

Plan Year 2021 Qualified Health Plan Choice and Premiums in HealthCare.gov States: Methodology

Plan Data

This report includes individual market qualified health plans (QHPs) for states with Exchanges using the HealthCare.gov eligibility and enrollment platform (HealthCare.gov states). It excludes Small Business Health Options Program (SHOP) plans and stand-alone dental plans (SADPs).

Plan year 2021 (PY21) QHPs are those that are certified as of the beginning of October 2020. PY14–PY20 QHPs are those that were certified and available during some part of Open Enrollment for the applicable plan years. This includes plans that were decertified or suppressed from display on HealthCare.gov later in the year, or temporarily suppressed at the beginning of Open Enrollment due to significant data errors. The prior reports that the Assistant Secretary of Planning and Evaluation (ASPE) published generally used the data publicly available at the time of report generation and excluded plans decertified or suppressed after Open Enrollment.

Except where otherwise noted, this report excludes catastrophic and child-only plans because they are not available to all consumers. It also excludes PY14 Virginia plans covering morbid obesity treatment because these plans mirror others that do not cover morbid obesity and enrollment in these plans would only have included consumers seeking morbid obesity treatment.

This report assumes plans cover all zip codes in a county. For the two HealthCare.gov states that define rating areas using zip codes, rather than counties (Alaska and Nebraska), this report uses the rating area that covers the most population based on Census data.

Enrollment Data

This report uses HealthCare.gov enrollment data. Table 1 shows the plan year enrollment cutoff dates; except for PY14, these dates match previous final Open Enrollment report cutoff dates. Special enrollment period enrollments after these cutoff dates are not included.

Table 1: Enrollment Cutoff Dates by Plan Year

Plan Year	Enrollment Cutoff Date
2014	December 2014
2015	February 22, 2015
2016	February 1, 2016
2017	January 31, 2017
2018	December 23, 2017
2019	December 22, 2018
2020	December 21, 2019

This report uses county-level plan selections to calculate state- and national-level weighted averages. PY21 metrics use PY20 plan selection weights because PY21 plan selections will not be known until after the end of Open Enrollment.

This report uses the term “enrollees” to refer to individuals with non-canceled plan selections as of the cutoff date; the term does not refer to “effectuated enrollees” – individuals who selected plans and paid the premium.

HealthCare.gov and State-based Exchange (SBE) Transitions

Except where otherwise noted, the metrics in this report include only states that use HealthCare.gov for given plan year. Since states can transition between HealthCare.gov and State-based Exchanges with their own eligibility and enrollment platforms, one plan year's metrics may include different states than another plan year's metrics. All appendix table values are set equal to "N/A" for states that do not use HealthCare.gov in a given plan year.

Definitions

Issuer

This report identifies an issuer using its unique five-digit Health Insurance Oversight System (HIOS) issuer ID. In some cases, one parent company has multiple HIOS issuer IDs. An entity's HIOS ID is state-specific, such that a company offering plans through two different state Exchanges appears as two separate issuers.

Plan

This report identifies a plan using its unique 14-digit HIOS standard component ID, which is state- and issuer-specific. Each non-catastrophic standard plan ID has two American Indians and Alaska Natives cost sharing reduction (CSR) plan variations, and silver plans have three additional income-based CSR plan variations. Unless otherwise specified, plan counts include only standard plans.

A plan's actuarial value (AV) determines its metal level (within an allowable de minimis range: bronze has a 60 percent AV, silver has a 70 percent AV, gold has an 80 percent AV, and platinum has a 90 percent AV). Not all states or counties have plans in every metal level; "N/A" indicates these scenarios. Beginning in PY18, certain bronze plans can have AVs that extend upwards to 65 percent. Although these bronze plans are sometimes labeled "expanded bronze," this report groups them in the standard bronze category.

CSRs are generally available to consumers with expected household incomes 100%–250% of the Federal Poverty Level (FPL) who are eligible for premium tax credits, and who select a silver plan. The CSR plan variation AVs are higher than standard silver plan AVs because CSR plan variations have reduced copayments, coinsurance values, deductibles, or maximum out of pocket limits. The 73% AV silver plan variation is available to consumers who are eligible for advance payments of the premium tax credit (APTC) and have a household income greater than 200% FPL and less than or equal to 250% FPL. The 87% AV silver plan variation is available to APTC-eligible consumers with a household income greater than 150% FPL and less than or equal to 200% FPL. The 94% AV silver plan variation is available to APTC-eligible consumers with a household income greater than or equal to 100% and less than or equal to 150% FPL. More details are available at 45 CFR 155.305, 155.350, 156.135, and 156.420.

Typical Family of Four

This report defines a typical family of four as two 40 year olds and two 0–14 year-old children, corresponding to one of the premium scenarios in the [QHP landscape files](#). Previous ASPE reports used a 40 year-old, a 38 year-old, and two 0–14 year-old children.

Essential Health Benefits (EHB) Premium

QHPs must offer a comprehensive package of items and services, known as Essential Health Benefits (EHBs). QHPs can also offer benefits beyond EHBs, and QHPs report the premium percentage attributable to EHB. Most QHPs have an EHB percentage of 100%; however, plans that cover benefits beyond EHB have EHB percentages smaller than 100%, reflecting the fact that some premium pays for benefits beyond EHB.

Second Lowest Cost Silver Plan (SLCSP)

The HealthCare.gov eligibility logic determines an enrollee's APTC amount using the SLCSP, also called the benchmark plan. This report finds the SLCSP in each county by ranking all of the silver QHPs by their EHB

premium amounts and finding the second lowest value. Enrollees' actual benchmark plans may vary based on their zip codes and plans' rating business rules. This report displays the EHB premiums for all SLCSP metrics to align with the APTC methodology. Previous ASPE reports found the SLCSP using the EHB premium, but displayed the total premium.

In some counties with three or more silver plans, the EHB premium amount for the two lowest-cost silver plans is exactly the same. For PY14–PY17, when this occurs, the SLCSP is the silver plan with the next highest premium relative to the tied lowest-cost silver plans. For PY18–PY21, when this occurs, the SLCSP premium equals the premium for the tied lowest-cost silver plans. This operational change resulted from an Internal Revenue Service (IRS) clarification on how to calculate APTC.¹

For PY19–PY21, the SLCSP logic aligns with updated regulations at 26 CFR 1.36B-3(f)(3) and incorporates stand-alone dental plan (SADP) premiums for children less than 19 years-old; the PY19 ASPE report did not incorporate this logic. When silver plans do not cover all pediatric dental EHB (Dental Check-Up for Children, Basic Dental Care – Child, Major Dental Care – Child), the logic adds the second lowest cost SADP EHB premium to the silver plan's EHB premium before ranking the silver plan EHB premiums and determining the SLCSP.

The SLCSP metrics for a typical family of four in this report use different logic depending on whether the SADP is age-rated or family tier-rated. If the SADP is age-rated, the logic uses two times the 0–14 year-old rate; if the SADP is family tier-rated, the logic uses the primary subscriber plus one dependent rate. In both cases, the logic multiplies the SADP rate by the EHB pediatric dental apportionment quantity. The logic excludes child-only SADPs because they are not available to a family with adults.

Maximum APTC

Individuals with expected household incomes 100%–400% of the FPL are generally APTC-eligible if they are not otherwise eligible for minimum essential coverage (MEC). More detail is available at 45 CFR 155.305(f) and 26 CFR 1.36B. The maximum household APTC equals the APTC-eligible family members' SLCSP EHB premium minus the required household contribution, which is based on the household's expected income as a percent of FPL and an applicable percentage the IRS determines annually.² After-APTC benchmark premiums will differ slightly between any two years for identical family compositions and income amounts because of changes in the applicable percentages and FPL guidelines. The APTC methodology for a given plan year uses the FPL guidelines from the previous year (i.e., those that are available at the beginning of a plan year's Open Enrollment). Alaska and Hawaii's FPLs are higher than those for the 48 contiguous states; consequently, the Alaska and Hawaii maximum APTC amount is higher for a given household income amount and benchmark plan premium.

If the required household contribution for a household with income 100%–400% of the FPL is greater than the SLCSP EHB premium, the maximum APTC is \$0 but the individuals are still APTC eligible. This report uses the maximum APTC that enrollees can receive, including when the amount is \$0. Enrollees will receive less than their maximum APTC if their maximum APTC is greater than their selected plan's EHB premium, or if they don't apply the maximum APTC amount and instead claim the credit when they file taxes. Enrollees can only apply APTC towards a plan's EHB premium.

¹ See question 21 of the IRS Questions and Answers on Premium Tax Credits at: <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit>.

² The FPL amounts for each year are available at <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>. The applicable percentages for PY21 are available at <https://www.irs.gov/pub/irs-drop/rp-20-36.pdf>.

This report’s maximum APTC calculation for a typical family of four with a household income of 250% FPL assumes all family members are APTC-eligible. However, in states with higher Medicaid or Children’s Health Insurance Program (CHIP) thresholds, the children could be Medicaid/CHIP-eligible and APTC-ineligible.

HealthCare.gov Enrollees

The HealthCare.gov enrollee maximum APTC and lowest cost plan (LCP) metrics include all enrollees who selected a non-catastrophic plan and have a non-missing county and zip code. This report includes tobacco users and calculates LCP premiums using tobacco rates when they exist. Previous ASPE reports excluded tobacco users from the maximum APTC and LCP metrics.

The HealthCare.gov enrollee metrics assume that families with multiple enrollment groups or policies maintain their selected grouping arrangement regardless of the selected plan. The LCP metrics assume that all family members select the same plan and require that the plan be available to all household enrollment groups. The PY21 estimates hold all PY20 enrollee characteristics unchanged and calculate premiums using the PY20 age, family composition, and household income as a percent of FPL. The metrics include bronze, silver, and gold LCP premiums and the LCP premium within an enrollee’s chosen metal level. The latter looks at the LCP in the metal level that corresponds to the enrollee’s Open Enrollment plan selection, so it represents a mix of metal levels. The bronze, silver, and gold LCP metrics look only at the LCP in the given metal level, regardless of an enrollee’s Open Enrollment plan selection.

For PY15–PY20, the HealthCare.gov enrollee maximum APTC metric uses the HealthCare.gov calculated maximum APTC amounts. For PY21, the report finds the SLCS and calculates an estimated maximum APTC using PY20 enrollment and eligibility data and PY21 plan data. In all plan years, the household maximum APTC is distributed among APTC-eligible enrollees using the relevant age rating curve and redistributed among policies using the logic described in 45 CFR 155.340(f).

The HealthCare.gov enrollee LCP metrics do not consider plans’ rating business rules. Since all medical plans are age-rated in HealthCare.gov states, rating business rules generally only affect premiums when the household contains more than three child enrollees less than age 21; in these cases, the three-child rating cap only applies if the children can enroll on the same policy. However, the PY21 SLCS determination considers rating business rules because the logic includes SADPs, which can be family tier-rated plans with relationship-dependent rates.

The HealthCare.gov enrollee metrics include child-only medical plans and SADPs when they would be available to a given enrollment group. Previous ASPE reports did not include child-only plans in any scenario.

This report calculates the policy-level LCP premium and distributes the amount among policy members based on each member’s individual premium amount. As a result, APTCs can lower the premiums of APTC-ineligible individuals who are on policies with APTC-eligible family members. When a policy includes more than 3 children such that some children are not rated, this report distributes the total child rate among all children younger than 21 years-old (e.g., if the policy includes 4 children, each with a rate of \$100, the policy-level premium is \$300 and each child’s premium is \$75).

Health Savings Account (HSA)-Eligible Plans

To qualify for an HSA individuals must enroll in a high deductible health plan (HDHP) per 26 U.S.C. 223(c)(2). This report identifies PY17–PY21 HSA-eligible plans using the “HSA-Eligible” field issuers provide in their QHP data. CMS did not check this field’s PY15–PY16 accuracy at the time of QHP data submission, so this report identifies PY15–PY16 HSA-eligible plans as those meeting the following conditions:

- The “HSA-Eligible” field equals “Yes”.
- The deductible value is greater than or equal to the plan year HDHP minimum deductible.

- The maximum out-of-pocket value is less than or equal to the plan year HDHP maximum out-of-pocket limit.³
- All benefit categories associated with the AV Calculator are subject to the deductible.

The HSA-eligible plan access metrics in this report exclude enrollees eligible for CSRs due to their American Indian or Alaskan Native status because plan variations with these CSRs are generally not HDHPs. Other than the silver metal level, the HSA-eligible plan access metrics include all other enrollees. Silver metal level HSA-eligible plan access metrics consider the enrollees' CSR-eligibility; the standard silver HSA-access metrics include only CSR-ineligible enrollees, and the silver plan CSR variation HSA-access metrics include only those enrollees eligible for the associated CSR level. The total, metal level-agnostic metrics consider enrollees to have HSA-eligible plan access if they have access to a non-silver HSA-eligible plan or an HSA-eligible silver plan/plan variation that corresponds to their CSR eligibility.

Median Individual Medical Deductible

The median individual medical deductible metric equals the average of the county-level median deductible in a given metal level or silver plan CSR variation, weighted county-level enrollment. If a plan has an integrated medical and drug deductible, this metrics uses the total individual deductible. If a plan has a separate medical and drug deductibles, this metric uses the individual medical deductible. If the in-network deductible equals "Not Applicable", this metric uses the combined in/out-of-network deductible; if both the in-network and combined in/out-of-network deductibles equal "Not Applicable," this metric considers the deductible \$0.

Plans with a Separate Drug Deductible

This report considers a plan to have a separate drug deductible if its "Medical & Drug Deductibles Integrated?" field equals "No" and it has a drug deductible greater than \$0. If the in-network drug deductible equals "Not Applicable", this metric uses the combined in/out-of-network drug deductible; if both the in-network and combined in/out-of-network drug deductibles equal "Not Applicable," this metric considers the drug deductible \$0.

Benefit Coverage Before the Deductible

A plan covers a benefit before the deductible if the benefit is not subject to a deductible. This report considers a benefit covered before the deductible if neither its copayment nor coinsurance use a cost sharing structure of "after the deductible", "with deductible" (for PY17–PY21), or "before deductible" (for PY14–PY16). In PY17, "with deductible" replaced the "before deductible" qualifier; in PY14–PY16, QHP guidance instructed issuers to use "before deductible" only when the benefit was subject to a deductible.

Regardless of copayment or coinsurance values, this report also considers a benefit covered before the deductible if the benefit's associated deductible (either medical or drug) equals \$0 or "Not Applicable".

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³ IRS Publication 969 for each tax year contains the minimum deductible and maximum out-of-pocket values.