Chapter 11: Actuarial Value Calculator

Contents

1. Overview

To satisfy the actuarial value (AV) requirements of 45 *Code of Federal Regulations* (CFR) 156.140 and 156.420, qualified health plan (QHP) issuers must use the Actuarial Value Calculator (AVC) developed and made available by the Department of Health and Human Services (HHS) for the given benefit year unless the plan design is not compatible with the AVC (a unique plan design) (45 CFR 156.135). To assist with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP Application, HHS recalculates this value to validate that an issuer's plan designs meet AV requirements.

As discussed in the final 2015 HHS Notice of Benefit and Payment Parameters, the 2015 AVC is the same as the 2014 version except for updates to account for the 2015 estimated annual limit

on sharing. Therefore, plans maintaining the same cost sharing from 2014 to 2015 should have the same AV.

2. Purpose

This chapter describes how the cost-sharing information from the Plans & Benefits Template is translated into inputs for the stand-alone AVC.

3. Data Requirements

To calculate AVs on the Plans & Benefits Template, do the following:

1. Select the relevant Cost Share Variances worksheet in the Plans & Benefits Template and fill out all cost-sharing information necessary to run the AVC.
2. Download the final 2015 stand-alone AVC, which is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#Premium Stabilization Programs. The AVC methodology document, also available at this location, and the user guide inside the AVC provide further guidance on how to use the stand-alone AVC.

Figure 11-1 shows key items in these instructions for calculating AVs from the Plans & Benefits Template.

Figure 11-1. AVC Highlights

- If any changes are made to the Plans & Benefits Template after running the **Check AV Calc** procedure, rerun the procedure so that the AVs in the AV Calculator Output Number field are updated to reflect the changes.
- When unique plan design features cause the AVC to yield a materially different AV result from that of other approved methods, the plan is not compatible with the AVC. In this case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).
- If the AV obtained from the template is not identical to that obtained from the stand-alone AVC, follow the instructions in Section 5.1 before deciding whether to designate the plan as unique and submit a screenshot or actuarial certification.
- The *Desired Metal Tier* for cost sharing reduction (CSR) silver plan variations in the AVC is set to "Silver" for the 73 percent silver plan variations, "Gold" for 87 percent silver plan variations, and "Platinum" for 94 percent silver plan variations.
- The AVC returns an error to the Plans & Benefits Template when the sum of the medical and drug maximum out-of-pocket (MOOP) values exceeds $6,850. However, while the AVC accepts MOOP values up to $6,850, plans still must adhere to the annual limitation on cost sharing established in regulation (expected to be $6,600 for self-only coverage and $13,200 for other than self-only coverage).

(continued on the next page)

- The *Blended Network/POS Plan* checkbox in the AVC is not related to the *Plan Type* selection in the Plans & Benefits Template. Non point-of-service (POS) plans can have multiple in-network tiers in the Plans & Benefits Template. If the issuer sets the *Multiple In Network Tiers?* field in the Plans & Benefits Template equal to "Yes," it results in the *Blended Network/POS Plan* checkbox being checked in the AVC.
- The *Subject to Deductible (Tier 1)* and *Subject to Deductible (Tier 2)* fields on the Benefits Package worksheet of the Plans & Benefits Template determine whether to check the *Tier 1 Subject to Deductible?* or *Tier 2 Subject to Deductible?* checkboxes in the AVC. Coinsurance and copay qualifiers ("after deductible" and "before deductible") in the Plans & Benefits Template are not considered when mapping to the AVC.
- Individual MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC.
- If the in-network MOOP or deductible is equal to "Not Applicable" in the Plans & Benefits Template, the combined in- and out-of-network MOOP or deductible is used for the AVC.
- While the coinsurance values in the Plans & Benefits Template represent the percentage of costs the enrollee pays for a given service, the coinsurance values in the AVC represent the percentage of costs the issuer pays.
- If the issuer enters a 0% *Default Coinsurance* in the Plans & Benefits Template, the AVC expects a copay-based plan. If the plan is a 0% coinsurance plan and not a copay-based plan, enter 0.01% in the relevant *Default Coinsurance* field.
- If a benefit has coinsurance equal to "No Charge" and a copay greater than "$0," the AVC assumes that the enrollee pays a copay until reaching the MOOP. If a benefit has a coinsurance equal to "0%" and a copay greater than "$0," the AVC assumes that the enrollee pays a copay until meeting the deductible, and then pays nothing after the deductible.
- During the deductible phase, the AVC splits certain benefits that do not have special cost-sharing provisions ("not having special cost-sharing provisions" during the deductible phase is defined as being subject to deductible and no copay) into either Primary Care and Specialist Office Visit components or Outpatient Facility and Output Professional components. The issuer can prevent a benefit from being split into its component parts during the deductible phase by entering a $0 copay, rather than "No Charge," for the given benefit in the Plans & Benefits Template.
- The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services cost-sharing fields are weighted averages of the Mental/Behavioral Health Outpatient Services and the Substance Abuse Disorder Outpatient Services cost-sharing fields in the Plans & Benefits Template (see Section 6.10.5).

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- If any plan on a Cost Share Variances worksheet has a *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* value other than "No Charge" or "No Charge after deductible" for either the Outpatient Facility Fee or Outpatient Surgery Physician/ Surgical Services benefit categories, the **Check AV Calc** procedure generates an error for other unrelated plans that follow the plan with an outpatient copay on the given worksheet (see Section 6.10.4).
- The AVC does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance (that differs from the relevant default coinsurance) are entered for a drug benefit in the Plans & Benefits Template, the AVC returns an error. If a drug benefit has only a copay or coinsurance, the issuer should enter "No Charge" instead of "$0" or "0%," or "No Charge after deductible" instead of "$0 Copay after the deductible" or "0% Coinsurance after the deductible," in the Plans & Benefits Template to avoid an error from the AVC.

4. Calculating Actuarial Values

The **Check AV Calc** procedure on the **Plans and Benefits** ribbon allows you to calculate AVs for all applicable plans. First, select the relevant Cost Share Variances worksheet and fill out all the cost-sharing information necessary to run the AVC. Then, click the **Check AV Calc** button, which prompts you to select the file location of the stand-alone AVC.[1] After you identify the AVC, a procedure autopopulates the AVC for each plan or plan variation and copies the resulting AVs into the Plans & Benefits Template.

After the procedure is complete, a validation message box (Figure 11-2) appears with the *Status/Error Message* from the AVC for each plan or plan variation. The *AV Calculator Output Number* (column F in the Cost Share Variances worksheet) is also updated with the AV from the AVC (cell B56 in the AVC). If an error prevented an AV from being calculated, the *AV Calculator Output Number* is left blank. Figure 11-3 shows an example of the AV output in the Plans & Benefits Template, and Figure 11-4 shows the output section of the AVC.

If any changes are made to the Plans & Benefits Template after running the **Check AV Calc** procedure, you must rerun the procedure so that the AVs in the *AV Calculator Output Number* field are updated to reflect the changes.

Issuers can use the stand-alone AVC to test plan designs, but they do not submit a completed stand-alone AVC or other supplemental documentation, such as a screenshot, except in scenarios described later (see Section 5.1). Instead, they submit a completed Plans & Benefits Template that includes the AVs populated by the **Check AV Calc** procedure.

[1] The 2015 AVC is posted on the Center for Consumer Information and Insurance Oversight (CCIIO) website under "March 4, 2014" at: http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html#Premium Stabilization Programs.

Figure 11-2. AVC Validation Report in Plans & Benefits Template

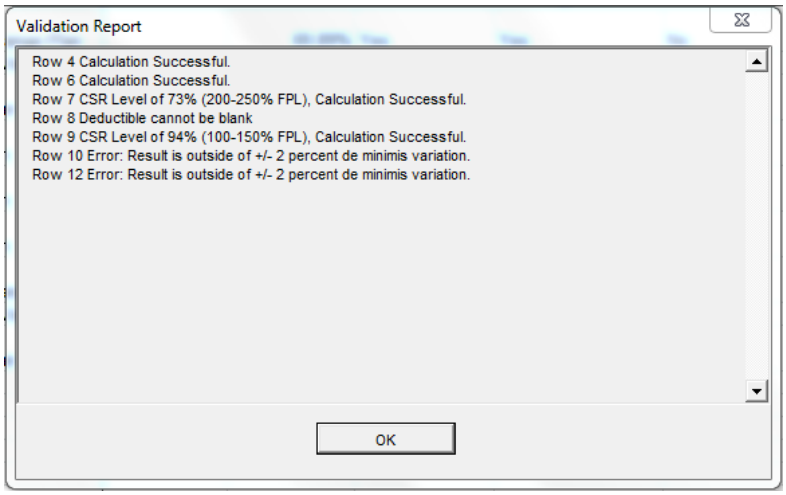
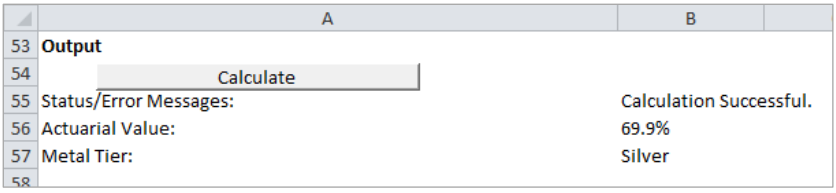


Figure 11-3. AV Output in Plans & Benefits Template

				Plan Cost Sharing Attributes	
HIOS Plan ID* (Standard Component + Variant)	**Plan Marketing Name***	**Level of Coverage* (Metal Level)**	**CSR Variation Type***	**Issuer Actuarial Value**	**AV Calculator Output Number***
12345AR1234567-01	Silver Test	Silver	Standard Silver On Exchange Plan		69.89%
12345AR1234567-02		Silver	Zero Cost Sharing Plan Variation		100.00%
12345AR1234567-03		Silver	Limited Cost Sharing Plan Variation		69.89%
12345AR1234567-04		Silver	73% AV Level Silver Plan		72.71%
12345AR1234567-05		Silver	87% AV Level Silver Plan		86.29%
12345AR1234567-06		Silver	94% AV Level Silver Plan		
12345AR1234568-01	Gold Test	Gold	Standard Gold On Exchange Plan		81.85%
12345AR1234568-02		Gold	Zero Cost Sharing Plan Variation		100.00%
12345AR1234568-03		Gold	Limited Cost Sharing Plan Variation		81.85%

Figure 11-4. AVC Output



5. Plans Using the AVC

The Plans & Benefits Template uses the AVC to calculate AVs for all standard, non-catastrophic plans, all silver plan CSR variations, and all limited cost sharing plan variations. If AVs cannot be calculated, the *AV Calculator Output Number* remains blank. If *Unique Plan Design?* equals "Yes" on the Benefits Package worksheet of the Plans & Benefits Template, the AV from the AVC is not used during validation; instead, the *Issuer Actuarial Value* entered by the issuer into the Cost Share Variances worksheet is used to validate that the plan's AV falls within the relevant de minimis range.

If the Cost Share Variance worksheet contains both unique plan designs and non-unique plan designs, the **Check AV Calc** procedure attempts to calculate an AV for the unique as well as the non-unique plan designs. If the stand-alone AVC returns an error for a unique plan design, resulting in a blank *AV Calculator Output Number*, the issuer does not need to address the error to validate the template; so long as the *Issuer Actuarial Value* falls within the relevant de minimis range for unique plan designs, the template validates. While not required, the Centers for Medicare & Medicaid Services (CMS) recommends that issuers run the **Check AV Calc** procedure on Cost Share Variance worksheets that contain only unique plan designs so that the issuer's submission includes the *AV Calculator Output Number* for plans that do not generate an error in the stand-alone AVC.

A de minimis variation of ±2 percentage points is used for standard metal-level plans, while ±1 percentage point is used for CSR silver plan variations. (See Section 7 for details on zero cost sharing and limited cost sharing plan variations.)

5.1 Unique Plan Design Considerations

When unique plan design features cause the AVC to yield a materially different AV result from that of other approved methods, the plan is not compatible with the AVC. In this case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).

If the plan design is unique for purposes of calculating AV, the issuer application should include the Unique Plan Design Supporting Documentation and Justification (see Chapter 16). The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice.

For plans compatible with the AVC, if the AV obtained from the template is not identical to the AV obtained from the stand-alone AVC, do the following:

1. Ensure the template has been filled out correctly per the instructions in this chapter.

2. Determine whether you can replicate the results of the stand-alone AVC using the Plans & Benefits Template and its **Check AV Calc** procedure.

    a. If you cannot replicate the stand-alone AVC results due to the design of the Plans & Benefits Template, but the AVs obtained from the stand-alone AVC and through the Plans & Benefits template **both** fall within the relevant de minimis range for the plan's metal level or CSR variation, you do not need to designate the plan as a unique

plan design. Instead, set the *Unique Plan Design?* field equal to "No" and leave the *Issuer Actuarial Value* field blank.

b. If the AV obtained via the Plans & Benefits Template does not fall within the relevant de minimis range but the AV obtained via the stand-alone AVC does, designate that particular plan as a unique plan design by setting the *Unique Plan Design?* field equal to "Yes." For this plan, complete the *Issuer Actuarial Value* field with the value from the stand-alone AVC. The AV from the stand-alone AVC must fall within the relevant de minimis range. Also, upload a screenshot of the stand-alone AVC as a supporting document in the Health Insurance Oversight System (HIOS) and include the *HIOS Plan ID (Standard Component)* and date in the file name and associated HIOS Description field. (In this situation, designating your plan as a unique plan design does not require submission of an actuarial certification, and the plan is not considered unique for review purposes.)

The AV in the Plans & Benefits Template may differ from the AV from the stand-alone AVC for the following reasons (among others):

1. One or more benefits used for the AV calculation are subject to the deductible—*Subject to Deductible (Tier 1)* or *Subject to Deductible (Tier 2)*—for the standard plan but not all of the silver plan CSR variations.

2. One of the following design features varies among the standard plan and at least one silver plan CSR variation:

   a. *Maximum Coinsurance for Specialty Drugs*

   b. *Maximum Number of Days for Charging an Inpatient Copay?*

   c. *Begin Primary Care Cost-Sharing After a Set Number of Visits?*

   d. *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?*

3. The plan design has Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services copays: a *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* value other than "No Charge" or "No Charge after deductible." For any plan that has these copays on the Cost Share Variances worksheet, the **Check AV Calc** procedure generates an error for other unrelated plans that follow the plan with an outpatient copay on the given worksheet (see Section 6.10.4).

4. One or more benefits that can be split into component parts have a coinsurance equal to the default coinsurance, but the issuer does not wish to split the benefits into its component parts during the coinsurance phase. The X-rays and Diagnostic Imaging category can be split into Primary Care and Specialist Office Visit components. The following benefits can be split into Outpatient Facility and Outpatient Professional components:

   a. Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

b. Imaging (CT/PET Scans, MRIs)

c. Rehabilitative Speech Therapy

d. Rehabilitative Occupational and Rehabilitative Physical Therapy

e. Laboratory Outpatient and Professional Services.

In the stand-alone AVC, the user can enter a benefit-specific coinsurance into the *Coinsurance, if different* field, even if this coinsurance is equal to the default coinsurance; however, the Plans & Benefits Template only maps a coinsurance value to the AVC if it differs from the default coinsurance. Entering a benefit-specific coinsurance prevents the benefit from being split into its component parts during the coinsurance phase.

6. Field Mapping

This section describes how the **Check AV Calc** procedure maps data from the Plans & Benefit Template into the AVC. You do not need to perform these mappings, which take place automatically. If any of the required data fields in the Plans & Benefits Template are blank or contain invalid values, the procedure returns an error.

The data fields described in the following sections generally are listed in the order that you would see them when completing the Plans & Benefits Template, starting with the Benefits Package worksheet and followed by the Cost Share Variances worksheet.

6.1 Metal Tier

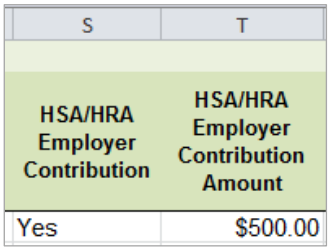
For standard plans, the *Level of Coverage* selected for the plan in the Plans & Benefits Template is mapped to the *Desired Metal Tier* in the AVC.

For silver plan CSR variations, the *Indicate if Plan Meets CSR Standard?* checkbox in the AVC is checked. To ensure that the correct continuance table is used for these plans, the *Desired Metal Tier* depends on the AV level of the variation. The *Desired Metal Tier* for silver plan variances is set equal to “Silver” for the 73 percent variation, “Gold” for the 87 percent variation, and “Platinum” for the 94 percent variation.

6.2 HSA/HRA Options

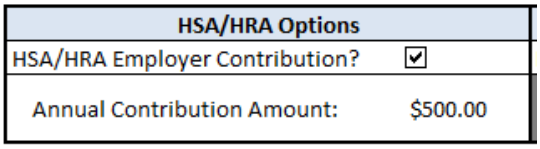
If *HSA/HRA Employer Contribution* is equal to “Yes” in the Benefits Package worksheet of the Plans & Benefits Template, the *HSA/HRA Employer Contribution?* checkbox in the AVC is checked. The dollar amount entered for the *HSA/HRA Employer Contribution Amount* in the Plans & Benefits Template is mapped to the *Annual Contribution Amount* in the AVC. Figure 11-5 shows the health savings account/health reimbursement account (HSA/HRA) input fields in the Plans & Benefits Template, and Figure 11-6 shows the corresponding input fields in the AVC.

Figure 11-5. HSA/HRA Input Fields in Plans & Benefits Template



S	T
HSA/HRA Employer Contribution	HSA/HRA Employer Contribution Amount
Yes	$500.00

Figure 11-6. HSA/HRA Input Fields in AVC



HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$500.00

6.3 Narrow Network Options

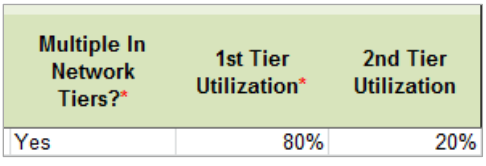
The AVC can accommodate plans utilizing a multi-tiered in-network plan design with up to two tiers of in-network services. You may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, out-of-pocket maximums,[2] and service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting AV is a blend of the AVs for the two tiers.

If *Multiple In Network Tiers?* is equal to "Yes" in the Cost Sharing Variances worksheet of the Plans & Benefits Template, the *Blended Network/POS Plan?* checkbox in the AVC is checked. The *1st Tier Utilization* and *2nd Tier Utilization* fields in the Plans & Benefits Template are mapped to the *1st Tier Utilization* and *2nd Tier Utilization* fields in the AVC. The Plans & Benefits Template requires that all silver plan CSR and limited cost sharing plan variations have the same *1st Tier Utilization* and *2nd Tier Utilization* as the standard plan.

The *Blended Network/POS Plan* checkbox in the AVC is not related to the *Plan Type* selection in the Plans & Benefits Template. Non-POS plans can have multiple in-network tiers in the Plans & Benefits Template, resulting in the *Blended Network/POS Plan* checkbox being checked in the AVC.

Figure 11-7 shows the multi-tier input fields in the Plans & Benefits Template, and Figure 11-8 shows the corresponding input fields in the AVC.

Figure 11-7. Multiple In-Network Tier Options in Plans & Benefits Template



Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization
Yes	80%	20%

[2] The Plans & Benefits Template uses the term maximum out-of-pocket (MOOP), while the AVC uses the term out-of-pocket maximum (OOPM). For the remainder of this document, MOOP is used.

Figure 11-8. Multiple Tier Options in AVC

Narrow Network Options	
Blended Network/POS Plan?	☑
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

6.4 Subject to Deductible?

For each benefit, if *Subject to Deductible (Tier 1)* is equal to "Yes" in the Benefits Package worksheet of the Plans & Benefits Template, the *Tier 1 Subject to Deductible?* checkbox for the corresponding benefit in the AVC is checked. If the plan has multiple in-network tiers and *Subject to Deductible (Tier 2)* is equal to "Yes" in the Benefits Package worksheet of the Plans & Benefits Template, the *Tier 2 Subject to Deductible?* checkbox for the corresponding benefit in the AVC is checked.

If a benefit is not covered, the corresponding *Subject to Deductible?* checkboxes in the AVC are checked because the enrollee is responsible for all costs associated with the benefit category during (and after) the deductible phase. Figure 11-9 shows the *Subject to Deductible* fields in the Plans & Benefits Template, and Figure 11-10 shows the corresponding *Tier 1 Subject to Deductible?* checkboxes in the AVC.

Figure 11-9. Subject to Deductible Fields in Plans & Benefits Template

	A	B	C	D	E	M	N	O	P
59	*Benefit Information*					*Deductible and Out of Pocket Exceptions*			
60	Benefits		EHB	State-Required Benefit	Is this Benefit Covered?	Subject to Deductible (Tier 1)	Subject to Deductible (Tier 2)	Excluded from In Network MOOP	Excluded from Out of Network MOOP
61	Primary Care Visit to Treat an Injury or Illness		Yes		Covered	No	No	No	No
62	Specialist Visit		Yes		Covered	No	No	No	No
63	Other Practitioner Office Visit (Nurse, Physician Assistant)		Yes		Covered	Yes	Yes	No	No
64	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes		Covered	Yes	Yes	No	No
65	Outpatient Surgery Physician/Surgical Services		Yes		Covered	Yes	Yes	No	No

Figure 11-10. Benefit Categories in AVC

Click Here for Important Instructions	Tier 1			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00
Specialist Visit	☐	☑	90%	
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	☐	☐	100%	$0.00
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	☑	☑		
Drugs	☑ All	☑ All		
Generics	☑	☑		
Preferred Brand Drugs	☑	☑		
Non-Preferred Brand Drugs	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑		

The coinsurance and copay drop-down menus in the Plans & Benefits Template include options such as "X% after deductible" and "$X before deductible." The qualifiers "after deductible" and "before deductible" are not considered when determining whether to check *Tier 1 Subject to Deductible?* or *Tier 2 Subject to Deductible?* in the AVC. On the Cost Share Variances worksheet, select the coinsurance and copay options that are consistent with what is entered on the Benefits Package worksheet regarding when the covered benefit is subject to the deductible.

6.5 MOOP and Deductible Values

The AVC standard population and claims data were developed using claims data that did not include any family cost-sharing information. Therefore, individual MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC.

Because some plans may have only combined in- and out-of-network MOOPs or deductibles, rather than separate in-network and out-of-network MOOPs or deductibles, the following logic determines which MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC.

The following applies if the plan does not have multiple in-network tiers:

1. If the *In Network* field is equal to a dollar value (**$X**), the *In Network* field is used for the AVC.

2. If the *In Network* field is equal to "Not Applicable" and the *Combined In/Out of Network* field is equal to a dollar value, the *Combined In/Out of Network* field is used for the AVC.

3. If the *In Network* and *Combined In/Out of Network* fields are equal to "Not Applicable," the Plans & Benefits Template returns an error when attempting to calculate an AV.

The following applies if the plan has multiple in-network tiers:

1. If the *In Network* and *In Network (Tier 2)* fields are equal to dollar values, the *In Network* and *In Network (Tier 2)* fields are used for the AVC.

2. If the *In Network* and *In Network (Tier 2)* fields are equal to "Not Applicable," and the *Combined In/Out of Network* field is equal to a dollar value, the *Combined In/Out of Network* field is used for the AVC. In this case, the *Combined In/Out of Network* MOOP or deductible is mapped to both the Tier 1 and Tier 2 MOOPs or deductibles, respectively, in the AVC.

3. The Plans & Benefits Template returns an error when attempting to calculate an AV in the following scenarios:

    a. The *In Network* field is equal to a dollar value and the *In Network (Tier 2)* field is equal to "Not Applicable."

    b. The *In Network* field is equal to "Not Applicable" and the *In Network (Tier 2)* field is equal to a dollar value.

    c. The *In Network, In Network (Tier 2),* and *Combined In/Out of Network* fields are equal to "Not Applicable."

6.5.1 Out of Pocket Maximums

If *Medical & Drug Maximum Out of Pocket Integrated?* is equal to "Yes" in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate OOP Maximum for Medical and Drug Spending?* checkbox in the AVC is unchecked. The following applies to integrated MOOPs:

1. The *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—In Network—Individual* or *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 OOP Maximum* in the AVC, depending on the logic above.

2. If the plan has multiple in-network tiers, the *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—In Network (Tier 2)—Individual* or *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 OOP Maximum* in the AVC.

Figure 11-11 shows the integrated medical and drug MOOP fields in the Plans & Benefits Template, and Figure 11-12 shows a corresponding example in the AVC.

Figure 11-11. Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Fields in Plans & Benefits Template

AJ	AK	AL	AM	AN	AO	AP	AQ
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)							
In Network		**In Network (Tier 2)**		**Out of Network**		**Combined In/Out Network**	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*
$4,000	$8,000			$10,000	$20,000	Not Applicat	Not Applicabl

Figure 11-12. Integrated Deductible and OOP Maximum in AVC

	Tier 1 Plan Benefit Design		
	Medical	**Drug**	**Combined**
Deductible ($)			$1,500.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

If *Medical & Drug Maximum Out of Pocket Integrated?* is equal to "No" in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate OOP Maximum for Medical and Drug Spending?* checkbox in the AVC is checked. The following applies to separate MOOPs:

1. The *Maximum Out of Pocket for Medical EHB Benefits—In Network—Individual* or *Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Medical OOP Maximum* in the AVC.

2. The *Maximum Out of Pocket for Drug EHB Benefits—In Network—Individual* or *Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Drug OOP Maximum* in the AVC.

3. If the plan has multiple in-network tiers, the following applies:

    a. The *Maximum Out of Pocket for Medical EHB Benefits—In Network (Tier 2)—Individual* or *Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Medical OOP Maximum* in the AVC.

    b. The *Maximum Out of Pocket for Drug EHB Benefits—In Network (Tier 2)—Individual* or *Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out*

Network—Individual value in the Plans & Benefits Template is mapped to the *Tier 2 Drug OOP Maximum* in the AVC.

Figure 11-13 shows the separate medical and drug MOOP fields in the Plans & Benefits Template, and Figure 11-14 shows a corresponding example in the AVC.

Figure 11-13. Maximum Out of Pocket for Medical EHB Benefits and Maximum Out of Pocket for Drug EHB Benefits Fields in Plans & Benefits Template

T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
Maximum Out of Pocket for Medical EHB Benefits								*Maximum Out of Pocket for Drug EHB Benefits*							
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*
$3,000	$6,000			$8,000	$16,000	Not Applicab	Not Applicab	$1,000	$2,000			$5,000	$10,000	Not Applicab	Not Applicab

Figure 11-14. Separate Deductible and OOP Maximum in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$1,500.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%	
OOP Maximum ($)			
OOP Maximum if Separate ($)	$3,000.00	$1,000.00	

The AVC will return an error to the Plans & Benefits Template when the sum of the medical and drug MOOPs exceeds $6,850. However, while the AVC will accept MOOPs up to $6,850, plans are still required to adhere to the annual limitation on cost sharing established in regulation (expected to be $6,600 for self-only coverage and $13,200 for other than self-only coverage).[3]

The AVC does not allow a plan to have separate MOOPs if it has an integrated medical and drug deductible. If *Medical & Drug Maximum Out of Pocket Integrated?* is equal to "No" and *Medical & Drug Deductibles Integrated?* is equal to "Yes" in the Plans & Benefits Template, the Plans & Benefits Template returns an error when attempting to calculate the AV.

6.5.2 Deductibles

If *Medical & Drug Deductibles Integrated?* is equal to "Yes" in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AVC is checked. The following applies to integrated deductibles:

1. The *Combined Medical & Drug EHB Deductible—In Network—Individual* or *Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Combined Deductible* in the AVC.

2. If the plan has multiple in-network tiers, the *Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Individual* or *Combined Medical & Drug EHB*

[3] These are the limits under the current proposal. Their finalization depends on the final rule on *Exchange and Insurance Market Standards for 2015 and Beyond* (79 *Federal Register* 15808).

Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the *Tier 2 Combined Deductible* in the AVC.

Figure 11-15 shows the integrated deductible fields in the Plans & Benefits Template, and Figure 11-12 shows a corresponding example in the AVC.

Figure 11-15. Combined Medical & Drug EHB Deductible Fields in Plans & Benefits Template

BL	BM	BN	BO	BP	BQ	BR	BS	BT	BU
Combined Medical & Drug EHB Deductible									
In Network			**In Network (Tier 2)**			**Out of Network**		**Combined In/Out Network**	
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*
$1,500	$3,000	30%	$2,000	$4,000	40%	$5,000	$10,000	Not Applicat	Not Applicable
$0	$0	0%	$0	$0	0%	$0	$0	$0	$0
$1,500	$3,000	30%	$2,000	$4,000	40%	$5,000	$10,000	Not Applicat	Not Applicable

If *Medical & Drug Deductibles Integrated?* is equal to "No" in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AVC is unchecked. The following applies to separate medical and drug deductibles:

1. The *Medical EHB Deductible—In Network—Individual* or *Medical EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Medical Deductible* in the AVC.

2. The *Drug EHB Deductible—In Network—Individual* or *Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Drug Deductible* in the AVC.

3. If the plan has multiple in-network tiers, the following applies:

    a. The *Medical EHB Deductible—In Network (Tier 2)—Individual* or *Medical EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Medical Deductible* in the AVC.

    b. The *Drug EHB Deductible—In Network (Tier 2)—Individual* or *Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Drug Deductible* in the AVC.

Figure 11-16 and Figure 11-17 show the separate medical and drug deductible fields, respectively, in the Plans & Benefits Template, and Figure 11-18 shows a corresponding example of separate medical and drug deductibles in the AVC.

Figure 11-16. Medical EHB Deductible Fields in Plans & Benefits Template

AR	AS	AT	AU	AV	AW	AX	AY	AZ	BA
Medical EHB Deductible									
In Network			**In Network (Tier 2)**			**Out of Network**		**Combined In/Out Network**	
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*
$1,500	$3,000	20%	$2,000	$4,000	30%	$3,000	$6,000	Not Applicat	Not Applicat
$0	$0	0%	$0	$0	0%	$0	$0	$0	$0
$1,500	$3,000	20%	$2,000	$4,000	30%	$3,000	$6,000	Not Applicat	Not Applicat

Figure 11-17. Drug EHB Deductible Fields in Plans & Benefits Template

BB	BC	BD	BE	BF	BG	BH	BI	BJ	BK
Drug EHB Deductible									
In Network			**In Network (Tier 2)**			**Out of Network**		**Combined In/Out Network**	
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Individual*	*Family*
$500	$1,000	20%	$800	$1,600	30%	$2,000	$4,000	Not Applicat	Not Applicat
$0	$0	0%	$0	$0	0%	$0	$0	$0	$0
$500	$1,000	20%	$800	$1,600	30%	$2,000	$4,000	Not Applicat	Not Applicat

Figure 11-18. Separate Medical and Drug Deductibles and Integrated OOP Maximum in AVC

	Tier 1 Plan Benefit Design		
	Medical	**Drug**	**Combined**
Deductible ($)	$1,500.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%	
OOP Maximum ($)	$4,000.00		
OOP Maximum if Separate ($)			

6.6 Default Coinsurance

While the coinsurance values in the Plans & Benefits Template represent the percentage of costs the enrollee pays for a given service, the coinsurance values in the AVC represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AVC must be set equal to 1–X%, where X% is the coinsurance value entered in the Plans & Benefits Template. For example, if enrollees pay 10 percent of specialist visit costs, the coinsurance in the Plans & Benefits Template would be equal to 10 percent. The coinsurance in the AVC would be equal to 90 percent to represent the 90 percent of costs incurred by the issuer.

If the plan has an integrated medical and drug deductible, it also must have an integrated default coinsurance in the AVC. If *Medical & Drug Deductibles Integrated*? is equal to "Yes" in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Combined Medical & Drug EHB Deductible—In Network—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 1 Combined Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).

2. If the plan has multiple in-network tiers, one minus the *Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 2 Combined Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).

Figure 11-15 shows the integrated medical and drug default coinsurance fields in the Plans & Benefits Template, and Figure 11-12 shows a corresponding example in the AVC.

If the plan has separate medical and drug deductibles, it also must have separate default coinsurance values in the AVC. If *Medical & Drug Deductibles Integrated?* is equal to "No" in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Medical EHB Deductible—In Network—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 1 Medical Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).

2. One minus the *Drug EHB Deductible—In Network—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 1 Drug Coinsurance* in the AVC.

3. If the plan has multiple in-network tiers, the following applies:

    a. One minus the *Medical EHB Deductible—In Network (Tier 2)—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 2 Medical Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).

    b. One minus the *Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 2 Drug Coinsurance* in the AVC.

Figure 11-16 and Figure 11-17 show the separate medical and drug default coinsurance fields, respectively, in the Plans & Benefits Template, and Figure 11-18 shows a corresponding example in the AVC.

If the issuer enters a 0% *Default Coinsurance* in the Plans & Benefits Template, the AVC expects a copay-based plan. If the plan is not a copay-based plan, but enrollees pay 0% coinsurance for services in the coinsurance range, the issuer should enter 0.01% in the relevant *Default Coinsurance* field in the Plans & Benefits Template. When using the stand-alone AVC, the issuer would either input 100% or 99.99% respectively since the stand-alone AVC represents the percentage of costs the issuer pays while the Plans & Benefits Template represents the percentage of costs the enrollee pays for a given service.

6.7 Subject to Coinsurance?

For each benefit, if *Coinsurance—In Network (Tier 1)* is equal to "X% Coinsurance after deductible" or "X%" in the Plans and Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked. For a plan with multiple in-network tiers, if *Coinsurance—In Network (Tier 2)* is equal to "X% Coinsurance after deductible" or "X%" in the Plans and Benefits Template, the *Tier 2 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked.

6.8 Copay Values

For each benefit, if *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to "$X Copay before deductible," "$X per day," "$X per stay," or "$X," the *Tier 1 Copay, if separate* field in the AVC is set equal to X. If *Copay—In Network (Tier 1)* is equal to "$X Copay after deductible" and the corresponding *Coinsurance—In Network (Tier 1)* field is equal to "No Charge" or "No Charge after deductible," the *Tier 1 Copay, if separate* field in the AVC is set equal to "X." If *Copay—In Network (Tier 1)* is equal to "No Charge" or "No Charge after deductible," the *Tier 1 Copay, if separate* field in the AVC is left blank.

When both coinsurance and copay values are present for a given benefit, the AVC can consider a copay in the deductible range and a coinsurance rate in the coinsurance range; however, the stand-alone AVC does not support applying the copay only in the coinsurance range. If a benefit's copay is only after deductible and before the MOOP, and the benefit also has a coinsurance, the AVC only considers the coinsurance value in the coinsurance range. Therefore, if *Copay—In Network (Tier 1)* is equal to "$X Copay after deductible" and *Coinsurance—In Network (Tier 1)* is equal to "X% Coinsurance after deductible" or "X%" in the Plans & Benefits Template, the *Tier 1 Copay, if separate* field in the AVC is left blank.

For a plan with multiple in-network tiers, the logic described above for Tier 1 also applies to Tier 2.

During the deductible phase, the X-rays and Diagnostic Imaging category is split into Primary Care and Specialist Office Visit components if special cost-sharing provisions are indicated for Primary Care or Specialist Office Visits, and the X-ray benefit category does not have special cost-sharing provisions (meaning it is subject to deductible and has no copay). Likewise, the following benefits are split into Outpatient Facility and Outpatient Professional components if special cost-sharing provisions are indicated for the Outpatient Facility or Professional categories, but not for the given benefit:

1. Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services
2. Imaging (CT/PET Scans, MRIs)
3. Rehabilitative Speech Therapy
4. Rehabilitative Occupational and Rehabilitative Physical Therapy
5. Laboratory Outpatient and Professional Services.

If any of these benefits or X-rays is subject to the deductible and does not have a copay, the issuer can prevent the benefit from being split into its component parts during the deductible phase by entering a $0 copay for the relevant benefit category in the Plans & Benefits Template. Entering "No Charge," rather than "$0," results in no copay value being mapped to the AVC, and the relevant benefit is split into its component parts during the deductible phase if it is subject to the deductible.

6.9 Different Coinsurance Values

A coinsurance value for a benefit category is mapped to the AVC only if the coinsurance for the given benefit differs from the relevant default coinsurance. For each benefit, if the *Tier 1 Subject to Coinsurance?* checkbox in the AVC is checked as described above, one minus X%, where X% is the coinsurance value from the *Coinsurance—In Network (Tier 1)* field in the Plans & Benefits Template, is mapped to the *Tier 1 Coinsurance, if different* field for the corresponding benefit in the AVC. For a plan with multiple in-network tiers, if the *Tier 2 Subject to Coinsurance?* checkbox in the AVC is checked, one minus X%, where X% is the coinsurance value from the *Coinsurance—In Network (Tier 2)* field, is mapped to the *Tier 2 Coinsurance, if different* field for the corresponding benefit in the AVC.

The AVC treats "No Charge" and 0% coinsurance differently when a benefit's copay is greater than $0. If the benefit has coinsurance equal to "No Charge" and a copay greater than $0, the relevant *Subject to Coinsurance?* checkbox in the AVC is unchecked, and the AVC assumes that the enrollee pays a copay until reaching the MOOP. If the benefit has a coinsurance equal to "0%" and a copay greater than "$0," the relevant *Subject to Coinsurance?* checkbox in the AVC is checked and "one minus X%" is entered into the relevant *Coinsurance, if different* field in the AVC. In the latter case, the AVC assumes that the enrollee pays a copay until meeting the deductible, and then pays nothing after the deductible.

Table 11-1 shows all possible mappings of coinsurance and copay values from the Plans & Benefits Template to the AVC.

Table 11-1. Benefit Category Cost-Sharing Mapping Between Plans & Benefits Template and AVC

Plans & Benefits Template		AVC		
Coinsurance	Copay	Subject to Coinsurance?	Coinsurance[4]	Copay
No Charge OR No Charge after deductible	No Charge OR No Charge after deductible	Unchecked	Blank	Blank
No Charge OR No Charge after deductible	$X OR $X Copay before deductible OR $X Copay after deductible OR $X Copay per day OR $X Copay per stay	Unchecked	Blank	$X
X% Coinsurance OR X% Coinsurance after deductible	No Charge OR No Charge after deductible OR $X Copay after deductible	Checked	1–X%	Blank
X% Coinsurance OR X% Coinsurance after deductible	$X OR $X Copay before deductible OR $X Copay per day OR $X Copay per stay	Checked	1–X%	$X

6.10 Benefit Categories

Table 11-2 shows the alignment of benefit categories in the Plans & Benefits Template and the AVC, and Figure 11-10 shows the benefit categories, along with their cost-sharing fields, in the AVC. If a plan does not cover a given benefit, the *Coinsurance, if different* field for the benefit in the AVC is set to "0%," and the *Subject to Coinsurance?* and *Subject to Deductible?* checkboxes are checked.

If a benefit included in the AVC is substituted for in the Plans & Benefits Template, the benefit is then considered not covered for purposes of mapping to the AVC. In this case, the preceding paragraph describes the mapping from the Plans & Benefits template to the AVC for the substituted benefit.

No inputs into the AVC are specific to the pediatric dental or vision benefits, which are treated as part of a whole group of unclassified benefits incorporated into the calculator. Pediatric dental

[4] The coinsurance value is only mapped to the AVC if the coinsurance for the benefit category differs from the relevant default coinsurance.

and vision are generally low-cost benefits that do not have a material impact on AV. Additional information on accounting for pediatric dental and vision benefits is available in the AVC methodology.

Table 11-2. Benefit Category Alignment between Plans & Benefits Template and AVC

Plans & Benefits Template Category Name	AVC Category Name
Emergency Room Services	Emergency Room Services
Inpatient Hospital Services (e.g., Hospital Stay)	All Inpatient Hospital Services (inc. MHSA)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (exc. Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services
Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	Imaging (CT/PET Scans, MRIs)
Rehabilitative Speech Therapy	Rehabilitative Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Rehabilitative Occupational and Rehabilitative Physical Therapy
Preventive Care/Screening/Immunization[5]	Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services	Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging	X-rays and Diagnostic Imaging
Skilled Nursing Facility	Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	Outpatient Surgery Physician/Surgical Services
Generic Drugs	Generics
Preferred Brand Drugs	Preferred Brand Drugs
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs
Specialty Drugs	Specialty Drugs (i.e., high-cost)

6.10.1 Inpatient Hospital Services

If the Inpatient Hospital Services *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to "$X Copay per Day," the *Apply Inpatient Copay per Day?* checkbox in the AVC is checked. If the Inpatient Hospital Services copay is charged per day for Tier 1, the AVC automatically assumes that the Inpatient Hospital Services copay is charged per day for Tier 2, if applicable, as well.

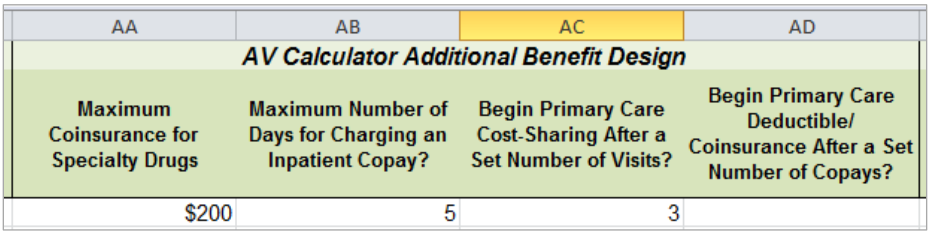
If *Maximum Number of Days for Charging an Inpatient Copay?* is equal to a whole number between 1 and 10 in the Benefits Package worksheet of the Plans & Benefits Template, the *Set a*

[5] As Section 2713 of the Public Health Service Act, codified in 45 CFR 147.130, requires that issuers offer certain preventive care services without cost sharing, the stand-alone AVC automatically takes into account no cost sharing for these services in the AV calculation and does not allow users to enter cost sharing for the Preventive Care/Screening/Immunization benefit category. Thus, regardless of the cost sharing in the Preventive Care/Screening/Immunization benefit category in the Plans & Benefits Template, no mapping occurs between the Plans & Benefits Template and the stand-alone AVC for this benefit category.

Maximum Number of Days for Charging an IP Copay? checkbox in the AVC is checked, and *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template is mapped to *# Days (1–10)* in the AVC. If the *Maximum Number of Days for Charging an Inpatient Copay?* field is blank in the Plans & Benefits Template, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox in the AVC is unchecked, and *# Days (1–10)* in the AVC is left blank.

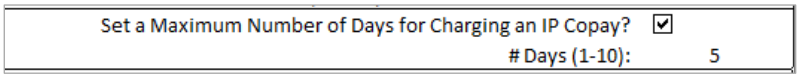
The *Maximum Number of Days for Charging an Inpatient Copay?* field is set only once in the Plans & Benefits Template for each plan and cannot differ among silver plan CSR and limited cost sharing plan variations. Furthermore, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox and *# Days (1–10)* field are input only once in the AVC, and the values cannot vary between Tier 1 and Tier 2. Figure 11-19 shows the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template, and Figure 11-20 shows the corresponding checkbox and field in the AVC.

Figure 11-19. AV Calculator Additional Benefit Design Fields in Plans & Benefits Template



AA	AB	AC	AD
AV Calculator Additional Benefit Design			
Maximum Coinsurance for Specialty Drugs	Maximum Number of Days for Charging an Inpatient Copay?	Begin Primary Care Cost-Sharing After a Set Number of Visits?	Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?
$200	5	3	

Figure 11-20. Maximum Number of Days for IP Copay Checkbox and Field in AVC



6.10.2 Skilled Nursing Facility

If the Skilled Nursing Facility *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to "$X Copay per Day," the *Apply Skilled Nursing Facility Copay per Day?* checkbox in the AVC is checked. If the skilled nursing facility copay is charged per day for Tier 1, the AVC automatically assumes that the skilled nursing facility copay is charged per day for Tier 2, if applicable, as well.

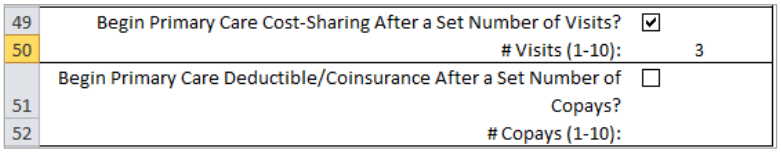
6.10.3 Primary Care

If *Begin Primary Care Cost-Sharing After a Set Number of Visits?* is equal to a whole number between 1 and 10 in the Benefits Package worksheet of the Plans & Benefits Template, the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is checked, and the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field in the Plans & Benefits Template is mapped to *# Visits (1–10)* in the AVC. If the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field is blank in the Plans & Benefits Template, the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is unchecked, and *# Visits (1–10)* in the AVC is left blank.

If *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* is equal to a whole number between 1 and 10 in the Benefits Package worksheet of the Plans & Benefits Template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC is checked, and the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field in the Plans & Benefits Template is mapped to *# Copays (1–10)* in the AVC. If the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field is blank in the Plans & Benefits Template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC is unchecked, and *# Copays (1–10)* in the AVC is left blank.

The *Begin Primary Care Cost-Sharing After a Set Number of Visits?* and *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* fields (Figure 11-19) are set only once in the Plans & Benefits Template for each plan and cannot differ among silver plan CSR and limited cost sharing plan variations. Furthermore, these primary care fields and checkboxes (Figure 11-21) are set only once in the AVC, and the values cannot vary between Tier 1 and Tier 2.

Figure 11-21. Primary Care Options in AVC



6.10.4 Outpatient Facility Fee and Surgery Physician/Surgical Services

The AVC does not support copay values for the Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services benefit categories. If either of these benefit categories has a *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* value other than "No Charge" or "No Charge after deductible" in the Plans & Benefits Template, the AVC returns an error. (For plans with either of these cost-sharing designs, see Section 5.1.)

If any plan on a Cost Share Variances worksheet has a *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* value other than "No Charge" or "No Charge after deductible" for either the Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services benefit categories, the **Check AV Calc** procedure generates an error for other unrelated plans that follow the plan with an outpatient copay on the given worksheet. The **Check AV Calc** procedure, which runs sequentially for all plans on a worksheet, does not clear out the outpatient copay fields in the AVC before running subsequent plans. To address this error, issuers have the following two options:

1. Place all plans with copay values for either the Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services benefit categories on their own Benefits Package and Cost Share Variances worksheets.

2. Follow step 2a in Section 5.1. Designate any plans below the plan with an Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services copay on a given Cost Share Variance worksheet as a unique plan design by setting the *Unique Plan Design?*

field equal to "Yes." For this plan, complete the *Issuer Actuarial Value* field with the value from the stand-alone AVC. Upload a screenshot of the stand-alone AVC as a supporting document in HIOS and include the HIOS Plan ID (Standard Component) and date in the file name and associated HIOS Description field. (In this situation, designating your plan as a unique plan design does not require submission of an actuarial certification and the plan is not considered unique for review purposes.)

6.10.5 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services cost-sharing fields are weighted averages of the Mental/Behavioral Health Outpatient Services and the Substance Abuse Disorder Outpatient Services cost-sharing fields in the Plans & Benefits Template. If *Coinsurance—In Network (Tier 1)* is equal to "X% Coinsurance after deductible" or "X%" for Mental/Behavioral Health Outpatient Services in the Plans & Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked. Then [0.8 × (*Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)*)] + [0.2 × (*Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)*)] is mapped to the *Tier 1 Coinsurance, if different* field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC.

In the following two scenarios, 0.8 × (*Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)*)] + [0.2 × (*Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)*)] is mapped to the *Tier 1 Copay, if separate* field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC:

1. When the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to "$X" or "$X before deductible" in the Plans & Benefits Template.

2. When the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to "$X after deductible" and the *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to "No Charge" or "No Charge after deductible" in the Plans & Benefits Template.

The logic described in the previous two paragraphs also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services.

The values in the *Subject to Deductible (Tier 1)* and *Subject to Deductible (Tier 2)* fields for Mental/Behavioral Health Outpatient Services in the Plans & Benefits Template determine whether to check the Tier 1 or Tier 2 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services *Subject to Deductible?* checkboxes in the AVC.

6.10.6 Drugs

The Plans & Benefits Template and the AVC require cost sharing for four types of drugs: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. (See Chapter 10 for ways to map the cost sharing entered on the Prescription Drug Template into the drug benefit categories in the Plans & Benefits Template.)

The AVC does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance (that differs from the relevant default coinsurance) are entered for a drug benefit in the Plans & Benefits Template, the AVC returns an error. If a drug benefit has only a copay, enter "No Charge" or "No Charge after the deductible," rather than "0%" or "0% Coinsurance after deductible," in the *Coinsurance—In Network (Tier 1)* or *Coinsurance—In Network (Tier 2)* fields in the Plans & Benefits Template to avoid an error from the AVC. Likewise, if a drug benefit has only a coinsurance, enter "No Charge" or "No Charge after the deductible," rather than "$0" or "$0 Copay after deductible," in the *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* fields in the Plans & Benefits Template.

6.10.6.1 Specialty Drugs

If the *Maximum Coinsurance for Specialty Drugs* field is not blank in the Benefits Package worksheet of the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is checked, and the *Maximum Coinsurance for Specialty Drugs* field in the Plans & Benefits Template is mapped to the *Specialty Rx Coinsurance Maximum* field in the AVC. If the *Maximum Coinsurance for Specialty Drugs* field is blank in the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is unchecked, and the *Specialty Rx Coinsurance Maximum* field in the AVC is left blank.

The *Maximum Coinsurance for Specialty Drugs* field (Figure 11-19) is set only once in the Plans & Benefits Template for each plan and cannot differ among the silver plan CSR and limited cost sharing plan variations. Furthermore, the specialty drugs maximum coinsurance checkbox and amount field (Figure 11-22) are set only once in the AVC, and the values do not vary between Tier 1 and Tier 2.

Figure 11-22. Specialty Drugs Maximum Payment Fields in AVC

7. Zero Cost Sharing and Limited Cost Sharing Plan Variations

Zero cost sharing plan variations, which are required to have zero cost sharing for all EHB categories, are automatically assigned an AV of 100 percent because they cover 100 percent of the average enrollee's costs. Limited cost sharing plan variations, which are required to have the same cost sharing and MOOPs as the standard plan for all EHB categories, must have the same AV as the standard plan. Although limited cost sharing plans variations must provide zero cost sharing to certain individuals for EHB items or services furnished directly by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization, or through referral under contract health services (45 CFR 156.420(b)(2)), these CSRs are not represented in the Plans & Benefits Template and are not included in the AV calculation.