

# Qualified Health Plan Issuer Application Instructions

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2021

**Extracted section:  
Appendix A Actuarial Value Calculator (AVC)**

[03/2020]

FINAL

## Appendix A: Actuarial Value Calculator (AVC)

### 1. Introduction

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 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.<sup>18</sup> This section describes how cost-sharing information from the Plans & Benefits Template is translated into the inputs for the standalone AVC. This information is applicable to QHP issuers.

### 2. Data Requirements

To complete this section, issuers will need the following:

1. Completed Plans & Benefits Template
2. Final standalone AVC.

### 3. Quick Reference

#### Key Changes for 2021

- ◆ No changes for the 2021 QHP Application.

#### Tips for Using the AVC

- ◆ **Download the final 2021 standalone AVC, which is available at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.**
- ◆ **If a user is having difficulty matching AVs from the Plans & Benefits Template to the standalone AVC, follow the instructions on troubleshooting in 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template.**
- ◆ **The AVC has an Additional Notes field that outputs error messages that can only be seen in the standalone AVC. These notes are intended to help AVC users understand the AVC's assumptions and provide some information on the AV calculation being run in the AVC. When an AV calculation is not returned because of an input error, check the Additional Notes field for an explanation of the error.**<sup>19</sup>
- ◆ **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.**
- ◆ **If 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 that case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).**

### 4. Detailed Section Instructions

The Plans & Benefits Template uses the AVC to calculate AVs for all standard, non-catastrophic plans, all silver plan cost-sharing reduction (CSR) variations, and all limited cost-sharing plan variations. The AVC cannot be used with catastrophic plans or stand-alone dental plans (SADPs). The **Check AV Calc** procedure skips catastrophic plans entered in the Plans & Benefits Template and stops running when used with the SADP Plans & Benefits Template. If the Cost Share Variances worksheet contains unique plan designs and non-unique plan designs, the **Check AV Calc** procedure attempts to calculate an AV for the unique and the non-unique plan designs. If the standalone 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's AV falls within the relevant de minimis range. While not required, CMS recommends that issuers run the **Check AV Calc** procedure on Cost Share Variances worksheets that contain unique plan designs so that the issuers' submissions include the AV Calculator Output Number for plans that do not generate an error in the standalone

<sup>18</sup> For additional information on the AVC, see the AVC Methodology at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

<sup>19</sup> Examples of these notes include how the special cost-sharing provisions are being engaged in the calculations.

AVC. **Table A-1** describes the steps involved when using the **Check AV Calc** procedure in the Plans & Benefits Template.

**Table A-1. Plans & Benefits Check AV Calc Steps**

Check AV Calc	Steps	
<p>The <b>Check AV Calc</b> procedure on the <b>Plans &amp; Benefits</b> ribbon allows the user to calculate AVs for all applicable plans.</p>	Step 1	Select the relevant Cost Share Variances worksheet and fill out all the cost-sharing information necessary to run the AVC.
	Step 2	Click the <b>Check AV Calc</b> button. The <b>Check AV Calc</b> procedure will prompt the user to select the file location of the standalone AVC. The AVC file selected should not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all of the messages to finish the <b>Check AV Calc</b> procedure.
	Step 3	<ul style="list-style-type: none"> <li>◆ A prompt will appear asking if the issuer would like to save the screenshots.</li> <li>◆ Select <b>Yes</b> if the screenshots will be saved. Using the prompt, select the file name and location to save the output and create a copy of the AVC with worksheets that contain AV screenshots for each plan and plan variation.</li> <li>◆ Select <b>No</b> if the screenshots will not be saved, and the <b>Check AV Calc</b> procedure will complete without creating any new files.</li> </ul>
	Step 4	A validation message box will appear with the status/error messages from the AVC for each plan or plan variation. The <b>AV Calculator Output Number</b> field (Column F in the Cost Share Variances worksheet) is updated with the AV from the AVC. If an error prevented an AV from being calculated, the <b>AV Calculator Output Number</b> field is left blank.
	Step 5	If any changes are made to the Plans & Benefits Template after running the <b>Check AV Calc</b> procedure, the user must rerun the procedure so that the AVs in the AV Calculator Output Number field are updated to reflect the changes.
	Step 6	After the AVC is completed, a procedure auto-populates the AV for each plan or plan variation and copies the resulting AVs into the Plans & Benefits Template. The AVC file selected should not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all messages to finish the <b>Check AV Calc</b> procedure.
<p>For Unique Plan Designs: Upload screenshot into HIOS.<sup>20</sup></p>	Step 7— (Optional)	<ul style="list-style-type: none"> <li>◆ Copy the screenshots into a Word document (the Health Insurance Oversight System [HIOS] does not allow Excel files as supporting documents).</li> <li>◆ Upload as a supporting document a screenshot of the standalone AVC with the <b>Plan Name</b>, <b>Plan ID</b>, and <b>HIOS Issuer ID</b> fields filled in, and include the plan ID (standard component) and date in the file name.</li> </ul>

#### 4.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 45 CFR 156.135(b), the issuer application should include the Unique Plan Design—Supporting Documentation and Justification.<sup>21</sup> 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.<sup>22</sup> For plan designs that are calculated in accordance with 45 CFR 156.135(a) and do not need to use an alternative method under

<sup>20</sup> Issuers can use the standalone AVC to test plan designs, but they do not need to submit a completed standalone AVC or other supplemental documentation, such as a screenshot, except in scenarios described in **Section 4.1 Unique Plan Design**. Instead, they should submit a completed Plans & Benefits Template that includes the AVs populated by the **Check AV Calc** procedure.

<sup>21</sup> When submitting a plan with a Unique Plan Design, issuers should consult state guidance and complete the Unique Plan Design—Supporting Documentation and Justification in accordance with the applicable state processes.

<sup>22</sup> This supporting document, including the certification section, is available at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

45 CFR 156.135(b), issuers should first try to use the integrated version of the AVC for those plans before reverting to the use of the unique plan design option.

For plans compatible with the AVC, issuers must always use an actuarially justifiable process when inputting their plan designs into the AVC.<sup>23</sup> If the AV obtained from the template is not identical to the AV obtained from the standalone AVC, do the following:

1. Ensure the template has been filled out correctly per the instructions in this appendix.
2. Follow the steps in **Section 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template** on troubleshooting the AVC.
3. After following the troubleshooting steps, determine whether the user can replicate the results of the standalone AVC using the Plans & Benefits Template and its **Check AV Calc** procedure.
  - a. If the user cannot replicate the standalone AVC results because of the design of the Plans & Benefits Template, but the AVs obtained from the standalone AVC and through the Plans & Benefits Template *both* fall within the relevant de minimis range for the plan's metal level or CSR variation, the user does not need to designate the plan as a unique plan design. Instead, the user should set the **Unique Plan Design** field equal to **No**, leave the **Issuer Actuarial Value** field blank, and run the integrated AVC.
  - 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 standalone 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 standalone AVC. The AV from the standalone AVC must fall within the relevant de minimis range. Also, upload, as a supporting document, a screenshot of the standalone AVC with the **Plan Name**, **Plan ID**, and **HIOS Issuer ID** fields filled in, and include the plan ID (standard component) and date in the file name. In this situation, designating the plan as a unique plan design does not require submission of an actuarial certification, and the plan is not considered unique for review purposes.

*Note:* There are certain cases in which issuers may not be able to match AVs between the Plans & Benefits Template and the AVC. The following are two examples in which the cost-sharing input in the Plans & Benefits Template may differ from the cost-sharing input in the AVC:

1. One or more benefits applies a coinsurance that is not subject to the deductible in the deductible range, which is not supported by the AVC.<sup>24</sup>
2. 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 their 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: Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services, Imaging (CT/PET Scans, MRIs), Speech Therapy, Occupational and Physical Therapy, Laboratory Outpatient, and Professional Services.

#### 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template

The screenshot feature, as mentioned at the start of this section, allows for a quick comparison between plan designs created using the Plans & Benefits Template and those manually entered into the standalone AVC. When using the **Check AV Calc** procedure in the Plans & Benefits Template, the user can select **Yes** after a prompt appears asking if the user wants to save the AVC screenshots. The user then selects the location where he or she wants the screenshots to be saved. Once the **Check AV Calc** procedure has finished, the user can open the folder and use the automatically generated screenshots to compare with those manually created in the

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<sup>23</sup> For additional guidance, see the May 16, 2014, CMS Frequently Asked Questions on Actuarial Value, available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Master-FAQs-5-16-14.pdf>.

<sup>24</sup> For more information, please refer to the AVC User Guide located in the first tab of the AVC here: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

standalone AVC. This side-by-side comparison can be very helpful in determining if the cost-sharing structure has been entered and applied as intended.

**Table A-2** describes the steps an issuer should take to compare the AV generated by the **Check AV Calc** procedure and the AV generated by the standalone AVC.

**Table A-2. Comparing Plans & Benefits and Standalone AVC Screenshots**

Create and Compare Screenshots	
Step 1	Calculate the plan's AV in the standalone AVC and save the screenshot.
Step 2	Calculate the plan's AV in the Plans & Benefits Template and save the screenshot.
Step 3	Compare the two screenshots created in Steps 1 and 2 line by line to identify the difference. The difference is what is causing the AV impact.

For example, if a plan is supposed to have a \$30 copay for Primary Care Visits, the cost sharing would be entered into the standalone AVC as shown in **Figure A-1**. However, if the user entered the benefit cost sharing in the Plans & Benefits Template as shown in **Figure A-2**, the AV from the standalone AVC and the AV returned from the **Check AV Calc** button in the Plans & Benefits Template would be significantly different. To resolve the discrepancy between the two AVs, the issuer could open the screenshot file created by the **Check AV Calc** macro and the standalone AVC. Upon comparing the standalone AVC screenshot (**Figure A-1**) and the screenshot generated by the **Check AV Calc** macro in the Plans & Benefits Template (**Figure A-3**), the issuer would see that the **Subject to Deductible?** checkbox is checked in the Plans & Benefits Template screenshot, indicating that the copay is being applied with the deductible only in the Plans & Benefits Template. The issuer could resolve this by referring to **Table A-4**, which shows how to correctly enter cost sharing to ensure that it maps from the **Primary Care Visit to Treat an Injury or Illness** field as intended.

**Figure A-1. Standalone AVC Screenshot**

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00

**Figure A-2. Example Plans & Benefits Template Cost Sharing**

Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$30.00		Not Applicable	No Charge after deductible		100.00%

**Figure A-3. Screenshot Created by Check AV Calc**

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00

## 5. Field Mapping

This section describes how the **Check AV Calc** procedure maps data from the Plans & Benefits Template into the AVC. The user does 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 layout of the following instructions is intended to align with the order that the fields appear in the Plans & Benefits Template.

## 5.1 Metal Tier

The Level of Coverage selected for the plan in the Plans & Benefits Template is mapped to the Desired Metal Tier in the AVC.

*Expanded Bronze Plans:* The AVC includes an option for users to indicate that the user is running an expanded bronze plan as finalized in the *HHS Notice of Benefit and Payment Parameters for 2018*.<sup>25</sup> The expanded bronze plan option in the AVC allows the user to calculate the AV for bronze plans that meet certain requirements and, therefore, the user would be allowed to use an expanded bronze plan de minimis range. The option may be used only if the bronze plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2) as established in 45 CFR 156.140(c). The AVC does not check the plan for compliance with the requirements to use the expanded bronze plan de minimis range. It is the responsibility of the issuer to ensure that its bronze plan meets the requirements under this policy in 45 CFR 156.140(c) if the issuer uses the expanded bronze plan de minimis range in the AVC. For those bronze plans, the allowable AV variation is -4 percentage points and +5 percentage points. Please see the AVC Methodology and the *HHS Notice of Benefit and Payment Parameters for 2018* for more information. For expanded bronze and silver plan CSR variations, the **Indicate if Plan Meets CSR or Expanded Bronze AV 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. The Desired Metal Tier must be set to **Bronze** for expanded bronze plans.

*De Minimis Range:* In April 2017, CMS released a final rule, *Patient Protection and Affordable Care Act; Market Stabilization*,<sup>26</sup> that amends 45 CFR 156.140(c), which establishes the de minimis variation range for the AV level of coverage. Specifically, for plan years beginning on or after January 1, 2018, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is -4 percentage points and +2 percentage points. An exception exists for bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is -4 percentage points and +5 percentage points.

## 5.2 Health Savings/Reimbursement Account Options

If **HSA/HRA Employer Contribution** is equal to **Yes** in the Cost Share Variances 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 A-4** shows the health savings account (HSA)/health reimbursement account (HRA) input fields in the Plans & Benefits Template and **Figure A-5** shows the corresponding input fields in the AVC.

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<sup>25</sup> The *HHS Notice of Benefit and Payment Parameters for 2018* is available at <https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>.

<sup>26</sup> The Market Stabilization final rule is available at <https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>.

**Figure A-4. HSA/HRA Input Fields in Plans & Benefits Template**

HSA/HRA Detail		
HSA Eligible *	HSA/HRA Employer Contribution	HSA/HRA Employer Contribution Amount
Yes	Yes	\$500.00

**Figure A-5. HSA/HRA Input Fields in AVC**

HSA/HRA Options	
HSA/HRA Employer Contribution?	<input checked="" type="checkbox"/>
Annual Contribution Amount:	\$500.00

### 5.3 Tiered Network Options

The AVC can accommodate plans using a multi-tiered, in-network plan design with up to two tiers of in-network services. The user may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, maximum out-of-pocket (MOOP) costs, 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.<sup>27</sup>

If **Multiple In Network Tiers?** is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the **Tiered Network 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 **Tiered Network Plan?** checkbox in the AVC is not related to the Plan Type selection in the Plans & Benefits Template. Non-point-of-service plans can have multiple in-network tiers in the Plans & Benefits Template, resulting in the **Tiered Network Option** checkbox being checked in the AVC.

**Figure A-6** shows the multi-tier input fields in the Plans & Benefits Template, and **Figure A-7** shows the corresponding input fields in the AVC.

**Figure A-6. Multiple In-Network Tier Options in Plans & Benefits Template**

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

**Figure A-7. Multi-Tier Options in AVC**

Tiered Network Option	
Tiered Network Plan?	<input checked="" type="checkbox"/>
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

With the **Not Applicable** option, issuers can explicitly indicate which benefits have tiered cost sharing in a plan with multiple in-network tiers. If a benefit has a **Copay—In Network (Tier 2)** and a **Coinsurance—In Network (Tier 2)** equal to **Not Applicable**, the **Check AV Calc** procedure assumes the benefit does not have tiered cost

<sup>27</sup> For more information on this option, please refer to the AVC Methodology and User Guide located in the first tab of the AVC here: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

sharing and uses the **Copay—In Network (Tier 1)** and **Coinsurance—In Network (Tier 1)** values when mapping to Tier 2 in the AVC. This exception to the Tier 2 mapping applies to all fields other than MOOP, default coinsurance, and deductibles, but for simplicity it will not be noted in the individual sections that follow.

## 5.4 MOOP and Deductible Values

The AVC uses the individual MOOP and deductible limits to calculate the AV of the plan. Therefore, individual MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC. The individual MOOPs and deductibles mapped to the AVC are *not* the family per-person MOOPs and deductibles.

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 that case, the Combined In/Out of Network MOOP or deductible is mapped to 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**.

### 5.4.1 Maximum Out of Pocket

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 MOOP** 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 MOOP** field in the AVC.



Figure A-8 shows the integrated medical and drug MOOP fields in the Plans & Benefits Template, and Figure A-9 shows a corresponding example in the AVC.

**Figure A-8. MOOP for Medical and Drug EHB Benefits (Total) Fields in Plans & Benefits Template**

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$4,000	\$4000 per person   \$8000 per group			\$10,000	\$10000 per person   \$20000 per group

**Figure A-9. Integrated Deductible, Coinsurance, and MOOP in AVC**

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$1,500.00
Coinsurance (% , Insurer's Cost Share)			70.00%
MOOP (\$)			\$4,000.00
MOOP 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 MOOP** field 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 MOOP** field 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 MOOP** 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 MOOP** in the AVC.

Figure A-10 shows the separate medical and drug MOOP fields in the Plans & Benefits Template, and Figure A-11 shows a corresponding example in the AVC.

**Figure A-10. MOOP for Medical EHB Benefits and MOOP for Drug EHB Benefits Fields in Plans & Benefits Template**

Maximum Out of Pocket for Medical EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$3,000	\$3000 per person   \$6000 per group			\$8,000	\$8000 per person   \$16000 per group

  

Maximum Out of Pocket for Drug EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$1,000	\$1000 per person   \$2000 per group			\$5,000	\$5000 per person   \$10000 per group

**Figure A-11. Separate Deductible and MOOP 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%	
MOOP (\$)			
MOOP 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 \$8,700. Because the AVC can be available before the finalization of the annual limit on cost sharing for a given plan year, there is an estimated annual limit on cost sharing in the AVC to ensure that the final AVC does not contain an annual limit on cost sharing that is lower than the finalized one. For the 2021 AVC, the MOOP limit and related functions have been set at \$8,700 to account for an estimated 2021 annual limitation on cost sharing. The final 2021 annual limitation on cost sharing was specified in the final annual *Notice of Benefit and Payment Parameters for 2021 Benefit Year (final 2021 Payment Notice)* and is \$8,550 for self-only coverage and \$17,100 for other than self-only coverage for 2021. Issuers that are required to meet AV standards must comply with the limit established in the regulation and may not use the projected estimates stated in the 2021 AVC when finalizing plan designs.

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.

## 5.4.2 Deductibles

If the user has a deductible greater than \$0, one service must be subject to the deductible or the AVC will return an error.

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.<sup>28</sup> 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 Deductible—Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 2 Combined Deductible** in the AVC.

**Figure A-12** shows the integrated deductible fields in the Plans & Benefits Template. **Figure A-9** displays a corresponding example in the AVC.

**Figure A-12. Combined Medical and Drug EHB Deductible Fields in Plans & Benefits Template**

Combined Medical and Drug EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	
\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	

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 A-13** and **Figure A-14** show the separate medical and drug deductible fields, respectively, in the Plans & Benefits Template, and **Figure A-15** shows a corresponding example of separate medical and drug deductibles in the AVC.

<sup>28</sup> For information on the combined versus separate deductible in the AVC, please refer to the AVC User Guide located on the first tab of the AVC at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

**Figure A-13. Medical EHB Deductible Fields in Plans & Benefits Template**

Medical EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person   \$3000 per group	20%	\$2,000	\$2000 per person   \$4000 per group	30%	\$3,000	\$3000 per person   \$6000 per group	
\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	
\$1,500	\$1500 per person   \$3000 per group	20%	\$2,000	\$2000 per person   \$4000 per group	30%	\$3,000	\$3000 per person   \$6000 per group	

**Figure A-14. Drug EHB Deductible Fields in Plans & Benefits Template**

Drug EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	
\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	0%	\$0	\$0 per person   \$0 per group	
\$1,500	\$1500 per person   \$3000 per group	30%	\$2,000	\$2000 per person   \$4000 per group	40%	\$5,000	\$5000 per person   \$10000 per group	

**Figure A-15. Separate Medical and Drug Deductibles and Integrated MOOP in AVC**

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$1,500.00	
Coinsurance (% , Insurer's Cost Share)	80.00%	70.00%	
MOOP (\$)	\$4,000.00		
MOOP if Separate (\$)			

### 5.5 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 percent, where X percent 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. **Table A-3** shows the mapping between the Plans & Benefits Template and the AVC and provides examples of coinsurance values in both.

**Table A-3. Coinsurance Mapping between the Plans & Benefits Template and the AVC**

Plans & Benefits (Enrollee's Cost Share)	AVC (Issuer's Cost Share)
X%	(1-X)%
10%	90%
40%	60%

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** percent 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** percent 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 A-12** shows the integrated medical and drug default coinsurance fields in the Plans & Benefits Template, and **Figure A-9** shows an 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** percent 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** percent 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** percent 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** percent value in the Plans & Benefits Template is mapped to the default **Tier 2 Drug Coinsurance** in the AVC.

## 5.6 Subject to Deductible?

The copay and coinsurance qualifiers in the Plans & Benefits Template determine whether the **Subject to Deductible?** checkbox in the AVC is checked (see **Figure A-16** and **Figure A-17**). For each benefit, if either the **Copay—In Network (Tier 1)** or the **Coinsurance—In Network (Tier 1)** field in the Plans & Benefits Template contains the text “with deductible” or “after deductible,” the **Tier 1 Subject to Deductible?** checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers (the plan has multiple tiers and both **Copay—In Network (Tier 2)** and **Coinsurance—In Network (Tier 2)** are not equal to **Not Applicable**), the same logic applies to Tier 2.

**Figure A-16. Fields in Plans & Benefits Template Mapping to Subject to Deductible? Fields in AVC**

Primary Care Visit to Treat an Injury or Illness						Specialist Visit					
Copay			Coinsurance			Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$20.00	\$25.00	\$40.00	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	10.00% Coinsurance after deductible	20.00% Coinsurance after deductible	40.00% Coinsurance after deductible

Figure A-17. Benefit Categories in AVC

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
<b>Medical</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<b>Drugs</b>	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Table A-4 shows all possible mappings of copay and coinsurance values from the Plans & Benefits Template to the AVC—including the **Subject to Deductible?** logic—for all benefits other than Mental/Behavioral Health and Substance Use Disorder benefits. For mental health and substance abuse benefits, see Table A-6. Section 5.11.4 **Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services** describes the copay and coinsurance mappings in more detail.

Table A-4. Benefit Category Cost-Sharing Mapping between Plans & Benefits Template and AVC

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
\$X Copay after deductible \$X Copay per Day after deductible, \$X Copay per Stay after deductible, or No Charge after deductible	X% or X% Coinsurance after deductible	Checked	Checked	(1-X)%	Blank	Unchecked
No Charge or Not Applicable	X% Coinsurance after deductible					
\$X, \$X Copay per Day, or \$X Copay per Stay	X% Coinsurance after deductible	Checked	Checked	(1-X)%	\$X	Unchecked

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
\$X Copay with deductible, \$X Copay per Day with deductible, or \$X Copay per Stay with deductible	X% or X% Coinsurance after deductible					
No Charge or Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge or Not Applicable					
No Charge after deductible	No Charge after deductible					
\$X Copay after deductible, \$X Copay per Day after deductible, or \$X Copay per Stay after deductible	No Charge, Not Applicable, or No Charge after deductible	Checked	Unchecked	Blank	\$X	Checked
\$X, \$X Copay per Day, or \$X Copay per Stay	No Charge after deductible	Checked	Unchecked	Blank	\$X	Unchecked
\$X Copay with deductible, \$X Copay per Day with deductible, or \$X Copay per Stay with deductible	No Charge, Not Applicable, or No Charge after deductible					
No Charge or Not Applicable	X%	Unchecked	Checked	(1-X)%	Blank	Unchecked
\$X, \$X Copay per Day, or \$X Copay per Stay	X%	Unchecked	Checked	(1-X)%	\$X	Unchecked
No Charge or Not Applicable	No Charge or Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X, \$X Copay per Day, or \$X Copay per Stay	No Charge or Not Applicable	Unchecked	Unchecked	Blank	\$X	Unchecked

## 5.7 Subject to Coinsurance?

For each benefit, if **Coinsurance—In Network (Tier 1)** is equal to **X% Coinsurance after deductible** or **X%** in the Plans & 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 & Benefits Template, the **Tier 2 Subject to Coinsurance?** checkbox for the corresponding benefit in the AVC is checked.

## 5.8 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,  $1-X\%$ , 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 benefit with multiple in-network tiers, if the **Tier 2 Subject to Coinsurance?** checkbox in the AVC is checked,  $1-X\%$ , 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 functionality does not support plan designs in which the benefit has a coinsurance without being subject to the deductible or a copay element. Please refer to the AVC User Guide for more information on the operation of copay and coinsurance cost sharing in the deductible and coinsurance ranges.<sup>29</sup>

The AVC treats **No Charge** (or **Not Applicable**) and **0%** coinsurance differently when a benefit's copay is greater than \$0. If the benefit has coinsurance equal to **No Charge** (or **Not Applicable**) 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 **100%** 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.

## 5.9 Copay Values

For each benefit, if **Copay—In Network (Tier 1)** in the Plans & Benefits Template is equal to **\$X, \$X Copay with deductible, \$X Copay per day, \$X Copay per stay, \$X Copay per stay with deductible, or \$X Copay per day with deductible**, then 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, \$X Copay per stay after deductible, or \$X Copay per day after deductible** and the corresponding **Coinsurance—In Network (Tier 1)** field is equal to **No Charge, No Charge after deductible, or Not Applicable**, then 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, No Charge after deductible, or Not Applicable**, then 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 standalone AVC does not support applying both a copay and a coinsurance 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 considers only the coinsurance value in the coinsurance range. Therefore, if **Copay—In Network (Tier 1)** is equal to **\$X Copay after deductible, \$X Copay per stay after deductible, or \$X Copay per day 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 benefits with multiple in-network tiers, the logic described above for Tier 1 also applies to Tier 2.

As discussed in the AVC Methodology and User Guide, five service types (Mental/Behavioral Health and Substance Use Disorder Outpatient Services; Imaging; Speech Therapy; Occupational Therapy and Physical

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<sup>29</sup> The AVC User Guide can be found on the first tab of the AVC located at <https://www.ghcpertification.cms.gov/s/Plans%20and%20Benefits>. The appendix at the end of the User Guide contains charts that provide detail and examples regarding the application of cost sharing within the deductible and coinsurance range.



Therapy; and Laboratory Outpatient and Professional Services) include services also classified as Outpatient-Facility and Outpatient-Professional. If special cost-sharing provisions are indicated for Outpatient-Facility or Outpatient-Professional claims and no special cost sharing is indicated for the service type, services including both an Outpatient-Facility and Outpatient-Professional component will be split into their component parts and the relevant cost sharing applied. The AVC also allows the user to indicate the cost sharing for Primary Care and/or Specialist Office Visits and X-rays. The standalone AVC will indicate if the special cost sharing was engaged in the AV calculation in the **Additional Notes** field. For additional information on the operations of these features, review the AVC Methodology and User Guide.

### 5.10 Copay Applies Only After Deductible

For each benefit, if **Copay—In Network (Tier 1)** is equal to **\$X after deductible, \$X Copay per stay after deductible, or \$X Copay per day after deductible** and **Coinsurance—In Network (Tier 1)** is equal to **No Charge, No Charge after deductible, or Not Applicable** in the Plans & Benefits Template, then the **Tier 1 Copay applies only after the deductible?** checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers, the same logic applies to Tier 2. Although the standalone AVC returns an error if the **Copay applies only after the deductible?** checkbox is checked and the benefit is also subject to a coinsurance, a copay after the deductible is never mapped from the Plans & Benefits Template if the benefit also has a coinsurance.

### 5.11 Benefit Categories<sup>30</sup>

**Table A-5** shows the alignment of benefit categories in the Plans & Benefits Template and the AVC, and **Figure A-17** displays the benefit categories, along with their cost-sharing fields, in the AVC.

If a benefit included in the AVC is substituted in the Plans & Benefits Template, the benefit is considered not covered for purposes of mapping to the AVC. When a benefit is not covered, 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.

No inputs into the AVC are specific to the pediatric dental or vision benefits. Pediatric dental and vision are generally low-cost benefits that do not have a material impact on AV. Additional information on how pediatric dental and vision benefits are taken into account in the AVC is available in the AVC methodology.

**Table A-5. 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 (including MHSU)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (excluding 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	Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Occupational and Physical Therapy

<sup>30</sup> The 2021 AVC uses new claims data from 2017 projected forward to 2021. For information about the considerations of the new claims data, please refer to the AVC Methodology at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits> and the AV Calculator User Guide.

Plans & Benefits Template Category Name	AVC Category Name
Preventive Care/Screening/Immunization <sup>31</sup>	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 (high-cost)

### 5.11.1 Inpatient Hospital Services

If **Inpatient Hospital Services Copay—In Network (Tier 1)** in the Plans & Benefits Template is equal to **\$X Copay per Day, \$X Copay per day with deductible, or \$X Copay per day after deductible**, then 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 also charged per day for Tier 2, if applicable.

If **Maximum Number of Days for Charging an Inpatient Copay?** is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, then the **Set a Maximum Number of Days for Charging an In Patient (IP) Copay?** checkbox in the AVC is checked and the **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 at the plan variation level, allowing the values to differ between variations. However, the **Set a Maximum Number of Days for Charging an IP Copay?** checkbox and the **# Days (1–10)** field cannot vary between Tier 1 and Tier 2. **Figure A-18** shows the **Maximum Number of Days for Charging an Inpatient Copay?** field in the Plans & Benefits Template, and **Figure A-19** shows the corresponding checkbox and field in the AVC.

When filling out the standalone AVC, issuers intending to use the **Maximum Number of Days for Charging an Inpatient Copay?** feature need to ensure that the **Apply Inpatient Copay per Day?** checkbox in the AVC (**Figure A-20**) is checked. Otherwise the AVC will return an error when trying to calculate the AV. On the Plans & Benefits Template side, the user needs to follow the instruction in the first paragraph and select a cost-sharing option that includes “per day” to ensure the **Apply Inpatient Copay per Day?** checkbox is checked in the AVC mapping.

<sup>31</sup> Section 2713 of the Public Health Service (PHS) Act, codified in 45 CFR 147.130, requires issuers to offer certain preventive care services without cost sharing, so the standalone 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 standalone AVC for this benefit category.

**Figure A-18. AVC Additional Benefit Design Fields in Plans & Benefits Template**

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 A-19. Maximum Number of Days for IP Copay Checkbox and Field in AVC**

Set a Maximum Number of Days for Charging an IP Copay? <input checked="" type="checkbox"/>
# Days (1-10): 5

**Figure A-20. Apply IP Copay Checkbox in AVC**

User Inputs for Plan Parameters	
Use Integrated Medical and Drug Deductible?	<input type="checkbox"/>
Apply Inpatient Copay per Day?	<input checked="" type="checkbox"/>
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	<input type="checkbox"/>
Desired Metal Tier	Silver <input type="button" value="v"/>

### 5.11.2 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**, **\$X Copay per day with deductible**, or **\$X Copay per day after deductible**, then 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 also charged per day for Tier 2, if applicable.

Users intending to charge a skilled nursing facility copay per day should ensure that they have selected the **Apply Skilled Nursing Facility Copay per Day?** checkbox while filling out the standalone AVC to ensure accuracy of AV calculations.

### 5.11.3 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 Cost Share Variances worksheet of the Plans & Benefits Template, then 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, then 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. As discussed in the AV Calculator User Guide, the use of this option does not imply a benefit designed for primary care visits after the initial fully covered visits have occurred. The user must still indicate whether or not primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under **Primary Care Visit to Treat an Injury or Illness**.

If **Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?** is equal to a whole number between 1 and 10 in the Cost Share Variances 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, then 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. Per the AV Calculator User Guide, the use of this option does not imply a benefit

design for primary care visits after the initial copays have occurred. The user must still indicate whether primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under **Primary Care Visit to Treat an Injury or Illness**.

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 A-21) are set at the plan variation level, allowing the values to differ between variations. However, these primary care fields and checkboxes (Figure A-21) cannot vary between Tier 1 and Tier 2. In addition to inputting any copay amount, these options must be used in conjunction with the **Subject to Deductible?** option for primary care services. Unchecking **Subject to Deductible?** with these options selected will trigger an error message.

**Figure A-21. Primary Care Options in AVC**

49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input checked="" type="checkbox"/>
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
52	# Copays (1-10):	

#### 5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services copay and coinsurance inputs 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. However, the **Check AV Calc** procedure uses only the copay and coinsurance values for the **Mental/Behavioral Health Outpatient Services** benefit in the Plans & Benefits Template when mapping to the **Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Subject to Deductible?**, **Subject to Coinsurance?**, and **Copay applies only after the deductible?** checkboxes in the AVC. The copay and coinsurance values for the Substance Abuse Disorder Outpatient Services benefit in the Plans & Benefits Template do not affect the mapping to these AVC checkboxes.

If either **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)** or **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)** fields in the Plans & Benefits Template contain the text “with deductible” or “after deductible,” the **Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Tier 1 Subject to Deductible?** checkbox in the AVC is checked.

If **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)** is equal to **X% Coinsurance after deductible** or **X%** 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,  $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)})]$  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,  $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)})]$  is mapped to the **Tier 1 Copay, if separate** field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC:

1. **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)** is equal to **\$X** or **\$X with deductible** in the Plans & Benefits Template
2. **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**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template.

If **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)** is equal to **\$X after deductible** and **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)** is equal

to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then the **Tier 1 Copay applies only after the deductible?** checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked.

The logic described above (and captured generically in **Table A-5**) also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services unless both the Tier 2 copay and Tier 2 coinsurance are equal to **Not Applicable**. If **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 2)** and **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 2)** are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)** and **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)** values when mapping to the Tier 2 checkboxes and fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC. If **Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 2)** and **Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 2)** are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the **Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)** and **Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)** values for Substance Abuse Disorder Outpatient Services when mapping to the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Tier 2 fields in the AVC.

**Table A-6** shows the detailed mappings described in this section.

**Table A-6. Mental/Behavioral Health and Substance Abuse Disorder Outpatient Cost-Sharing Mapping between Plans & Benefits Template and AVC**

Plans & Benefits Template—Mental/Behavioral Health Outpatient Services		AVC—Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
\$X Copay after deductible or No Charge after deductible	X% or X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
No Charge or Not Applicable	X% Coinsurance after deductible					
\$X	X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	X% or X% Coinsurance after deductible					
No Charge or Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge, Not Applicable, or No Charge after deductible					
\$X Copay after deductible	No Charge, Not Applicable, or No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Checked
\$X	No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	No Charge, Not Applicable, or No Charge after deductible					

Plans & Benefits Template—Mental/Behavioral Health Outpatient Services		AVC—Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
No Charge or Not Applicable	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
\$X	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
No Charge or Not Applicable	No Charge or Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X	No Charge or Not Applicable	Unchecked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked

### 5.11.5 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.

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, No Charge after the deductible, or Not Applicable** 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, No Charge after the deductible, or Not Applicable** 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.

#### 5.11.5.1 Specialty Drugs

If the **Maximum Coinsurance for Specialty Drugs** field includes a positive number in the Cost Share Variances 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 A-22) is set at the plan variation level, allowing the values to differ between variations. However, the **Specialty Drugs Maximum Coinsurance** checkbox and **Amount** field (Figure A-22) cannot vary between Tier 1 and Tier 2.

**Figure A-22. Specialty Drugs Maximum Payment Fields in AVC**

Set a Maximum on Specialty Rx Coinsurance Payments? <input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum: \$200

## 6. Zero Cost-Sharing and Limited Cost-Sharing Plan Variations

Zero cost-sharing plan variations, which are required to have zero cost sharing for all essential health benefit (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 plan variations must provide zero cost sharing to certain individuals for EHB items or services furnished directly by the Indian Health Service, an Indian tribe, a tribal organization, or an 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.