**Section 2001.12 Cost-Sharing**

a) Cost-Sharing Under Group Health Plans

A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under subsections (a)(1) and (2). (See 42 USC 300gg-6(b).) Requirements relating to cost-sharing are:

1)Annual Limitation on Cost-Sharing

A) 2014

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under 26 USC 223(c)(2)(A)(ii) for self-only and family coverage, respectively, for taxable years beginning in 2014.

B) 2015 and Later

In the case of any plan year beginning in a calendar year after 2014, the limitation under this subsection (a)(1)(B) shall:

i) in the case of self-only coverage, be equal to the dollar amount under subsection (a)(1)(A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under subsection (a)(4) for the calendar year; and

ii) in the case of other coverage, twice the amount in effect under subsection (a)(1)(B)(i).

C) If the amount of any increase under subsection (a)(1)(B)(i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

2) Annual Limitation on Deductibles for Employer-Sponsored Plans

A) In General

i) In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed $2,000 in the case of a plan covering a single individual and $4,000 in the case of any other plan.

ii) The amounts under subsection (a)(3)(A)(i) may be increased by the maximum amount of reimbursement that is reasonably available to a participant under a flexible spending arrangement described in 26 USC 106(c)(2) (determined without regard to any salary reduction arrangement).

B) Indexing of Limits

In the case of any plan year beginning in a calendar year after 2014:

i) the dollar amount under subsection (a)(1)(A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under subsection (a)(4) for the calendar year; and if the amount of any increase under subsection (a)(2)(B)(i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

ii) the dollar amount under subsection (a)(1)(A)(ii) shall be increased to an amount equal to twice the amount in effect under subsection (a)(1)(A)(i) for plan years beginning in the calendar year, determined after application of subsection (a)(2)(B)(i).

C) Actuarial Value

The limitation under this subsection (a) shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

D) Coordination with Preventive Limits

Nothing in this subsection (a) shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the federal Public Health Service Act (45 CFR 130).

3) Cost-Sharing

A) In general, the term "cost-sharing" in this Section includes:

i) deductibles, coinsurance, copayments or similar charges; and

ii) any other expenditure required of an insured individual that is a qualified medical expense (within the meaning of 26 USC 223(d)(2)) with respect to EHB covered under the plan.

B) Exceptions

The term "cost-sharing" in this Section does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

4) Premium Adjustment Percentage

For purposes of subsections (a)(1)(B)(i) and (a)(2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary). (See 42 USC 18022(c).)

b) Levels of Coverage

The levels of coverage described in this subsection (b) are as follows:

1)Bronze Level

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

2) Silver Level

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

3) Gold Level

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

4) Platinum Level

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan. (See 42 USC 18022(d).)

c) Actuarial Value (AV) Calculation for Determining Level of Coverage

1) Calculation of AV

Subject to subsection (c)(2), to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS.

2) Exception to the Use of the AV Calculator

If a health plan's design is not compatible with the AV Calculator, the issuer must meet the following:

A) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in subsection (c)(2)(B) or (C).

B) Calculate the plan's AV by:

i) Estimating a fit of its plan design into the parameters of the AV Calculator; and

ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies.

C) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator.

D) The calculation methods described in subsections (c)(2)(B) and (C) may include only in-network cost-sharing, including multi-tier networks.

3) Employer Contributions to Health Savings Accounts and Amounts Made Available Under Certain Health Reimbursement Arrangements

For plans other than those in the individual market that at the time of purchase are offered in conjunction with a Health Savings Account (HSA) or with integrated Health Reimbursement Accounts (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:

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

B) 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.

4) Use of State-Specific Standard Population for the Calculation of AV

Beginning in 2015, if submitted by the State and approved by HHS, a State-specific data set will be used as the standard population to calculate AV in accordance with subsection (c)(1). The data set may be approved by HHS if it is submitted in accordance with subsection (c)(5) and:

A) Supports the calculation of AVs for the full range of health plans available in the market;

B) Is derived from a non-elderly population and estimates those likely to be covered by private health plans on or after January 1, 2014;

C) Is large enough that:

i) The demographic and spending patterns are stable over time; and

ii) It includes a substantial majority of the State's insured population, subject to the requirement in subsection (c)(4)(B);

D) Is a statistically reliable and stable basis for area-specific calculations; and

E) Contains claims data on health care services typically offered in the then-current market.

5) Submission of State-Specific Data

AV will be calculated using the default standard population described in subsection (c)(6), unless a data set in a format specified by HHS that can support the use of the AV Calculator as described in subsection (c)(1) is submitted by a State and approved by HHS consistent with subsection (c)(4) by a date specified by HHS.

6) Default Standard Population

The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in subsection (c)(1). (See 45 CFR 156.135.)

d)Actuarial Value Levels of Coverage

1) General Requirement for Levels of Coverage

AV, calculated as described in subsection (c), and within a de minimis variation as defined in subsection (d)(3), determines whether a health plan offers a bronze, silver, gold or platinum level of coverage.

2) The levels of coverage are:

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

B) A silver health plan is a health plan that has an AV of 70 percent.

C) A gold health plan is a health plan that has an AV of 80 percent.

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

3) De Minimis Variation

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 ±2 percentage points. (See 45 CFR 146.140.)

e) Determination of Minimum Value

1) Acceptable Methods for Determining Minimum Value

An employer-sponsored plan provides minimum value (MV) if the percentage of the total allowed costs of benefits provided under the plan is no less than 60 percent. 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:

A) The MV Calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under subsection (e)(2).

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

C) If the plan is a group health plan, it 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 subsections (e)(1)(A) or (B). 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.

D) If the plan is in the small group market that meets any of the levels of coverage, as described in subsection (d), it satisfies MV.

2) Benefits that May Be Counted Towards the Determination of MV

A) 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.

B) For the purposes of applying the options described in subsection (e)(1) 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.

3) Standard Population

The standard population for MV determinations described in subsection (e)(1) 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.

4) 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:

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

B) 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. (45 CFR 156.145)

f) Application

In determining the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, this Section shall apply. (See 42 USC 18022(d)(2)(C).)

g) Allowable Variance

There may be a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates. (See 42 USC 18022(d)(3).)

h) Plan Reference

In this Section, any reference to a bronze, silver, gold or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold or platinum level of coverage, as the case may be. (See 42 USC 18022(d)(4).)

i) Catastrophic Plan

1) In General

A health plan not providing a bronze, silver, gold or platinum level of coverage shall be treated as meeting the requirements of subsection (b) with respect to any plan year if:

A) the only individuals who are eligible to enroll in the plan are individuals described in subsection (c)(2); and

B) the plan provides:

i) except as provided in subsection (c)(1)(B)(ii), the essential health benefits determined under Section 2001.11(c), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (a)(1) for the plan year (except as provided for in PHS Act section [2713](http://www.law.cornell.edu/uscode/text/42/2711)); and

ii) coverage for at least three primary care visits.

2) Individuals Eligible for Enrollment

An individual is described in this subsection (i)(2) for any plan year if the individual:

A) has not attained the age of 30 before the beginning of the plan year; or

B)has a certification in effect for any plan year under this Part that the individual is exempt from the requirement under 26 USC [5000A](http://www.law.cornell.edu/uscode/text/26/5000A) by reason of:

i) 26 USC [5000A](http://www.law.cornell.edu/uscode/text/26/5000A)(e)(1) (relating to individuals without affordable coverage); or

ii) 26 USC [5000A](http://www.law.cornell.edu/uscode/text/26/5000A)(e)(5) (relating to individuals with hardships).

3) Restriction to Individual Market

If a health insurance issuer offers a health plan described in this subsection (i), the issuer may only offer the plan in the individual market. (See 42 USC 18022(e).)

j) Child-Only Plans

If a qualified health plan is offered through the Health Benefits Exchange in any level of coverage specified under subsection (c), the issuer shall also offer that plan through the Health Benefits Exchange 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, and such plan shall be treated as a qualified health plan. (See 42 USC 18022(f).)

k) Payments to Federally Qualified Health Centers

If any item or service covered by a qualified health plan is provided by a Federally Qualified Health Center (as defined in 42 USC [1396d](http://www.law.cornell.edu/uscode/text/42/1396d)(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under 42 USC [1396a](http://www.law.cornell.edu/uscode/text/42/1396a)[(bb)](http://www.law.cornell.edu/uscode/text/42/usc_sec_42_00001396---a000-#bb)) for such item or service. (See 42 USC 18022(g).)

l) Mutually Agreed Payment Rates

Nothing in subsection (k) precludes a Qualified Health Plan issuer and a Federally Qualified Health Center from mutually agreeing upon payment rates other than those that would have been paid to the center under 42 USC 1396a(bb), as long as the mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in 45 CFR 156.235(d). (See 45 CFR 156.235(e).)

(Source: Amended at 38 Ill. Reg. 23379, effective November 25, 2014)