§ 147.145

(1) Conclusion. In this Example 6, medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.0720 (415.0 \( \div \) 587.142 = 0.0720). The employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

Example 6. (i) Facts. On March 23, 2010, a self-insured group health plan provides two tiers of coverage—self-only and family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 90% for family coverage, but keeps the same contribution rate for self-only coverage.

(ii) Conclusion. In this Example 6, the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

Example 7. (i) Facts. On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1000 for self-only coverage and $3000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5000 - 1000)/5000) for self-only coverage and 67% ((12,000 - 3000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1200 for self-only coverage and $5000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6000 - 1200)/6000) for self-only coverage and 67% ((15,000 - 5000)/15,000) for family coverage.

(ii) Conclusion. In this Example 7, because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under section 125 of the Internal Revenue Code.

Example 9. (i) Facts. A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan increases coinsurance under Option H from 10% to 15%.

(ii) Conclusion. In this Example 9, the coverage under Option H is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options F and G is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

(75 FR 34566, June 17, 2010, as amended at 75 FR 70121, Nov. 15, 2010)
(iii) For purposes of section 2703(a) of the Public Health Service Act, a health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students.

(2) Annual limits. (i) Notwithstanding the annual dollar limits requirements of §147.126, for policy years beginning before September 23, 2012, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than $100,000.

(ii) Notwithstanding the annual dollar limits requirements of §147.126, for policy years beginning on or after September 23, 2012, but before January 1, 2014, a health insurance issuer offering student health insurance coverage may not establish an annual dollar limit on essential health benefits that is lower than $500,000.

(iii) For policy years beginning on or after January 1, 2014, a health insurance issuer offering student health insurance coverage must comply with the annual dollar limits requirements in §147.126.

(3) Single risk pool. Student health insurance coverage is not subject to the requirements of section 1312(c) of the Affordable Care Act.

(c) Student administrative health fees—

(1) Definition. A student administrative health fee is a fee charged by the institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage.

(2) Preventive services. Notwithstanding the requirements under section 2713 of the Public Health Service Act and its implementing regulations, student administrative health fees as defined in paragraph (c)(1) of this section are not considered cost-sharing requirements with respect to specified recommended preventive services.

(d) Notice—(1) Requirements. (i) A health insurance issuer that provides student health insurance coverage, and does not meet the annual dollar limits requirements under section 2711 of the Public Health Service Act, must provide a notice informing students that the policy does not meet the minimum annual limits requirements under section 2711 of the Public Health Service Act. The notice must include the dollar amount of the annual limit along with a description of the plan benefits to which the limit applies for the student health insurance coverage.

(ii) The notice must state that the student may be eligible for coverage as a dependent in a group health plan of a parent’s employer or under the parent’s individual market coverage if the student is under the age of 26.

(iii) The notice must be prominently displayed in clear, conspicuous 14-point bold type on the front of the insurance policy or certificate and in any other plan materials summarizing the terms of the coverage (such as a summary description document).

(iv) The notice must be provided for policy years beginning before January 1, 2014.

(2) Model language. The following model language, or substantially similar language, can be used to satisfy the notice requirement of this paragraph (d): “Your student health insurance coverage, offered by [name of health insurance issuer], may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: [Dollar amount] on [which covered benefits—notice should describe all annual limits that apply]. If you have any
§ 147.150 Coverage of essential health benefits.

(a) Requirement to cover the essential health benefits package. A health insurance issuer offering health insurance coverage in the individual or small group market must ensure that such coverage includes the essential health benefits package as defined in section 1302(a) of the Affordable Care Act effective for plan or policy years beginning on or after January 1, 2014.

(b) Cost-sharing under group health plans. [Reserved]

(c) Child-only plans. If a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d)(1) of the Affordable Care Act, the issuer must offer coverage in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.

[78 FR 12865, Feb. 25, 2013]

§ 147.160 Parity in mental health and substance use disorder benefits.

(a) In general. The provisions of §146.130 of this subchapter apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner and to the same extent as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the large group market.

(b) Applicability date. The provisions of this section apply for policy years beginning on or after the applicability dates set forth in §146.136(1) of this subchapter. This section applies to non-grandfathered and grandfathered health plans as defined in §147.140.

[78 FR 68296, Nov. 13, 2013]