

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.

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(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), (b), and (c) of this section) until the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care 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.

(c) *Coverage to prevent surprise medical bills.* A catastrophic plan must provide benefits as required under sections 2799A-1 and 2799A-2 of the Public Health Service Act and their implementing regulations in §§ 149.110, 149.120, and 149.130 or any applicable State law providing similar protections to individuals, and will not violate paragraph (a)(3) of this section solely because of the provision of such benefits before the annual limitation on cost sharing is reached.

(d) *Application for family coverage.* For other than self-only coverage, each individual enrolled must meet the requirements of paragraph (a)(5) of this section.

[78 FR 13442, Feb. 27, 2013, as amended at 78 FR 65096, Oct. 30, 2013; 86 FR 36985, July 13, 2021]

### Subpart C—Qualified Health Plan Minimum Certification Standards

SOURCE: 77 FR 18469, Mar. 27, 2012, unless otherwise noted.

## 45 CFR Subtitle A (10–1–23 Edition)

### § 156.200 QHP issuer participation standards.

(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.

(b) *QHP issuer requirement.* A QHP issuer must—

(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;

(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 of this subchapter and, in the small group market, §§ 155.705 and 155.706 of this subchapter;

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20, except that individual market silver QHPs must have an AV of 70 percent, with a *de minimis* allowable AV variation of –0 percentage points and +2 percentage points;

(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;

(5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Affordable Care Act consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act

(6) Pay any applicable user fees assessed under § 156.50; and

(7) Comply with the standards under 45 CFR part 153.

(c) *Offering requirements.* A QHP issuer must offer through the Exchange:

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in § 156.140 throughout each service area in which it offers coverage through the Exchange; and,