Actuarial values in ACA health plans: Impact of cost-sharing adjustments

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Estimating the impact of cost-sharing changes on the federal actuarial values (AVs) for ACA individual and small group plans is often a guessing game. As HHS limits the number of non-standardized plan options, having a reference of AV impacts driven by cost-sharing changes in sample standard plans for each metal level will be useful in issuers' product portfolio strategy.

Introduction

The U.S. Department of Health and Human Services (HHS) AV Calculator (AVC) is a tool used to determine the AV of qualified health plans (QHPs), as part of the Patient Protection and Affordable Care Act of 2010 (ACA) requirement for health plans to fall within a specified AV range for each metal level. The AV, sometimes referred to as a paid-to-allowed ratio, measures the percentage of total healthcare expenses covered by a health plan for an average enrollee. Please see Figure 1 for the 2026 AV range for each metal level. See Appendix A for more details on the historical AV ranges by metal level.

FIGURE 1: 2026 AV RANGE BY METAL LEVEL

METAL LEVEL	AV RANGE
Platinum	88–92%
Gold	78–82%
Silver1	68–72%
Silver 73	73–74%
Silver 87	87–88%
Silver 94	94–95%
Bronze2	58–62%

The AVC models the cost of essential health benefits (EHBs) covered by a plan, such as primary care visits, hospitalizations, and prescription drugs. It also considers cost sharing such as deductibles, copayments, and coinsurance.

HHS first required QHPs to use the AVC starting in plan year 2014, and the AVC has since undergone several updates and revisions. Please see Appendix A for a table listing the significant AVC changes by year.

1. Range is 70%–72% for an on-exchange silver plan in the individual market.
2. Range is 58%–65% for an expanded bronze health plan that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code.

AVC sensitivity analysis

Testing the impact of specific AVC input changes by plan can be a time-consuming, manual process. To assist with this process, we compiled Figures 2–15 as a reference for the estimated impact to AV of changes to specific benefits and global inputs in the AVC for all standard metal level plans, including the silver cost-sharing reduction (CSR) plans. For each impact to the AV, only one benefit was changed at a time, while all other benefits were kept the same. The starting benefits are the 2026 Standardized Plan Options Set One as shown in Appendix B.[3] The tables show the following information:

- Impact of removing deductible applicability: This measures the difference in AV between selecting "Subject to the deductible" and "Not subject to the deductible" for each specific benefit, regardless of whether the base plan benefit actually is subject to deductible.
- Impact of removing coinsurance applicability: This measures the difference in AV between selecting "Subject to coinsurance" and "Not subject to coinsurance" for each specific benefit if the base plan benefit is subject to coinsurance. We excluded benefits with copays, listed as "N/A," because the AVC user guide specifies that copays paid in conjunction with coinsurance in the coinsurance range are not supported. Additionally, a separate copay and coinsurance for a drug benefit is also not directly supported.
- Impact of changing from a $10 copay to a $20 copay: This measures the change in AV if a particular benefit not subject to coinsurance had a $10 copay and changed to a $20 copay. In reality, the base plan may have a starting copay other than $10. The AV impact of a $10 increase to a different starting copay could vary from the impact reflected in the table. The magnitude of the variation will depend on other cost-sharing parameters. To the extent the plan design is similar to the baseline design tested in this paper, the variation may be minimal.
- Impact of changing from 10% coinsurance to 20% coinsurance: This measures the change in AV if a particular benefit without a copay had 10% member coinsurance (90% insurer cost share) and changed to 20% member coinsurance (80% insurer cost share). In reality, the base plan may have a different starting member coinsurance other than 10%. The AV impact of a 10% increase to a different starting coinsurance could vary from the impact reflected in the table. The magnitude of the variation will depend on other cost-sharing parameters. To the extent the plan design is similar to the baseline design tested in this paper, the variation may be minimal.
- Impact of a $50 copay applying after a deductible: This measures the change in AV if a particular benefit is subject to a deductible with a $50 copay and changes to a $50 copay that applies only after the deductible is met. The benefit is set so that it is not subject to coinsurance. In reality, the base plan may have a starting copay other than $50. The AV impact could vary using different copays, but this should give the user a general idea of the impact of having a copay apply only after the deductible has been met.
- Impact of a $1,000 increase/decrease to deductible and maximum out-of-pocket (MOOP); applying inpatient (IP) and skilled nursing facility (SNF) copays per day rather than per admission; the addition of $1,000 health savings account (HSA) or health reimbursement arrangement (HRA) employer contribution; the addition of a copay maximum when specialty drugs are subject to coinsurance; and copay limitations for inpatient and office visits. Note that for the addition of the specialty drug copay maximum, we set the specialty coinsurance equal to the plan coinsurance and then measured the impact of applying the specialty drug copay maximum.

Note that all impacts to the AV displayed in Figures 2–15 have been rounded to two decimal places, meaning a 0.00% change might be non-zero, but rounds to 0.00%. Each of these benefit changes do not necessarily result in an AV-compliant plan; this exercise is to estimate differential AV changes and not (necessarily) to ensure compliance. The AV impacts shown are percentage point changes rather than percentage changes; in other words, if an AV changes from 70.0% to 71.0%, the AV impact shown would be 71.0% minus 70.0%, which equals 1.0%.

3. Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. (October 10, 2024). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program. Federal Register, vol. 89, no. 197, page 74. Retrieved January 21, 2025, from https://www.govinfo.gov/content/pkg/FR-2024-10-10/pdf/2024-23103.pdf.

Based on Figures 2–15, the following benefit changes tend to have the largest impact on AV, although estimated impacts vary depending on the metal level:

- Adding an HSA/HRA employer contribution. This has the largest impact, on average, compared to all other AVC input changes that we measured. When including employer contributions to HSAs and HRAs that are integrated with group health plans, the AVC calculations assume that such contributions may only be used for cost sharing; thus, it would only be appropriate to input a contribution when this is known to be true. Note that we did not model HSA/HRA employer contributions for the silver CSR variants, which are only available in the individual market.
- Changing deductible or MOOP.
- Changing deductible applicability. The highest-impact services are emergency room services, specialist visits, primary care physician (PCP) visits, lab outpatient (OP) and professional services, X-rays and diagnostic imaging, OP surgery, and OP facility visits.
- Copay changes. A $10 copay increase has the highest impact for generic drugs, followed by specialist visit, mental health/substance use disorder (MH/SUD), lab OP and professional services, and OP surgery.

AVC strategy

All metal levels have a range of acceptable AVs. Most metal levels have a +/- 2 percentage point range, giving AVC users the option of configuring their plan benefits close to the low, middle, or upper end of the range. We present some potential strategies for each option:

- High end of the AV range: This can allow a benefit plan to stand out as a high-value option to the consumer. Marketable features like lower deductibles or out-of-pocket maximums can be touted compared to other benefit plans in the same metal level. The trade-off is that these plans may have higher expected premiums due to the richer benefits.
- Middle of the AV range: This gives the user the most flexibility from year to year. The AVC is updated every year, with some updates having larger impacts than others. Having a plan in the middle of the range makes it more likely to be in range the next year with few or no changes.
- Low end of the AV range: This is expected to allow a benefit plan to be a low-cost option to the consumer compared to other benefit plans in the same metal level. The trade-off is leaner benefits, including higher deductibles and copays, which may be viewed as a barrier to using care by the consumer. Having a plan in the low end of the range makes it more likely to be in range the next year with few or no changes, as the AV tends to trend upward from year to year if benefits are kept the same.

Starting with the 2025 Notice of Benefit and Payment Parameters,[4] the number of non-standardized options is limited for issuers offering QHPs through Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal platform (SBE-FPs). The number of non-standardized options per product type, metal level (excluding catastrophic), inclusion of pediatric and/or adult dental coverage, and inclusion of adult vision coverage in any service area is limited to four non-standardized options for 2024 and two non-standardized options for 2025 and beyond. Given the limitation in the number of off-exchange plan offerings, consider which end of the AV range is most important for the off-exchange offerings.

4. Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. (April 15, 2024). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program. Federal Register, vol. 89, no. 73. Retrieved January 23, 2025, from https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf.

AVC limitations

Because AV ranges correspond with specific metal levels, the AVC allows consumers to make plan design comparisons regarding the benefit richness of plans. It was not developed for pricing purposes, and the AV results generally should not be used directly for pricing.

Another constraint within the AVC is that it only lets users calculate AVs one plan design at a time. To address this limitation, Milliman has created a batch version of the AVC that issuers can license. This tool, with Milliman consulting support, allows the user to calculate and compare the AVs for multiple plan designs at the same time.

As in prior years, AVs produced by the AVC may not match the AVs used in pricing, due to certain limitations of the AVC:

- There is limited flexibility in the cost-sharing inputs and the application of the cost-sharing parameters on services. Certain cost-sharing features are not supported by the AVC. For example, the only option that is available for member cost sharing before the deductible is met is a copay, including for services that are not subject to the deductible.
- There are limited benefit inputs. Separate inputs for some services, such as maternity, urgent care, home health, ambulance, and durable medical equipment (DME), are not explicitly included.
- Geographic area, demographics, reimbursement arrangements, and utilization management all have an impact on the cost of services, but the AVC does not include adjustments for these.
- Differences in actual or assumed mix of services as compared to the underlying AVC data may produce differences from expected AVs produced by the AVC.
- There occasionally are non-intuitive changes in AVs based on changes to plan parameters. For example, removing the deductible applicability to X-rays and diagnostic imaging on the standard federal 2026 silver 94 CSR plan results in a decrease in AV instead of the expected increase as shown in Figure 12. Similarly, removing the coinsurance applicability from X-rays and diagnostic imaging on the standard federal 2026 expanded bronze CSR plan results in a decrease in AV instead of the expected increase as shown in Figure 14.

Many users of the AVC find it is increasingly difficult to develop a bronze plan with a lean enough plan design to meet the required range of bronze AVs. However, the availability of the expanded bronze option for certain bronze plans has provided additional flexibility in designing a plan that meets the requirements.

Actual pricing AVs (i.e., the ratio of plan paid costs to allowed costs), particularly in the individual market, may be significantly different from AVC AVs (e.g., some bronze plans designed with a 60% AV may actually have a pricing AV in the 70–75% range).

Caveats and limitations

This white paper is intended to summarize the findings from Milliman's analysis using the AV Calculator. This information may not be appropriate, and should not be used, for other purposes.

The analysis in this paper is based on data from a variety of sources, including the federal AV Calculator and our interpretation of guidance from the Centers for Medicare and Medicaid Services (CMS). We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

This report is intended for informational purposes only. Milliman makes no representation or warranties regarding the contents of this report. Likewise, readers of this report are instructed that they are to place no reliance upon this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Kathie Ely, Cameron Gleed, and Katrina Sevilla are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this report.

FIGURE 2: PLATINUM AV SENSITIVITY ANALYSIS TABLE BY TIER 1 BENEFIT CATEGORY

TIER 1 BENEFIT	IMPACT OF REMOVING DEDUCTIBLE APPLICABILITY[5]	IMPACT OF REMOVING COINSURANCE APPLICABILITY[6]	IMPACT OF CHANGING FROM $10 COPAY TO $20 COPAY	IMPACT OF CHANGING FROM 10% COINSURANCE TO 20% COINSURANCE	IMPACT OF $50 COPAY APPLYING AFTER DEDUCTIBLE[7]
Emergency Room Services	0.00%	N/A	-0.02%	-0.38%	0.00%
All IP Hosp. (inc. MH/SUD)	0.00%	N/A	0.00%	-0.13%	0.00%
PCP (exc. Well-Baby, Prev., X-Rays)	0.00%	N/A	-0.17%	-0.24%	0.00%
Specialist Visit	0.00%	N/A	-0.31%	-0.51%	0.00%
MH/SUD	0.00%	N/A	-0.25%	-0.27%	0.00%
Imaging (CT/PET Scans, MRIs)	0.00%	N/A	-0.02%	-0.13%	0.00%
Rehabilitative ST	0.00%	N/A	-0.01%	-0.01%	0.00%
PT/OT	0.00%	N/A	-0.21%	-0.13%	0.00%
Lab OP and Prof. Services	0.00%	N/A	-0.51%	-0.19%	0.00%
X-Rays and Diagnostic Imaging	0.00%	N/A	-0.10%	-0.20%	0.00%
Skilled Nursing Facility	0.00%	N/A	0.00%	0.00%	0.00%
OP Facility (e.g., ASC)	0.00%	N/A	-0.11%	-0.35%	0.00%
OP Surg. Phys./Surg. Services	0.00%	N/A	-0.26%	-0.38%	0.00%
Generic Drugs	0.00%	N/A	-1.00%	-0.32%	0.00%
Preferred Brand Drugs	0.00%	N/A	-0.08%	-0.33%	0.00%
Non-Preferred Brand Drugs	0.00%	N/A	-0.06%	-0.22%	0.00%
Specialty High-Cost Drugs	0.00%	N/A	0.00%	-0.03%	0.00%

FIGURE 3: PLATINUM AV SENSITIVITY ANALYSIS TABLE FOR OTHER AVC INPUTS

CHANGE IN BENEFIT	CHANGE IN AV
Increasing Deductible by $1,000[8]	N/A
Decreasing Deductible by $1,000[9]	N/A
Increasing MOOP by $1,000	-0.53%
Decreasing MOOP by $1,000	0.73%
Apply IP Copay per Day	-0.02%
Apply SNF Copay per Day	0.00%
Add $1,000 HSA/HRA Employer Contribution	0.00%
Applying $100 Max Copay on Specialty High-Cost Drugs Coinsurance	0.00%
5 Days Maximum for IP Copay and Apply IP Copay per Day	0.00%
PCP Cost Sharing Applies After 5 Visits	0.15%
PCP Ded./Coins After 5 Copays and PCP Subject to Deductible	0.00%

5. Deductible is $0.

6. No services are subject to coinsurance.

7. Deductible is $0.

8. No services are subject to the deductible.

9. Decreasing the deductible by $1,000 would make the deductible negative.

FIGURE 4: GOLD AV SENSITIVITY ANALYSIS TABLE BY TIER 1 BENEFIT CATEGORY

TIER 1 BENEFIT	IMPACT OF REMOVING DEDUCTIBLE APPLICABILITY	IMPACT OF REMOVING COINSURANCE APPLICABILITY	IMPACT OF CHANGING FROM $10 COPAY TO $20 COPAY	IMPACT OF CHANGING FROM 10% COINSURANCE TO 20% COINSURANCE	IMPACT OF $50 COPAY APPLYING AFTER DEDUCTIBLE
Emergency Room Services	1.24%	0.39%	-0.01%	-0.16%	0.02%
All IP Hosp. (inc. MH/SUD)	0.02%	0.37%	0.00%	-0.14%	0.00%
PCP (exc. Well-Baby, Prev., X-Rays)	1.06%	N/A	-0.21%	-0.05%	0.38%
Specialist Visit	1.36%	N/A	-0.38%	-0.17%	0.62%
MH/SUD	0.87%	N/A	-0.29%	-0.08%	0.44%
Imaging (CT/PET Scans, MRIs)	0.37%	0.13%	-0.01%	-0.05%	0.02%
Rehabilitative ST	0.01%	N/A	0.00%	0.00%	0.01%
PT/OT	0.15%	N/A	-0.20%	-0.04%	0.23%
Lab OP and Prof. Services	1.07%	0.11%	-0.27%	-0.05%	0.60%
X-Rays and Diagnostic Imaging	0.89%	0.10%	-0.06%	-0.06%	0.18%
Skilled Nursing Facility	0.00%	0.00%	0.00%	0.00%	0.00%
OP Facility (e.g., ASC)	1.01%	0.67%	-0.14%	-0.25%	0.29%
OP Surg. Phys./Surg. Services	2.59%	0.34%	-0.37%	-0.14%	0.90%
Generic Drugs	0.80%	N/A	-1.15%	-0.06%	1.04%
Preferred Brand Drugs	0.42%	N/A	-0.08%	-0.17%	0.12%
Non-Preferred Brand Drugs	0.33%	N/A	-0.05%	-0.12%	0.08%
Specialty High-Cost Drugs	0.00%	N/A	0.00%	-0.02%	0.00%

FIGURE 5: GOLD AV SENSITIVITY ANALYSIS TABLE FOR OTHER AVC INPUTS

CHANGE IN BENEFIT	CHANGE IN AV
Increasing Deductible by $1,000	-1.26%
Decreasing Deductible by $1,000	2.08%
Increasing MOOP by $1,000	N/A
Decreasing MOOP by $1,000	0.77%
Apply IP Copay per Day	0.00%
Apply SNF Copay per Day	0.00%
Add $1,000 HSA/HRA Employer Contribution	6.14%
Applying $100 Max Copay on Specialty High-Cost Drugs Coinsurance	0.04%
5 Days Maximum for IP Copay and Apply IP Copay per Day	0.00%
PCP Cost Sharing Applies After 5 Visits	0.56%
PCP Ded./Coins After 5 Copays and PCP Subject to Deductible	-0.05%

FIGURE 6: STANDARD SILVER AV SENSITIVITY ANALYSIS TABLE BY TIER 1 BENEFIT CATEGORY

TIER 1 BENEFIT	IMPACT OF REMOVING DEDUCTIBLE APPLICABILITY	IMPACT OF REMOVING COINSURANCE APPLICABILITY	IMPACT OF CHANGING FROM $10 COPAY TO $20 COPAY	IMPACT OF CHANGING FROM 10% COINSURANCE TO 20% COINSURANCE	IMPACT OF $50 COPAY APPLYING AFTER DEDUCTIBLE
Emergency Room Services	2.53%	0.00%	0.00%	0.00%	0.00%
All IP Hosp. (inc. MH/SUD)	0.31%	0.00%	0.00%	0.00%	0.00%
PCP (exc. Well-Baby, Prev., X-Rays)	1.45%	N/A	-0.15%	0.00%	0.03%
Specialist Visit	2.13%	N/A	-0.29%	0.00%	0.18%
MH/SUD	1.34%	N/A	-0.22%	0.00%	0.05%
Imaging (CT/PET Scans, MRIs)	0.78%	0.00%	0.00%	0.00%	0.00%
Rehabilitative ST	0.02%	N/A	0.00%	0.00%	0.00%
PT/OT	0.15%	N/A	-0.13%	0.00%	0.02%
Lab OP and Prof. Services	1.65%	0.00%	0.00%	0.00%	0.00%
X-Rays and Diagnostic Imaging	1.34%	-0.19%	0.00%	0.00%	0.00%
Skilled Nursing Facility	0.00%	0.00%	0.00%	0.00%	0.00%
OP Facility (e.g., ASC)	2.67%	0.00%	0.00%	0.00%	0.00%
OP Surg. Phys./Surg. Services	3.88%	0.00%	0.00%	0.00%	0.00%
Generic Drugs	0.83%	N/A	-0.85%	0.00%	0.14%
Preferred Brand Drugs	1.38%	N/A	-0.05%	0.00%	0.03%
Non-Preferred Brand Drugs	1.03%	N/A	0.00%	0.00%	0.00%
Specialty High-Cost Drugs	0.03%	N/A	0.00%	0.00%	0.00%

FIGURE 7: STANDARD SILVER AV SENSITIVITY ANALYSIS TABLE FOR OTHER AVC INPUTS

CHANGE IN BENEFIT	CHANGE IN AV
Increasing Deductible by $1,000	0.00%
Decreasing Deductible by $1,000	0.23%
Increasing MOOP by $1,000	N/A
Decreasing MOOP by $1,000	1.55%
Apply IP Copay per Day	0.00%
Apply SNF Copay per Day	0.00%
Add $1,000 HSA/HRA Employer Contribution	7.72%
Applying $100 Max Copay on Specialty High-Cost Drugs Coinsurance	0.00%
5 Days Maximum for IP Copay and Apply IP Copay per Day	0.00%
PCP Cost Sharing Applies After 5 Visits	0.55%
PCP Ded./Coins After 5 Copays and PCP Subject to Deductible	-0.12%

FIGURE 8: SILVER 73 AV SENSITIVITY ANALYSIS TABLE BY TIER 1 BENEFIT CATEGORY

TIER 1 BENEFIT	IMPACT OF REMOVING DEDUCTIBLE APPLICABILITY	IMPACT OF REMOVING COINSURANCE APPLICABILITY	IMPACT OF CHANGING FROM $10 COPAY TO $20 COPAY	IMPACT OF CHANGING FROM 10% COINSURANCE TO 20% COINSURANCE	IMPACT OF $50 COPAY APPLYING AFTER DEDUCTIBLE
Emergency Room Services	1.77%	0.17%	0.00%	-0.04%	0.01%
All IP Hosp (inc. MH/SUD)	0.05%	0.07%	0.00%	-0.02%	0.00%
PCP (exc. Well-Baby, Prev., X-Rays)	1.29%	N/A	-0.19%	-0.01%	0.23%
Specialist Visit	1.63%	N/A	-0.31%	-0.04%	0.42%
MH/SUD	1.06%	N/A	-0.24%	-0.02%	0.29%
Imaging (CT/PET Scans, MRIs)	0.54%	0.05%	0.00%	-0.01%	0.02%
Rehabilitative ST	0.01%	N/A	0.00%	0.00%	0.00%
PT/OT	0.09%	N/A	-0.15%	-0.01%	0.14%
Lab OP and Prof Services	1.44%	0.05%	-0.14%	-0.01%	0.35%
X-Rays and Diagnostic Imaging	1.20%	0.00%	-0.03%	-0.02%	0.11%
Skilled Nursing Facility	0.00%	0.00%	0.00%	0.00%	0.00%
OP Facility (e.g., ASC)	1.55%	0.22%	-0.05%	-0.06%	0.18%
OP Surg. Phys./Surg. Services	3.39%	0.13%	-0.18%	-0.03%	0.51%
Generic Drugs	0.67%	N/A	-1.02%	-0.01%	0.65%
Preferred Brand Drugs	0.62%	N/A	-0.06%	-0.05%	0.08%
Non-Preferred Brand Drugs	0.52%	N/A	0.00%	-0.03%	0.04%
Specialty High-Cost Drugs	-0.01%	N/A	0.00%	0.00%	0.00%

FIGURE 9: SILVER 73 AV SENSITIVITY ANALYSIS TABLE FOR OTHER AVC INPUTS

CHANGE IN BENEFIT	CHANGE IN AV
Increasing Deductible by $1,000	-0.54%
Decreasing Deductible by $1,000	0.98%
Increasing MOOP by $1,000	-1.21%
Decreasing MOOP by $1,000	1.37%
Apply IP Copay per Day	0.00%
Apply SNF Copay per Day	0.00%
Add $1,000 HSA/HRA Employer Contribution	N/A[10]
Applying $100 Max Copay on Specialty High-Cost Drugs Coinsurance	0.01%
5 Days Maximum for IP Copay and Apply IP Copay per Day	0.00%
PCP Cost-Sharing Applies After 5 Visits	0.69%
PCP Ded./Coins After 5 Copays and PCP Subject to Deductible	-0.06%

10. This plan design is specifically for the individual line of business, which will not have an HSA/HRA employer contribution.

FIGURE 10: SILVER 87 AV SENSITIVITY ANALYSIS TABLE BY TIER 1 BENEFIT CATEGORY

TIER 1 BENEFIT	IMPACT OF REMOVING DEDUCTIBLE APPLICABILITY	IMPACT OF REMOVING COINSURANCE APPLICABILITY	IMPACT OF CHANGING FROM $10 COPAY TO $20 COPAY	IMPACT OF CHANGING FROM 10% COINSURANCE TO 20% COINSURANCE	IMPACT OF $50 COPAY APPLYING AFTER DEDUCTIBLE
Emergency Room Services	0.23%	0.39%	-0.01%	-0.13%	0.01%
All IP Hosp. (inc. MH/SUD)	0.00%	0.05%	0.00%	-0.01%	0.00%
PCP (exc. Well-Baby, Prev., X-Rays)	0.56%	N/A	-0.17%	-0.06%	0.30%
Specialist Visit	0.63%	N/A	-0.26%	-0.17%	0.39%
MH/SUD	0.35%	N/A	-0.20%	-0.10%	0.25%
Imaging (CT/PET Scans, MRIs)	0.06%	0.13%	-0.01%	-0.04%	0.01%
Rehabilitative ST	0.00%	N/A	0.00%	0.00%	0.00%
PT/OT	0.05%	N/A	-0.12%	-0.04%	0.09%
Lab OP and Prof. Services	0.55%	0.16%	-0.26%	-0.05%	0.40%
X-Rays and Diagnostic Imaging	0.34%	0.16%	-0.05%	-0.06%	0.12%
Skilled Nursing Facility	0.00%	0.00%	0.00%	0.00%	0.00%
OP Facility (e.g., ASC)	0.27%	0.38%	-0.10%	-0.13%	0.17%
OP Surg. Phys./Surg. Services	1.41%	0.40%	-0.36%	-0.13%	0.67%
Generic Drugs	0.45%	N/A	-0.89%	-0.09%	0.61%
Preferred Brand Drugs	0.10%	N/A	-0.05%	-0.09%	0.07%
Non-Preferred Brand Drugs	0.00%	N/A	-0.02%	-0.07%	0.04%
Specialty High-Cost Drugs	0.00%	N/A	0.00%	-0.01%	0.00%

FIGURE 11: SILVER 87 AV SENSITIVITY ANALYSIS TABLE FOR OTHER AVC INPUTS

CHANGE IN BENEFIT	CHANGE IN AV
Increasing Deductible by $1,000	-1.62%
Decreasing Deductible by $1,000[11]	N/A
Increasing MOOP by $1,000	-1.30%
Decreasing MOOP by $1,000	1.81%
Apply IP Copay per Day	0.00%
Apply SNF Copay per Day	0.00%
Add $1,000 HSA/HRA Employer Contribution	N/A[12]
Applying $100 Max Copay on Specialty High-Cost Drugs Coinsurance	0.00%
5 Days Maximum for IP Copay and Apply IP Copay per Day	0.00%
PCP Cost-Sharing Applies After 5 Visits	0.30%
PCP Ded./Coins After 5 Copays and PCP Subject to Deductible	-0.01%

11. Decreasing the deductible by $1,000 would make the deductible negative.
12. This plan design is specifically for the individual line of business, which will not have an HSA/HRA employer contribution.

FIGURE 12: SILVER 94 AV SENSITIVITY ANALYSIS TABLE BY TIER 1 BENEFIT CATEGORY

TIER 1 BENEFIT	IMPACT OF REMOVING DEDUCTIBLE APPLICABILITY[13]	IMPACT OF REMOVING COINSURANCE APPLICABILITY	IMPACT OF CHANGING FROM $10 COPAY TO $20 COPAY	IMPACT OF CHANGING FROM 10% COINSURANCE TO 20% COINSURANCE	IMPACT OF $50 COPAY APPLYING AFTER DEDUCTIBLE[14]
Emergency Room Services	0.00%	0.69%	-0.01%	-0.28%	0.00%
All IP Hosp. (inc. MH/SUD)	0.00%	0.16%	0.00%	-0.06%	0.00%
PCP (exc. Well-Baby, Prev., X-Rays)	0.00%	N/A	-0.12%	-0.17%	0.00%
Specialist Visit	0.00%	N/A	-0.19%	-0.34%	0.00%
MH/SUD	0.00%	N/A	-0.18%	-0.19%	0.00%
Imaging (CT/PET Scans, MRIs)	0.00%	0.19%	-0.01%	-0.07%	0.00%
Rehabilitative ST	0.00%	N/A	0.00%	0.00%	0.00%
PT/OT	0.00%	N/A	-0.14%	-0.07%	0.00%
Lab OP and Prof. Services	0.00%	0.32%	-0.35%	-0.13%	0.00%
X-Rays and Diagnostic Imaging[15]	-0.07%	0.32%	-0.07%	-0.13%	0.00%
Skilled Nursing Facility	0.00%	0.00%	0.00%	0.00%	0.00%
OP Facility (e.g., ASC)	0.00%	0.48%	-0.06%	-0.19%	0.00%
OP Surg. Phys./Surg. Services	0.00%	0.50%	-0.16%	-0.21%	0.00%
Generic Drugs	0.00%	N/A	-0.74%	-0.21%	0.00%
Preferred Brand Drugs	0.00%	N/A	-0.05%	-0.19%	0.00%
Non-Preferred Brand Drugs	0.00%	N/A	-0.04%	-0.13%	0.00%
Specialty High-Cost Drugs	0.00%	N/A	0.00%	-0.01%	0.00%

FIGURE 13: SILVER 94 AV SENSITIVITY ANALYSIS TABLE FOR OTHER AVC INPUTS

CHANGE IN BENEFIT	CHANGE IN AV
Increasing Deductible by $1,000[16]	N/A
Decreasing Deductible by $1,000[17]	N/A
Increasing MOOP by $1,000	-1.14%
Decreasing MOOP by $1,000	1.57%
Apply IP Copay per Day	0.00%
Apply SNF Copay per Day	0.00%
Add $1,000 HSA/HRA Employer Contribution	N/A[18]
Applying $100 Max Copay on Specialty High-Cost Drugs Coinsurance	0.01%
5 Days Maximum for IP Copay and Apply IP Copay per Day	0.00%
PCP Cost-Sharing Applies After 5 Visits	0.00%
PCP Ded/Coins After 5 Copays and PCP Subject to Deductible	0.00%

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13. Deductible is $0.
14. Deductible is $0.
15. We recognize that with a $0 deductible, there should be no impact to the AV if the deductible applicability is added or removed. However, the AVC does show an impact to the AV if the $0 deductible applicability is added or removed for X-rays and diagnostic imaging.
16. No services are subject to the deductible.
17. Decreasing the deductible by $1,000 would make the deductible negative.
18. This plan design is specifically for the individual line of business, which will not have an HSA/HRA employer contribution.

FIGURE 14: EXPANDED BRONZE AV SENSITIVITY ANALYSIS TABLE BY TIER 1 BENEFIT CATEGORY

TIER 1 BENEFIT	IMPACT OF REMOVING DEDUCTIBLE APPLICABILITY	IMPACT OF REMOVING COINSURANCE APPLICABILITY	IMPACT OF CHANGING FROM $10 COPAY TO $20 COPAY	IMPACT OF CHANGING FROM 10% COINSURANCE TO 20% COINSURANCE	IMPACT OF $50 COPAY APPLYING AFTER DEDUCTIBLE
Emergency Room Services	3.14%	0.00%	0.00%	0.00%	0.00%
All IP Hosp. (inc. MH/SUD)	0.26%	0.00%	0.00%	0.00%	0.00%
PCP (exc. Well-Baby, Prev., X-Rays)	1.25%	N/A	-0.17%	0.00%	0.00%
Specialist Visit	1.25%	N/A	-0.28%	0.00%	0.00%
MH/SUD	0.87%	N/A	-0.18%	0.00%	0.00%
Imaging (CT/PET Scans, MRIs)	0.76%	0.00%	0.00%	0.00%	0.00%
Rehabilitative ST	0.01%	N/A	0.00%	0.00%	0.00%
PT/OT	0.08%	N/A	-0.11%	0.00%	0.00%
Lab OP and Prof. Services	1.88%	0.00%	0.00%	0.00%	0.00%
X-Rays and Diagnostic Imaging	1.57%	-0.08%	0.00%	0.00%	0.00%
Skilled Nursing Facility	0.00%	0.00%	0.00%	0.00%	0.00%
OP Facility (e.g., ASC)	2.48%	0.00%	0.00%	0.00%	0.00%
OP Surg. Phys./Surg. Services	4.20%	0.00%	0.00%	0.00%	0.00%
Generic Drugs	0.22%	N/A	-0.83%	0.00%	0.00%
Preferred Brand Drugs	0.90%	N/A	0.00%	0.00%	0.00%
Non-Preferred Brand Drugs	0.53%	N/A	0.00%	0.00%	0.00%
Specialty High-Cost Drugs	0.00%	N/A	0.00%	0.00%	0.00%

FIGURE 15: EXPANDED BRONZE AV SENSITIVITY ANALYSIS TABLE FOR OTHER AVC INPUTS

CHANGE IN BENEFIT	CHANGE IN AV
Increasing Deductible by $1,000[19]	0.00%
Decreasing Deductible by $1,000[20]	0.00%
Increasing MOOP by $1,000[21]	N/A
Decreasing MOOP by $1,000	1.67%
Apply IP Copay per Day	0.00%
Apply SNF Copay per Day	0.00%
Add $1,000 HSA/HRA Employer Contribution	9.31%
Applying $100 Max Copay on Specialty High-Cost Drugs Coinsurance	0.00%
5 Days Maximum for IP Copay and Apply IP Copay per Day	0.00%
PCP Cost-Sharing Applies After 5 Visits	0.93%
PCP Ded./Coins After 5 Copays and PCP Subject to Deductible	-0.06%

19. The deductible is high relative to the MOOP, such that the resulting AV change is <0.01%.
20. Ibid.
21. Increasing the MOOP by $1,000 exceeds the MOOP limit.

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Appendix A

VERSION YEAR	MOOP LIMIT IN THE AVC[22]	DE MINIMIS RANGES	CONTINUANCE TABLE DATA	OTHER NOTABLE CHANGES
2014[23]	$6,500	+/- 2% for each metal level +/- 1% for CSRs	Uses claims data from the Health Intelligence Company (HIC) database for calendar year 2010, trended to 2014. Restricted to small group PPO/POS with drug coverage and plans with at least 50 enrollees.	N/A; initial year
2015[24]	$6,850	Same as 2014	Same as 2014 (no additional trend applied).	N/A
2016[25]	$6,850	Same as 2015	Trends forward claims data an additional two years from the final 2015 AVC, which was based on estimated 2014 claim costs, at a rate of 6.5% per annum.	Uses effective coinsurance to determine when the MOOP limit is reached in the AVC instead of the general coinsurance rate. Previously, the AVC used the user-specified general coinsurance rate to calculate the level of spending at which an enrollee would reach the MOOP. With the effective coinsurance change, this calculation is simplified by automatically incorporating all elements of the plan benefit design into the calculation of the level of spending at which the MOOP is reached. Allows MOOP to be lower than the sum of separate medical and drug deductibles. Allows services to apply to the deductible first before copayments apply. Calculation of the per-member-per-year benefit at the level of spending at which MOOP is reached in the case of a separate medical/drug deductible and combined MOOP no longer calculates the drug benefit as exclusive from the medical benefit.

22. Prior to a CMS policy change for PY2023, often the MOOP limit in the AVC has not matched the actual MOOP limit finalized for each year, as the final AVC was typically released prior to the final MOOP being known. The actual MOOP limits for each year are $6,350 for 2014; $6,600 for 2015; $6,850 for 2016; $7,150 for 2017; $7,350 for 2018; $7,900 for 2019; $8,150 for 2020; $8,550 for 2021; $8,700 for 2022; $9,100 for 2023; $9,450 for 2024; $9,200 for 2025.

23. U.S. Department of Health and Human Services. Final 2014 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://wayback.archive-it.org/2744/20200125161048/https:/www.cms.gov/CCIIO/Resources/Files/Downloads/av-calculator-methodology.pdf.

24. U.S. Department of Health and Human Services. Patient Protection and Affordable Care Act; 2015 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-methodology.pdf.

25. U.S. Department of Health and Human Services. (January 16, 2015). Final 2016 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-Methodology.pdf.

VERSION YEAR	MOOP LIMIT IN THE AVC[22]	DE MINIMIS RANGES	CONTINUANCE TABLE DATA	OTHER NOTABLE CHANGES
2017[26]	$7,200	Same as 2016	Trends forward claims data an additional year from the final 2016 AVC, at a rate of 6.5% per annum.	Includes inputs for plan name and HIOS ID.
2018[27]	$7,600	-4 percentage points to +2 percentage points, except if a bronze health 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 section 223(c)(2) of the Internal Revenue Code, in which case the allowable variation in AV for such expanded bronze plan is between -4 percentage points and +5 percentage points +/- 1% for CSRs	The continuance tables are now based on 2015 individual and small group claims from a national claims database; 2015 claims data are the most current data of this type that are available. Trends used are 3.25% for medical costs and 11.5% for drug costs, annually. Enrollment demographic distribution in the claims data is adjusted to reflect the projected 2018 population.	Includes ability to enter a plan design with a copayment for the OP facility fee and OP surgery physician/surgical Services. Updates the use of effective coinsurance to calculate the benefit in the coinsurance range to apply to plans with a combined medical and drug deductible. Modified MOOP algorithm begins with the imputed MOOP and iteratively calculates the point at which the MOOP is reached. Previous versions of the AVC first calculated a plan's effective coinsurance rate based on average spending and then calculated the level of spending at which MOOP is reached. AV of plans with two tiers is now calculated as a utilization-weighted average of the AV of each tier, and the order of plans entered in Tier 1 or Tier 2 no longer impacts the AV of the plan. Cost sharing below the deductible that does not contribute to meeting the deductible now impacts the spending level at which the deductible is reached. For plans with separate medical and drug deductibles and a combined MOOP, the equivalent combined deductible is calculated and compared against the MOOP. If the equivalent combined deductible is greater than the MOOP, then the equivalent combined deductible is set equal to the MOOP. Previously, the AVC compared spending at the deductibles with spending at the point the MOOP is reached and reduced the prescription drug deductible if spending at the deductible exceeded spending at the point MOOP is reached. Allows users to indicate if a plan's design meets the requirements in the final 2018 Payment Notice to apply the expanded bronze plan de minimis range.

26. U.S. Department of Health and Human Services. (January 16, 2015). Final 2016 Actuarial Value Calculator Methodology. Retrieved January 29, 2025, from Archive-It (https://archive-it.org/) at https://wayback.archive-it.org/2744/20200125161118/https:/www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf

27. U.S. Department of Health and Human Services. (April 13, 2017). Revised Final 2018 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/revised-final-2018-av-methodology-41317.pdf.

VERSION YEAR	MOOP LIMIT IN THE AVC[22]	DE MINIMIS RANGES	CONTINUANCE TABLE DATA	OTHER NOTABLE CHANGES
2019[28]	$8,000	Same as 2018	Adds a one-year projection factor of 5.4% for medical costs and 11.5% for drug costs.	N/A
2020[29]	$8,250	Same as 2019	Adds a one-year projection factor of 6.1% for medical costs and 9.8% for drug costs.	N/A
2021[30]	$8,700	Same as 2020	The continuance tables are based on 2017 individual and small group claims from a national claims database, projected to the 2021 plan year. Trends used from 2017 to 2018 are 3.25% for medical spending and 9% for drug spending, and each additional year from 2018 to 2021 are 5.4% for medical spending and 8.7% for drug spending. Enrollment demographic distribution in the claims data is adjusted to reflect the projected 2021 population. Caps enrollee spending at $1 million to better reflect standard enrollee expected spending and reduce the effect of the few enrollees with very high spending.	Updated the algorithm to more accurately calculate spending during the deductible phase for plans with benefits that are subject to the deductible and have a copay (i.e., benefits that have a “copay with deductible”). The algorithm reduces the deductible and MOOP in these cases to ensure that total enrollee spending when the deductible is met does not exceed the MOOP.
2022[31]	$9,300	Same as 2021	No trend is applied from 2021 to 2022 in recognition of uncertainty of future health care spending due to the COVID-19 pandemic.	N/A

28. U.S. Department of Health and Human Services. (December 28, 2017). Final 2019 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2019-AV-Calculator-Methodology.pdf.
29. U.S. Department of Health and Human Services. (March 19, 2019). Final 2020 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2020-AV-Calculator-Methodology.pdf.
30. U.S. Department of Health and Human Services. (March 6, 2020). Final 2021 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-AV-Calculator-Methodology.pdf.
31. U.S. Department of Health and Human Services. (May 6, 2021). Final 2022 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2022-AV-Calculator-Methodology.pdf.

VERSION YEAR	MOOP LIMIT IN THE AVC[22]	DE MINIMIS RANGES	CONTINUANCE TABLE DATA	OTHER NOTABLE CHANGES
2023[32]	$9,100	-2 percentage points to +2 percentage points, except if a bronze health 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 section 223(c)(2) of the Internal Revenue Code, in which case the allowable variation in AV for such plan is between -2 percentage points and +5 percentage points +1/0 percentage points for CSRs +2/0 percentage points for on-exchange individual market silver plans	The continuance tables are based on 2018 individual and small group claims from a national claims database, projected to the 2023 plan year. Claims are trended forward from 2018 to 2021 at an annual rate of 5.4% for medical spending and 8.7% for drug spending. Trend from 2021 to 2022 is at an annual rate of 3.2% for medical spending and 4.55% for drug spending. For 2022 to 2023, trend factors of 5.80% for medical costs and 8.70% for drug costs are applied. The demographic weights used in constructing the continuance tables are adjusted to reflect the projected 2023 population. Enrollee spending is capped at the 99.9th percentile of annual allowed amounts for all enrollees in the claims data to better reflect standard population enrollee expected spending and reduce the impact on AVs from outlier observations with very high spending.	N/A
2024[33]	$9,450	Same as 2023	Adds a one-year projection factor of 5.4% for medical costs and 8.2% for drug costs.	Includes changes to the way copays paid by an enrollee are counted toward the deductible. In previous AVCs, copays paid by enrollees during the deductible phase for services that aren't subject to deductible did accumulate to the deductible. In the final 2024 AVC, these copays no longer accrue to the deductible. The copays are still counted toward the MOOP.
2025[34]	$9,200	Same as 2024	The continuance tables are based on 2021 individual and small group claims from a national claims database, projected to the 2025 plan year. Trend from 2021 to 2022 is at an annual rate of 3.2% for medical spending and 4.55% for drug spending. For 2022 to 2023, trend factors of 5.8% for medical costs and 8.7% for drug costs are applied. Trend from 2023 to 2024 is at an annual rate of 5.4% for medical spending and 8.2% for drug spending. For 2024 to 2025, trend factors of 6.4% for medical spending and 9.9% for drug costs are applied. The demographic weights used in constructing the continuance tables are adjusted to reflect the projected 2025 population.	N/A

32. U.S. Department of Health and Human Services. (April 28, 2022). Final 2023 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/sites/default/files/2022-04/Final-2023-AV-Calculator-Methodology.pdf.

33. U.S. Department of Health and Human Services. (April 17, 2023). Final 2024 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/files/document/2024-av-calculator-methodology.pdf.

34. U.S. Department of Health and Human Services. (April 2, 2024). Final 2025 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/files/document/final-2025-av-calculator-methodology.pdf.

VERSION YEAR	MOOP LIMIT IN THE AVC[22]	DE MINIMIS RANGES	CONTINUANCE TABLE DATA	OTHER NOTABLE CHANGES
			Enrollee spending is capped at the 99.5th percentile of annual allowed amounts for all enrollees in the claims data to better reflect standard population enrollee expected spending and reduce the impact on AVs from outlier observations with very high spending, and better ensure the viability of bronze plans.	
2026[35]	$10,150	Same as 2025	Adds a one-year trend projection factor of 6.4% for medical costs and 10.1% for drugs costs.	N/A

35. U.S. Department of Health and Human Services. (October 16, 2024). Final 2026 Actuarial Value Calculator Methodology. Retrieved January 23, 2025, from https://www.cms.gov/files/document/final-2026-av-calculator-methodology.pdf.

Appendix B: 2026 Standardized Plan Options Set One[36]

	EXPANDED BRONZE	STANDARD SILVER	SILVER 73 CSR	SILVER 87 CSR	SILVER 94 CSR	GOLD	PLATINUM
Actuarial Value	64.42%	70.01%	73.07%	87.04%	94.11%	78.04%	88.03%
Deductible	$7,500	$6,000	$3,000	$700	$0	$2,000	$0
Annual Limitation on Cost Sharing	$9,200	$8,900	$7,400	$3,300	$2,200	$8,200	$5,200
Emergency Room Services	60%	40%	40%	30%	25%*	25%	$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	60%	40%	40%	30%	25%*	25%	$350*
Primary Care Visit	$60*	$40*	$40*	$20*	$0*	$30*	$10*
Urgent Care	$90*	$60*	$60*	$30*	$5*	$45*	$15*
Specialist Visit	$120*	$80*	$80*	$40*	$10*	$60*	$20*
Mental Health & Substance Use Disorder Outpatient Office Visit	$60*	$40*	$40*	$20*	$0*	$30*	$10*
Imaging (CT/PET Scans, MRIs)	60%	40%	40%	30%	25%*	25%	$100*
Speech Therapy	$60*	$40*	$40*	$20*	$0*	$30*	$10*
Occupational, Physical Therapy	$60*	$40*	$40*	$20*	$0*	$30*	$10*
Laboratory Services	60%	40%	40%	30%	25%*	25%	$30*
X-rays/Diagnostic Imaging	60%	40%	40%	30%	25%*	25%	$30*
Skilled Nursing Facility	60%	40%	40%	30%	25%*	25%	$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	60%	40%	40%	30%	25%*	25%	$150*
Outpatient Surgery Physician & Services	60%	40%	40%	30%	25%*	25%	$150*
Generic Drugs	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	$50	$40*	$40*	$20*	$15*	$30*	$10*
Non-Preferred Brand Drugs	$100	$80	$80	$60	$50*	$60*	$50*
Specialty Drugs	$500	$350	$350	$250	$150*	$250*	$150*

*Benefit category not subject to the deductible

36. Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services. (October 10, 2024). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program. Federal Register, vol. 89, no. 197, page 74. Retrieved January 23, 2025, from https://www.govinfo.gov/content/pkg/FR-2024-10-10/pdf/2024-23103.pdf.

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