that row to the highest cumulative-average-cost-per-enrollee listed in the continuance table.⁸ This spreads the cost for pediatric dental services across the spending distribution but puts the bulk of those costs in the highest spending brackets, under the assumption that enrollees who spend more on all services are likely to spend more on pediatric dental services.

Pediatric vision services must also be covered by all EHB benchmark plans. Spending for these services is incorporated into the continuance tables by the same method for pediatric dental services using a cost estimate from a public employee health plan.

Generally, habilitative services are intended to create and/or maintain function. Given the transitional nature of the proposed approach to habilitation services in EHB and that the utilization of these services is assumed to be low across the entire enrollee population, at this time the continuance tables do not incorporate any additional adjustments for these services.

The AV Calculator Interface:

This section describes the AV Calculator interface and how inputs into the calculator are used to determine AV. Under the proposal reflected in this proposed rule, the inputs for the calculator were determined through a combination of consultation with actuarial experts and testing the magnitude of the effect of parameters on the calculated actuarial value. The calculator is designed to produce a summarized AV rounded to the nearest tenth of a percentage point based on the continuance tables described above and the cost sharing inputs described below.

⁸ For example, assume that the highest cumulative average cost per enrollee is \$10,000. If the spending limit for a row of the continuance table is \$1,000, the weight is proportional to 1,000/10,000.

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 costs paid by the plan relative to the total costs of covered services is the AV of the plan. No summary calculator could capture every single potential plan variation. However, empirically, the vast majority of the variation between the AVs of health plans is captured by a finite number of variables, and the calculator focuses on accurately determining plan actuarial values based on this set of key plan characteristics. Therefore, the calculator includes only these key characteristics that have a significant effect on actuarial value, and all of these key characteristics are listed below.

The user inputs a combination of metal tier 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 tier input allows the AV Calculator to account for induced demand by using the set of continuance tables for that specified metal tier. This is necessary to take into account the differences in utilization that are based on generosity of the health plan (i.e. induced utilization).

Deductibles, general rates for coinsurance, and out-of-pocket maximums 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 prescription expenses or separate deductibles for each type of spending. Similarly, if a plan design has separate medical and drug maximum out-of-pocket 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 copayments for the following medical services, which have a less significant effect on actuarial value than the deductible, general coinsurance, and out-of-pocket maximum. In addition the AV Calculator considers whether they are subject to deductible.

- Emergency Room Services
- All Inpatient Hospital Services (inc. mental health and substance use disorder services)
- Primary Care Visit to Treat an Injury or Illness (exc. Preventive Well Baby, Preventive, and X-rays)
- Specialist Visit
- Mental/Behavioral Health and Substance Use Disorder Outpatient Services
- Imaging (CT/PET Scans, MRIs)
- Rehabilitative Speech Therapy
- Rehabilitative Occupational and Rehabilitative Physical Therapy
- Preventive Care/Screening/Immunization
- Laboratory Outpatient and Professional Services
- X-rays and Diagnostic Imaging
- Skilled Nursing Facility
- Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
- Outpatient Surgery Physician/Surgical Services

- Drug Categories
 - Generics
 - Preferred Brand Drugs
 - Non-Preferred Brand Drugs
 - Specialty High-Cost Drugs

The AVC does not allow the user to subject recommended preventive care to a copay or deductible because the Affordable Care Act directs that these services be covered by the plan at 100%.⁹

The AVC also allows users to specify other plan details. For inpatient and skilled nursing facility services, the default option is that copayments and coinsurance costs apply per stay, but these may be applied at the per day level by choosing the corresponding options. If inpatient copayment costs are applied per day, the user may specify that these copayments only apply for a set number of days chosen by the user, ranging from the first one to ten days in the hospital. Users may also specify that cost sharing for primary care 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 does not 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 primary care copayment. Users may specify that if the unit cost for a given service falls below the copay for that service, the enrollee is charged the unit cost rather than the copay. Users may specify cost-sharing for four tiers of prescription drugs: generics, preferred brand drugs, non-preferred brand drugs, and specialty high-cost drugs. Additionally, the user may specify that for specialty tier drugs, the enrollee pays the lesser of either the specialty drug coinsurance or a set dollar limit chosen by the user. The calculator also incorporates health savings accounts (HSAs) and health reimbursement arrangements (HRAs) that are integrated with group health plans; to use this option the user must include an annual amount contributed by the employer or in the case of HRAs, the amount first made available.

Plans typically apply very different cost-sharing structures to in-network and out-of-network utilization. However, our empirical analysis of the claims database and other analyses by the American Academy of Actuaries indicate that relatively little utilization actually occurs out of network in terms of total dollars. In testing of the AV Calculator, actuarial values including and excluding out-of-network spending differed by less than one percent. For standard plans with in-network and out-of-network tiers, the AV Calculator therefore produces estimates of actuarial value based only on in-network utilization and allows the user to specify only in-network cost-sharing parameters. This is consistent with proposed § 156.135(b)(4).

Under our proposal, plans utilizing a multi-tiered network may be accommodated by the AV Calculator. Users may input separate cost-sharing parameters—such as deductibles, coinsurance rates, MOOPs, and schedules for service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting actuarial value is a blend of the AV for the two tiers.

⁹ For the purposes of the AVC, preventive care means the services required to be covered without cost sharing under the ACA and its implementing regulations. *See* 45 C.F.R. § 147.130 and 77 Fed. Reg. 16501 (Mar. 21, 2012).

Calculating Actuarial Value

AV is calculated as the percentage of total expenditures covered by the plan. Under our proposed rule, the denominator of this calculation is simply the average allowed cost of all services for the standard population in the year for a specified metal tier; the numerator is calculated as the share of average allowed cost covered by the plan, using the cost-sharing parameters specified.

The remainder of this section describes each step in the calculation of actuarial value for the various plan structures that may be specified by the user. Before proceeding with the calculation, the 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 calculator also checks that the deductible is less than the MOOP and that the MOOP (or sum of the MOOPs, for plans with separate medical and drug MOOPs) is less than \$6,500.¹⁰

Under our proposal to use an AV Calculator, if the user's chosen inputs for deductible and MOOP are not 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 AVC 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 Tier

The user enters the desired metal tier for the calculation, and the 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

Under this proposal and consistent with proposed § 156.135(c), employer contributions to the HSA or HRA are counted toward actuarial value. When the HSA or HRA Employer Contribution box is checked and the entered annual contribution amount is positive, the calculator treats this as covered "first-dollar" spending for covered EHB services and applies the

¹⁰ CMS has estimated that the MOOP allowable by law in 2014 will be \$6,450 extrapolated from the 2013 maximum of defined by the IRS: <http://www.irs.gov/pub/irs-drop/rp-12-26.pdf>. The MOOP is rounded up here for simplicity.

benefit as if the annual contribution amount applied at the very beginning of an enrollee's spending during their benefit year to enrollee spending that is less than or equal to the deductible.

To be considered in this way, the AV Calculator requires that the HSA or HRA annual contribution amount be less than or equal to the deductible for the purposes of including the HSA or HRA contribution in the actuarial value of the plan.¹¹ 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 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 below. For each medical or drug benefit type listed in the continuance tables, the calculator determines how much to subtract from the numerator based on whether the benefit is subject to the deductible and/or a copayment:

- If the benefit type is not subject to either deductible or copayment, all spending for that benefit is covered by the plan. The calculator uses the relevant continuance table for combined expenses to identify the average cost of that service when total average spending is equal to the Annual HSA or HRA Contribution Amount. This is equal to plan-covered expenses for this benefit for spending up to the deductible. The calculator subtracts these expenses from the numerator.
- If the benefit type is subject to a copayment, but not to deductible, the calculator follows a similar process as in the prior bullet, identifying the average cost of that service when total average spending is equal to the Annual HSA or HRA Contribution Amount. The calculator then divides the result by the frequency for that benefit to obtain an estimate of the per-service cost. The difference between this cost and the enrollee's copayment for the benefit, which is covered by the plan, is then multiplied by the frequency for the benefit to produce the plan-covered expenses for this benefit for spending up to the deductible. The calculator subtracts the resulting value from the numerator. The calculator may use one of several variations on this process to calculate plan-covered spending up to the HSA contribution amount depending on whether the user selects options that affect how the AVC applies copays or general cost-sharing requirements.¹²

¹¹ If an employer offers a HSA or HRA integrated with a health plan that exceeds the health plan deductible, that plan design can be accounted for using an alternate AV calculation method as described in § 156.135(b).

¹² Variations on the process include the following: (a) If the user selects the option to prevent copays from exceeding the per-service cost, the AVC compares the per-service cost to the copay for that service; if the per-service cost is lower than the copay, the AVC substitutes the per-service cost for the copay for calculations in this step. (b) If the user limits IP copays to a set number of days, the AVC compares the IP frequency at the Annual HSA Contribution 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 AVC 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. (c) If the user selects the option restricting primary care cost sharing to care after a set number of visits, the AVC first determines whether or not the primary care frequency at the Annual HSA Contribution Amount exceeds the set number of visits. If the frequency is less than or equal to the set number of

- If the benefit type is subject to deductible and among a particular subset of benefit types (mental health and substance abuse, advanced imaging, rehabilitative speech therapy, occupational and physical therapy, and diagnostic laboratory), and if the plan has no separate deductible for outpatient professional and/or facility services, the calculator follows the processes described in the prior two bullets for the outpatient professional and outpatient facility portions of the service category. The calculator determines whether to follow the process described in the first or second bullet for the outpatient professional and outpatient facility portions based on the deductible and copayment requirements for those two benefit types.
- For x-ray, diagnostic imaging, and non-preventive well-baby benefits, if they are subject to deductible and if primary care and/or specialist office visit benefits are not subject to deductible, the calculator applies the steps laid out in the first two bullets to the primary care and specialist portions of those service categories. The calculator determines whether to follow the process described in the first or second bullet for the primary care and specialist portions based on the deductible and copayment requirements for those two benefit types.
- For primary care services, if the user specifies that the deductible and/or coinsurance applies only after a set number of visits with copayments, the AVC compares the set number of copay visits to the frequency of visits when total average spending is equal to the Annual HSA Contribution Amount. If the frequency of visits is less than or equal to the set number of copay visits, then the calculator uses the process described in the second bullet to compute plan-covered expenses. However, if the frequency of visits exceeds the set number of copay visits, the calculator computes plan-covered expenses by multiplying the set number of copay visits by the copay amount and subtracting the result from the average cost for primary care services for spending at the Annual HSA Contribution Amount.

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 Below Deductible Amount

The AV Calculator next computes any plan-covered expenses for spending below the amount of the deductible for each benefit type and includes these expenses in the numerator. The computation process depends on whether the plan includes separate medical and drug deductibles or a combined deductible. For plans with a combined (“integrated”) deductible, the calculator computes the deductible portion of the benefit in the same way for both medical and drug benefit types. For plans with separate deductibles, the calculator computes the deductible portion of the benefit separately for medical and drug benefit types. This section first describes

visits, the copay does not 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 AVC subtracts the set number of visits from the frequency and multiplies the result by the copay to obtain total enrollee copay spending. The AVC then subtracts total enrollee copay spending from the average cost for that service to compute total plan-covered spending.

the computation process that applies to plans with combined deductibles and to medical benefits in plans with separate deductibles, and then describes the computation for drug benefit types in plans with separate deductibles.

For plans with a combined deductible, the calculator computes plan-covered expenses in the deductible range for all medical and drug benefit types listed in the calculator, relying on the continuance table for combined expenses. For plans with separate deductibles, the calculator uses only medical benefit types and utilizes the continuance table for medical expenses. The process for calculating plan-covered expenses for a given benefit type varies depending on whether the benefit type is subject to the deductible or to a copayment as follows:

- If the benefit type is subject to neither deductible nor copayment, the plan covers all spending on that benefit type below the deductible. The calculator identifies the average cost of that benefit listed in the row of the continuance table corresponding to spending at the plan deductible (which may be pro-rated, if necessary). This is total per-member spending for this benefit in the relevant range, all of which is included in plan-covered expenses.
- If the benefit type is subject to copayment but not deductible, the plan covers all spending on that benefit type in this range, less enrollee copayments. The calculator identifies the average cost of that benefit, as above. Next, the calculator divides this amount by the benefit type frequency to estimate the per-service cost. Subtracting the copayment for the benefit type from the per-service cost produces plan-covered expenses per service for this benefit type. The calculator multiplies this result by the benefit type frequency to produce total plan-covered expenses for the benefit type. This is added to the total plan covered expenses. The calculator may use one of several variations on this process, similar to those described above in the section on HSAs and HRAs, to compute plan-covered spending, depending on whether the user selects options that affect how the AVC applies copays or general cost-sharing requirements. In this instance, the AVC computes plan-covered spending based on the average spending and frequency for each benefit type at the deductible level.
- If the benefit type is subject to deductible and is among a subset of benefit types (mental health and substance abuse, advanced imaging, rehabilitative speech therapy, occupational and physical therapy, and diagnostic laboratory), and if the plan has no separate deductible for outpatient professional and/or facility services, the calculator follows the process described in the prior two bullets for the outpatient professional and outpatient facility portions of the service category. The calculator determines whether to follow the process described in the first or second bullet for the outpatient professional and outpatient facility portions based on the deductible and copayment requirements for those two benefit types.
- For x-ray, diagnostic imaging, and non-preventive well baby benefits, if they are subject to deductible and if primary care and/or specialist office visit benefits are not subject to deductible, the calculator applies the steps laid out in the first two bullets to the primary care and specialist portions of those service categories. The calculator determines whether to follow the process described in the first or second bullet for the primary care and specialist portions based on the deductible and copayment requirements for those two benefit types.

- For primary care services, if the user specifies that the deductible and/or coinsurance applies only after a set number of visits with copayments, the AVC 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 calculator uses the process described in the second bullet to compute plan-covered expenses. However, if the frequency of visits exceeds the set number of copay visits, the calculator computes the per-service cost for spending at the deductible using the process described in the second bullet. The calculator then computes total plan-covered spending at the deductible by multiplying this 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.

To calculate plan-covered expenses up to the amount of the deductible for drugs in plans with separate medical and drug deductibles, the calculator relies on the continuance tables for the plan metal tier that are constructed from drug claims. For each drug benefit type, the calculator identifies the average cost for that benefit listed in the row of the continuance table that corresponds to the plan drug deductible (which may be pro-rated, if necessary). If the benefit type is not subject to either deductible or copayment, the calculator adds this per-member spending amount to the total plan-covered expenses in full. If the benefit type is subject to copayment but not deductible, the calculator divides average cost for that benefit by the frequency for the benefit type to estimate the per-service cost. The calculator next subtracts the copayment for the benefit type from the per-service cost and multiplies the resulting value by the benefit-type frequency to produce total plan-covered expenses for the benefit type. This result is added to the total plan-covered expenses. If the user selects the option to prevent copays from exceeding the service unit costs, the AVC uses a process similar to that described above in the section on HSAs and HRAs to determine whether to substitute the copay amount with the service unit cost in the above calculations. In this instance, the AVC computes plan-covered spending based on the average spending and frequency for each benefit type at the deductible level.

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 deductible.

The calculator also tracks the average cost per enrollee at the amount of the deductible, which is used in later steps. For plans with an integrated deductible, this is the average cost per enrollee at a level of spending equal to the deductible, listed in the corresponding row of the combined continuance table. For plans with separate deductibles, this is the sum of the average cost per enrollee at spending equal to the medical deductible, listed in the corresponding row of the medical continuance table, and the average cost per enrollee at spending equal to the drug deductible, listed in the corresponding row of the drug continuance table. For plans with separate medical and drug deductibles, the calculator uses the drug-claim continuance table to track the average cost per enrollee corresponding to the plan drug deductible (which may be pro-rated); this value is also used in later steps.

Step 5: Determine Applicable Spending Level for MOOP

To identify the spending level at which an enrollee will hit the MOOP, the calculator first determines a modified MOOP that takes into consideration benefit types excluded from coinsurance. It examines each medical and drug benefit type and if a benefit has a copayment, the calculator multiplies this copayment by the average frequency at the deductible for the

benefit type. The resulting value, which represents the amount of copayment an enrollee pays for that benefit type at the deductible, is subtracted from the MOOP to obtain the amount that an enrollee would have to pay in coinsurance for the remaining service types before reaching the MOOP limit. The calculator may use one of several variations on this process, similar to those described above in the section on HSAs and HRAs, to compute the amount of copay an enrollee pays for each benefit type, depending on whether the user selects options that affect how the AVC applies copays or general cost-sharing requirements. In this instance, the AVC computes total copay spending based on the average spending and frequency for each benefit type at the deductible level. Additionally, if the user specifies that primary care services are subject to copays for a set number of visits before the deductible and/or coinsurance applies, the AVC subtracts from the MOOP the lesser of the following two amounts: either the frequency of primary care visits at the deductible multiplied by the copay amount or the set number of copay visits multiplied by the copay amount.

If the benefit type is subject to coinsurance and is among a subset of benefit types that have both a professional and facility component (mental health, substance abuse, imaging, pediatric vision, pediatric dental, rehabilitative speech therapy, occupational therapy, physical therapy, and laboratory), and if the plan has no coinsurance requirements for outpatient professional and/or facility services, the calculator applies the process described in the prior paragraph to the outpatient professional and facility portions of the service category. To do so, the calculator relies on the coinsurance and copayment requirements for outpatient professional and outpatient facility services.

Similarly, for x-ray and non-preventive well baby benefits, if they are subject to coinsurance and if primary care and/or specialist office visit benefits are not subject to coinsurance, the calculator applies the process described in the first paragraph of this section to the primary care and specialist portions of the service category. To do so, the calculator relies on the coinsurance and copayment requirements for primary care and specialist office visits.

Upon completion of these adjustments, the resulting “modified MOOP” represents the amount that an enrollee would have to pay in coinsurance for all remaining service types before reaching the MOOP limit. If the plan has separate MOOPs for medical and drug spending, the 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 calculator computes the spending level at which the modified MOOP will apply. To do so, the calculator subtracts the deductible from the modified MOOP and divides the resulting value by one minus the coinsurance rate, or the percentage of costs borne by the enrollee for services subject to coinsurance; it then adds the 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. The calculator matches this amount to the appropriate row in the combined continuance table to obtain the average cost per enrollee at the modified MOOP limit. For plans with separate MOOPs, the 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.

While the modified MOOP created by this adjustment does not capture the precise effect of copayments, it provides a value that adequately fulfills the needs of the remaining calculation

steps. Small differences between the modified MOOP calculated by this method and the exact MOOP that applies are unlikely to have a significant effect on the output of the AV Calculator.

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 deductible and the amount corresponding to the modified MOOP), the calculator examines each of the medical and drug benefits listed in the calculator to determine whether they are subject to coinsurance and copayment. The computation for each benefit type depends on the coinsurance and copayment requirements applying to that type. First, the calculator computes plan-covered expenses for benefits not subject to the overall plan coinsurance rate or benefits subject to the overall plan coinsurance rate within set limits. Second, the calculator computes the average cost per enrollee at the modified MOOP adjusted for costs for all services not subject to the overall plan coinsurance rate. Finally, this adjusted average cost is used to compute plan-covered expenses for benefits subject to the overall plan coinsurance rate. The narrower the range between the deductible and the MOOP, as in the case for bronze plans, the smaller the role this computation plays in the overall actuarial value of the plan.

The calculator computes plan-covered expenses for benefits not subject to the overall plan coinsurance rate and benefits subject to a restricted form of the plan coinsurance rate as follows:

- For each benefit type that is subject to coinsurance at a coinsurance rate different from the overall plan coinsurance rate, the calculator 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 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.¹³
- For each benefit type subject to copayment but not coinsurance, the calculator divides average cost at spending at the deductible for that benefit by the frequency for that benefit type to estimate the per-service cost at that spending level. The calculator then subtracts the benefit copayment 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 calculator follows a similar process to calculate plan-covered spending for the benefit corresponding to spending at the modified MOOP.

¹³ 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 beneficiary cost sharing on specialty high-cost drugs, the calculator compares this specialty-drug spending limit to the beneficiary cost-sharing amount under the specialty-drug coinsurance rate. To compute this latter value, the AVC 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 beneficiary cost-sharing amount is less than or equal to the specialty-drug spending limit, the calculation proceeds as described above. However, if the beneficiary cost-sharing amount exceeds the specialty-drug spending limit, the AVC 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.

Finally, the 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 calculator may use one of several variations on this process, similar to those described above in the section on HSAs and HRAs, to compute plan-covered spending, depending on whether the user selects options that affect how the AVC applies copays or general cost-sharing requirements. In this instance, the AVC 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.

- If the benefit type is subject to coinsurance and is among a subset of benefit types (mental health and substance abuse, advanced imaging, rehabilitative speech therapy, occupational and physical therapy, and diagnostic laboratory), and if outpatient professional and/or facility services are not subject to coinsurance, the calculator applies the process described in the first two bullets to the outpatient professional and outpatient facility portions of the service category. The calculator determines whether to follow the process described in the first or second bullet for the outpatient professional and outpatient facility portions based on the coinsurance and copayment requirements for those two benefit types.
- For x-ray, diagnostic imaging, and non-preventive well baby benefits, if they are subject to coinsurance and if primary care and/or specialist office visit benefits are not subject to coinsurance, the calculator applies the steps laid out in the first two bullets to the primary care and specialist portions of those service categories. The calculator determines whether to follow the process described in the first or second bullet for the primary care and specialist portions based on the coinsurance and copayment requirements for those two benefit types.
- 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 beneficiary cost sharing on those drugs, the calculator follows a process analogous to that described above to determine whether the beneficiary cost-sharing amount for spending between the deductible and the modified MOOP exceeds the specialty-drug spending limit. If the beneficiary cost-sharing amount is less than or equal to the specialty-drug spending limit, the calculator treats the benefit as subject to plan coinsurance and incorporates it into the numerator using the process described below. However, if the beneficiary cost-sharing amount exceeds the specialty-drug spending limit, the AVC 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, the 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 calculator computes the beneficiary cost-sharing amount by subtracting the set number of visits from the frequency and multiplying the result by the coinsurance rate.

The AVC then computes plan-covered spending by subtracting the beneficiary 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.¹⁴

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 except those that are subject to the plan's overall coinsurance rate.

Next, to account for spending on services already considered in this step, the calculator subtracts the sum of the average cost for each of those services from average cost per enrollee for spending at the modified MOOP to obtain adjusted average cost at the modified MOOP.

Finally, the process for computing plan-covered expenses in the coinsurance range for the remaining benefit types depends on both whether the plan has integrated or separate deductibles and whether the deductible or deductibles equal the MOOP. If the plan has an integrated deductible, plan-covered expenses for services not already considered in this step (i.e., services subject to the overall plan coinsurance rate) are equal to the coinsurance rate multiplied by spending on these remaining services. This spending is calculated as the difference between average cost at the level corresponding to the modified MOOP, adjusted as described above for spending on services already considered in this step, and average cost at the level corresponding to the deductible.

If the plan has separate medical and drug deductibles, the remaining plan-covered expenses in this range have two components. The first component, for medical spending, is equal to the coinsurance rate multiplied by spending on medical services in the range between the modified MOOP and deductible. This spending is calculated as the difference between average cost at the level corresponding to the modified MOOP, adjusted as described above for spending on services already considered in this step, and average cost for drug benefits subject to the plan's overall coinsurance rate at spending corresponding to the modified MOOP, less the difference between average cost at the deductible and average cost for all drug benefits at the deductible. That is, the calculator adjusts both the modified MOOP and the deductible for costs attributed to drugs so that spending on medical services can be considered separately. The second component, for drug spending, is calculated in a parallel manner, and is equal to the drug coinsurance rate multiplied by drug spending in the range between the modified MOOP and deductible. This spending is computed as the difference between average cost for drug benefits subject to the plan's overall coinsurance rate at spending corresponding to the modified MOOP and average cost for all drug benefits at the deductible. Again, the calculator adjusts both the modified MOOP and the deductible for costs attributed to medical services so that spending on prescription drugs can be considered separately.

¹⁴ The AVC 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 AVC 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 calculator computes plan-covered spending in this range as described above but contracting the copay amount multiplied by the copay visit limit.

If the medical deductible for a plan with separate deductibles is equal to the MOOP, the calculator computes the medical component using a coinsurance rate equal to one, because all medical expenses in this range are covered by the plan. If the drug deductible is equal to the MOOP, the calculator computes the drug component using a drug coinsurance rate equal to one, because all drug expenses in this range are covered by the plan.

For plans with separate MOOPs for medical and drug spending, the calculator uses a variation of the process described above: calculating plan-covered expenses separately for medical and drug spending falling between the corresponding separate deductibles and modified MOOPs. This variation is described below. First, for benefits not subject to the overall plan coinsurance rate or benefits subject to a restricted form of the plan coinsurance rate, the calculator uses the same process as described above to calculate spending between the deductible and the modified MOOP, but it uses the medical deductible and modified MOOP for calculations involving medical benefits and the drug deductible and modified MOOP for drug benefits. At the conclusion of this step, the numerator includes plan-covered expenses in the range of spending between each benefit type's corresponding MOOP and deductible for all services except those that are subject to the plan's overall unrestricted coinsurance rate.

Second, the calculator subtracts the sum of the average cost of medical services not subject to the unrestricted plan coinsurance rate from the average cost per enrollee at the modified medical MOOP, and performs a corresponding calculation for drug services not subject to the unrestricted plan coinsurance rate. This step adjusts the average costs for medical and drug benefits at the corresponding modified MOOPs to account for spending on benefits not subject to the unrestricted plan coinsurance rate.

Finally, for benefits subject to the plan coinsurance rate without restriction, the calculator uses a similar process as described above to calculate spending between the deductible and the MOOP; however, this step relies on the separate medical and drug deductibles and modified MOOPs to calculate spending for medical and drug benefits. As in the above process, the calculator computes spending separately for medical and drug benefits. However, it is unnecessary to adjust the deductible and modified MOOP to account for spending in the other benefit type due to the separate medical and drug deductibles and modified MOOPs.

At the conclusion of this step, the numerator includes plan-covered expenses for all spending below the MOOP (or MOOPs).

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 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 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 Network Blending, if Applicable

If the plan is a blended network/POS plan, the calculator multiplies the numerator calculated in step 7 by the portion of total claims cost specified by the user as anticipated to be used in the first tier. The result becomes the preliminary numerator. The calculator then repeats steps 3 through 7, utilizing the information about the deductible, coinsurance rate, MOOP and benefit-specific deductible, coinsurance, and copayment 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 second tier network. Once this process is complete, the calculator adds the preliminary and secondary numerators to produce the new final numerator.

Step 9: Calculate AV and Corresponding Metal Tier

In the final step, the calculator computes the final actuarial value amount, classifies the plan by metal tier, and determines whether the metal tier matches the desired metal tier input by the user.

To compute the actuarial value, the calculator divides the numerator by the denominator. Under this proposal, if the actuarial value is outside of these ranges, the calculator outputs the actuarial value and the message “Error: Result is outside of +/- 2 percent de minimis variation”.

The AV Calculator compares the observed metal tier to the user’s desired metal tier. If the desired metal tier matches the observed metal tier, the calculator outputs the actuarial value, metal tier, and the message, “Calculation Successful.” If the plan does not match the desired metal tier, the calculator provides the user the option to reset the “Desired Metal Tier” parameter to the observed metal tier and rerun the actuarial value calculation. If the user declines, the calculator outputs the actuarial value, the metal tier, and the message, “Calculation resolved without matching metal tiers.”

Additionally, users may select the option to determine whether the plan design satisfies the Affordable Care Act cost-sharing reduction (CSR) requirements for enrollees falling below 250% of the Federal Poverty Level (FPL) under section 1402 of the Affordable Care Act. Under section 1402, issuers of qualified health plans must provide plans to eligible lower-income enrollees, who have enrolled in silver qualified health plans through the Exchange, with reduced cost sharing, and these plans must have specified AV depending on the enrollee’s household income. The CSR option will produce an additional output message after an AV calculation, which describes whether the plan satisfies the AV requirements for enrollees at a particular percentage of FPL.