§ 156.140 Levels of coverage.

(a) *General requirement for levels of coverage.* AV, calculated as described in § 156.135 of this subpart, and within a de minimis variation as defined in paragraph (c) of this section, determines whether a health plan offers a bronze, silver, gold, or platinum level of coverage.

(b) *The levels of coverage* are:

(1) *A bronze health plan* is a health plan that has an AV of 60 percent.

(2) *A silver health plan* is a health plan that has an AV of 70 percent.

(3) *A gold health plan* is a health plan that has an AV of 80 percent.

(4) *A platinum health plan* is a health plan that has as an AV of 90 percent.

(c) *De minimis variation.* 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, except if a health plan under paragraph (b)(1) of this section (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 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.

[78 FR 12866, Feb. 25, 2013, as amended at 81 FR 94180, Dec. 22, 2016; 82 FR 18382, Apr. 18, 2017]

§ 156.145 Determination of minimum value.

(a) *Acceptable methods for determining MV.* An employer-sponsored plan provides minimum value (MV) only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services. An employer-sponsored plan may use one of the following methods to determine whether the percentage of the total allowed costs of benefits provided under the plan is not less than 60 percent.

(1) The MV Calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under the rules in paragraph (b) of this section.

(2) Any safe harbor established by HHS and the Internal Revenue Service.

(3) A group health plan may seek certification by an actuary to determine MV if the plan contains non-standard features that are not suitable for either of the methods described in paragraphs (a)(1) or (2) of this section. The determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

(4) Any plan in the small group market that meets any of the levels of coverage, as described in § 156.140 of this subpart, satisfies minimum value.

(b) *Benefits that may be counted towards the determination of MV.* (1) In the event that a group health plan uses the MV Calculator and offers an EHB outside of the parameters of the MV Calculator, the plan may seek an actuary, who is a member of the American Academy of Actuaries, to determine the value of that benefit and adjust the result derived from the MV Calculator to reflect that value.

(2) For the purposes of applying the options described in paragraph (a) of this section in determining MV, a group health plan will be permitted to take into account all benefits provided by the plan that are included in any one of the EHB-benchmarks.

(c) *Standard population.* The standard population for MV determinations described in paragraph (a) of this section is the standard population developed by HHS for such use and described through summary statistics issued by HHS. The standard population for MV must reflect the population covered by self-insured group health plans.

(d) *Employer contributions to health savings accounts and amounts made available under certain health reimbursement arrangements.* For employer-sponsored self-insured group health plans and insured group health plans that at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly

made available under such HRAs for the current year are:

(1) Counted towards the total anticipated medical spending of the standard population that is paid by the health plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

(i) Any current year HSA contributions are accounted for; and

(ii) The amounts newly made available under such integrated HRAs for the current year are accounted for.

[78 FR 12866, Feb. 25, 2013, as amended at 80 FR 10872, Feb. 27, 2015]

§ 156.150 Application to stand-alone dental plans inside the Exchange.

(a) *Annual limitation on cost-sharing.* For a stand-alone dental plan covering the pediatric dental EHB under § 155.1065 of this subchapter in any Exchange, cost sharing may not exceed $350 for one covered child and $700 for two or more covered children.

(1) For plan years beginning after 2017, for one covered child—the dollar limit applicable to a stand-alone dental plan for one covered child specified in this paragraph (a) increased by the percent increase of the consumer price index for dental services for the year 2 years prior to the applicable plan year over the consumer price index for dental services for 2016.

(2) For plan years after 2017, for two or more covered children—twice the dollar limit for one child described in paragraph (a)(1) of this section.

(b) *Calculation of AV.* A stand-alone dental plan:

(1) May not use the AV calculator in § 156.135; and

(2) Must have the plan's actuarial value of coverage for pediatric dental essential health benefits certified by a member of the American Academy of Actuaries using generally accepted actuarial principles and reported to the Exchange.

(c) *Consumer price index for dental services defined.* The consumer price index for dental services is a sub-component of the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index specific to dental services.

(d) *Increments of cost sharing increases.* Any increase in the annual dollar limits described in paragraph (a)(1) of this section that does not result in a multiple of 25 dollars will be rounded down, to the next lowest multiple of 25 dollars.

[78 FR 12866, Feb. 25, 2013, as amended at 79 FR 13840, Mar. 11, 2014; 81 FR 12349, Mar. 8, 2016; 83 FR 17069, Apr. 17, 2018]

§ 156.155 Enrollment in catastrophic plans.

(a) *General rule.* A health plan is a catastrophic plan if it meets the following conditions:

(1) Meets all applicable requirements for health insurance coverage in the individual market (including but not limited to those requirements described in parts 147 and 148 of this subchapter), and is offered only in the individual market.

(2) Does not provide a bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the Affordable Care Act.

(3) Provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act, except that the plan provides no benefits for any plan year (except as provided in paragraphs (a)(4) and (b) of this section) until the annual limitation on cost sharing in section 1302(c)(1) of the act is reached.

(4) Provides coverage for at least three primary care visits per year before reaching the deductible.

(5) Covers only individuals who meet either of the following conditions:

(i) Have not attained the age of 30 prior to the first day of the plan or policy year.

(ii) Have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of the Affordable Care Act.

(b) *Coverage of preventive health services.* A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services, in accordance with section 2713 of the Public Health Service Act.