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## Part II

### Department of Health and Human Services

45 CFR Part 153, 155, 156, *et al.*

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Proposed Rule



SHOP for which it is effective for plan years beginning on or after October 1, 2013.

\* \* \* \* \*

**Large employer** means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define larger employer by substituting "51 employees" for "101 employees." The number of employees shall be determined using the method set forth in section 4980H (c)(2)(E) of the Code, effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which the method shall be used for plan years beginning on or after October 1, 2013.

\* \* \* \* \*

**Small employer** means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of plan years beginning before January 1, 2016, a State may elect to define small employer by substituting "50 employees" for "100 employees." The number of employees shall be determined using the method set forth in section 4980H (c)(2)(E) of the Code, effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which the method shall be used for plan years beginning on or after October 1, 2013.

\* \* \* \* \*

28. Section 155.220 is amended by revising paragraph (b) to read as follows—

**§ 155.220 Ability to States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.**

\* \* \* \* \*

(b)(1) *Web site disclosure.* The Exchange or SHOP may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange and may elect to limit the information to information regarding licensed agents and brokers who have completed any required Exchange or SHOP registration and training process.

(2) A Federally-facilitated Exchange or SHOP will limit the information provided on its Web site regarding licensed agents and brokers to information regarding licensed agents and brokers who have completed registration and training.

\* \* \* \* \*

29. Section 155.305 is amended by revising paragraph (g)(3) to read as follows:

**§ 155.305 Eligibility standards.**

\* \* \* \* \*

(g) \* \* \*

(3) *Special rule for family policies.* To the extent that an enrollment in a QHP in the individual market offered through an Exchange under a single policy covers two or more individuals who, if they were to enroll in separate individual policies would be eligible for different cost sharing, the Exchange must deem the individuals under such policy to be collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible:

- (i) Individuals not eligible for changes to cost sharing;
- (ii) Individuals described in § 155.350(b) (the special cost-sharing rule for Indians regardless of income);
- (iii) Individuals described in paragraph (g)(2)(iii) of this section;
- (iv) Individuals described in paragraph (g)(2)(ii) of this section;
- (v) Individuals described in paragraph (g)(2)(i) of this section; and
- (vi) Individuals described in § 155.350(a) (the cost-sharing rule for Indians with household incomes under 300 percent of the FPL).

\* \* \* \* \*

30. Section 155.330 is amended by adding paragraph (g) to read as follows:

**§ 155.330 Eligibility redetermination during a benefit year.**

\* \* \* \* \*

(g) *Recalculation of advance payments of the premium tax credit and cost-sharing reductions.* (1) When recalculating the amount of advance payments of the premium tax credit for which a tax filer is determined eligible as a result of an eligibility redetermination in accordance with this section, the Exchange must —

- (i) Account for any advance payments already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit

for the benefit year, calculated in accordance with 26 CFR 1.36B-3; and

- (ii) Ensure that that the advance payment provided on the tax filer's behalf is greater than or equal to zero and is calculated in accordance with 26 CFR 1.36B-3(d)(1).

(2) When redetermining eligibility for cost-sharing reductions in accordance with this section, the Exchange must determine an individual eligible for the category of cost-sharing reductions that corresponds to his or her expected annual household income for the benefit year (subject to the special rule for family policies set forth in § 155.305(g)(3).

31. Section 155.340 is amended by adding paragraphs (e) and (f) to read as follows:

**§ 155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.**

\* \* \* \* \*

(e) *Allocation of advance payments of the premium tax credit between policies.* If advance payments of the premium tax credit are to be made on behalf of a tax filer (or two tax filers who are a married couple), and individuals in the tax filer's tax household are enrolled in more than one QHP or stand-alone dental plan, then the advance payments must be allocated as follows:

- (1) That portion of the advance payment of the premium tax credit that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR § 1.36B-3(e), for the QHP policies properly allocated to EHB must be allocated among the QHP policies in proportion to the respective portions of the premiums for the policies properly allocated to EHB; and

(2) Any remaining advance payment of the premium tax credit must be allocated among the stand-alone dental policies (if any) in proportion to the respective portions of the adjusted monthly premiums for the stand-alone dental policies properly allocated to the pediatric dental essential health benefit.

(f) *Reduction of enrollee's portion of premium to account for advance payments of the premium tax credit.* If an Exchange is facilitating the collection and payment of premiums to QHP issuers and stand-alone dental plans on behalf of enrollees under § 155.240, and if a QHP issuer or stand-alone dental plan has been notified that it will receive an advance payment of the premium tax credit on behalf of an enrollee for whom the Exchange is facilitating such functions, the Exchange must—

(1) Reduce the portion of the premium for the policy collected from the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit; and

(2) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s) and the remaining premium owed for the policy.

32. Section 155.705 is amended by revising paragraph (b)(3) and by adding new paragraphs (b)(10)(i), (b)(10)(ii), (b)(11)(i) and (b)(11)(ii) to read as follows:

**§ 155.705 Functions of a SHOP.**

\* \* \* \* \*

(b) \* \* \*

(3) (i) *SHOP options with respect to employer choice requirements.* With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(ii) A Federally-facilitated SHOP will only permit a qualified employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section.

\* \* \* \* \*

(10) \* \* \*

(i) Subject to sections 2702 and 2703 of the Public Health Service Act, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of qualified employees accepting coverage under the employer's group health plan, divided by the number of qualified employees offered coverage, excluding from the calculation any employee who, at the time the employer submits the SHOP application, is enrolled in coverage through another employer's group health plan or through a governmental plan such as Medicare, Medicaid, or TRICARE.

(ii) Notwithstanding paragraph (b)(10)(i) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) \* \* \*

(i) To determine the employer and employee contributions, a SHOP may establish one or more standard methods that employers may use to define their

contributions toward employee and dependent coverage.

(ii) A Federally-facilitated SHOP must use the following method for employer contributions:

(A) The employer will select a level of coverage as described in paragraph (b)(2) and (b)(3) of this section.

(B) The employer will select a QHP within that level of coverage to serve as a reference plan on which contributions will be based.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage under the reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage under the reference plan.

(D) An employer may establish, to the extent allowed by Federal and State law, different percentages for different employee categories.

(E) Either State law or the employer may require that a Federally-facilitated SHOP base contributions on a calculated composite premium for the reference plan for employees, for adult dependents, and for dependents below age 21.

(F) The resulting contribution amounts for each employee's coverage may then be applied toward the QHP selected by the employee.

33. Section 155.1030 is added to read as follows:

**§ 155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.**

(a) *Review of plan variations for cost-sharing reductions.* (1) The Exchange must ensure that each issuer that offers or seeks to offer a health plan at any level of coverage in the individual market on the Exchange submits the required plan variations for the health plan as described in § 156.420 of this subchapter. The Exchange must certify that the plan variations meet the requirements of § 156.420.

(2) The Exchange must provide to HHS the actuarial values of each QHP and silver plan variation, calculated under § 156.135 of this subchapter, in the manner and timeframe established by HHS.

(b) *Information for administering advance payments of the premium tax credit and advance payments of cost-sharing reductions.* (1) The Exchange must collect and review annually the rate allocation, the expected allowed claims cost allocation, and the actuarial memorandum that an issuer submits to the Exchange under § 156.470 of this subchapter, to ensure that such

allocations meet the standards set forth in § 156.470(c) and (d).

(2) The Exchange must submit, in the manner and timeframe established by HHS, to HHS the approved allocations and actuarial memorandum underlying the approved allocations for each health plan at any level of coverage or stand-alone dental plan offered, or proposed to be offered in the individual market on the Exchange.

(3) The Exchange must collect annually any estimates and supporting documentation that a QHP issuer submits to receive advance payments of certain cost-sharing reductions, under § 156.430(a) of this subchapter, and submit, in the manner and timeframe established by HHS, the estimates and supporting documentation to HHS for review.

(4) HHS may use the information provided to HHS by the Exchange under this section for the approval of the estimates that an issuer submits for advance payments of cost-sharing reductions, as described in § 156.430 of this subchapter, and the oversight of the advance payments of cost-sharing reductions and premium tax credits programs.

**PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

34. The authority citation for part 156 is revised to read as follows:

*Authority:* Title I of the Affordable Care Act, sections 1301–1304, 1311–1312, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, and 1412, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

35. Section 156.20 is amended by adding definitions for “Federally-facilitated SHOP” and “Issuer group” in alphabetical order to read as follows:

**§ 156.20 Definitions.**

\* \* \* \* \*

*Federally-facilitated SHOP* has the meaning given to the term in § 155.20 of this subchapter.

\* \* \* \* \*

*Issuer group* means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.

\* \* \* \* \*

36. Section 156.50 is amended by revising paragraph (b) and by adding paragraph (c) to read as follows:

**§ 156.50 Financial support.**

\* \* \* \* \*

(b) *Requirement for State-based Exchange user fees.* A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under § 155.160 of this subchapter.

(c) *Requirement for Federally-facilitated Exchange user fee.* To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the billable members enrolled through the Exchange in the plan offered by the issuer, and the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for the applicable benefit year. For purposes of this paragraph, billable members are defined under 45 CFR 147.102(c)(1) as each family member in a policy, with a limitation of three family members under age 21.

37. Section 156.200 is amended by adding paragraphs (f) and (g) to read as follows:

**§ 156.200 QHP issuer participation standards.**

\* \* \* \* \*

(f) *Broker compensation in a Federally-facilitated Exchange.* A QHP issuer must pay the same broker compensation for QHPs offered through a Federally-facilitated Exchange that the QHP issuer pays for similar health plans offered in the State outside a Federally-facilitated Exchange.

(g) *Certification standard specific to a Federally-facilitated Exchange.* A Federally-facilitated Exchange may certify a QHP in the individual market of a Federally-facilitated Exchange only if the QHP issuer meets one of the conditions below:

(1) The QHP issuer also offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage as described in section 1302(d) of the Affordable Care Act;

(2) The QHP issuer does not offer small group market products in that State, but another issuer in the same issuer group offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or

(3) Neither the issuer nor any other issuer in the same issuer group offers a small group market product in that State.

38. Section 156.215 is added to read as follows:

**§ 156.215 Advance payments of the premium tax credit and cost-sharing reduction standards.**

(a) *Standards relative to advance payments of the premium tax credit and cost-sharing reductions.* In order for a health plan to be certified as a QHP initially and to maintain certification to be offered in the individual market on the Exchange, the issuer must meet the requirements related to the administration of cost-sharing reductions and advance payments of the premium tax credit set forth in subpart E of this part.

(b) [Reserved]

39. Section 156.285 is amended by adding paragraph (c)(7) to read as follows:

**§ 156.285 Additional standards specific to SHOP.**

\* \* \* \* \*

(c) \* \* \*

(7) A QHP issuer must enroll a qualified employee only if the Exchange—

(i) Notifies the QHP issuer that the employee is a qualified employee; and

(ii) Transmits information to the QHP issuer as provided in § 155.400(a) of this subchapter.

\* \* \* \* \*

40. Subpart E is added to read as follows:

**Subpart E—Health Insurance Issuer Responsibilities With Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions**

Sec.

156.400 Definitions.

156.410 Cost-sharing reductions for enrollees.

156.420 Plan variations.

156.425 Changes in eligibility for cost-sharing reductions.

156.430 Payment for cost-sharing reductions.

156.440 Plans eligible for advance payments of the premium tax credit and cost-sharing reductions.

156.460 Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.

156.470 Allocation of rates and claims costs for advance payments of cost-sharing reductions and the premium tax credit.

**Subpart E—Health Insurance Issuer Responsibilities With Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions**

\* § 156.400 Definitions.

The following definitions apply to this subpart:

*Advance payments of the premium tax credit* has the meaning given to the term in § 155.20 of this subchapter.

*Affordable Care Act* has the meaning given to the term in § 155.20 of this subchapter.

*Annual limitation on cost sharing* means the annual dollar limit on cost sharing required to be paid by an enrollee that is established by a particular qualified health plan.

*De minimis variation* means 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 as established in § 156.140(c)(1).

*De minimis variation for a silver plan variation* means a single percentage point.

*Federal poverty level or FPL* has the meaning given to the term in § 155.300(a) of this subchapter.

*Indian* has the meaning given to the term in § 155.300(a) of this subchapter.

*Limited cost sharing plan variation* means, with respect to a QHP at any level of coverage, the variation of such QHP described in § 156.420(b)(2).

*Maximum annual limitation on cost sharing* means the highest annual dollar amount that qualified health plans (other than QHPs with cost-sharing reductions) may require in cost sharing for a particular year, as established for that year under § 156.130.

*Most generous or more generous* means, between a QHP (including a standard silver plan) or plan variation, and one or more other plan variations of the same QHP, the QHP or plan variation designed for the category of individuals last listed in § 155.305(g)(3) of this subchapter.

*Plan variation* means a zero cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation.

*Reduced maximum annual limitation on cost sharing* means the dollar value of the maximum annual limitation on cost sharing for a silver plan variation that remains after applying the reduction, if any, in the maximum annual limitation on cost sharing required by section 1402 of the Affordable Care Act as announced in the annual HHS notice of benefit and payment parameters.

*Silver plan variation* means, with respect to a standard silver plan, any of the variations of that standard silver plan described in § 156.420(a).

*Stand-alone dental plan* means a plan offered through an Exchange under § 155.1065 of this subchapter.

*Standard plan* means a QHP offered at one of the four levels of coverage, defined at § 156.140, with an annual limitation on cost sharing that conforms to the requirements of § 156.130(a). A standard plan at the bronze, silver, gold, or platinum level of coverage is referred to as a standard bronze plan, a standard silver plan, a standard gold plan, and a standard platinum plan, respectively.

*Zero cost sharing plan variation* means, with respect to a QHP at any level of coverage, the variation of such QHP described in § 156.420(b)(1).

#### § 156.410 Cost-sharing reductions for enrollees.

(a) *General requirement.* A QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pay only the cost sharing required of an eligible individual for the applicable covered service under the plan variation. The cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected.

(b) *Assignment to applicable plan variation.* If an individual is determined to be eligible to enroll in a QHP in the individual market offered through an Exchange and elects to do so, the QHP issuer must assign the individual under enrollment and eligibility information submitted by the Exchange as follows—

(1) If the individual is determined eligible by the Exchange for cost-sharing reductions under § 155.305(g)(2)(i), (ii), or (iii) of this subchapter (subject to the special rule for family policies set forth in § 155.305(g)(3) of this subchapter) and chooses to enroll in a silver health plan, the QHP issuer must assign the individual to the silver plan variation of the selected silver health plan described in § 156.420(a)(1), (2), or (3), respectively.

(2) If the individual is determined eligible by the Exchange for cost-sharing reductions for Indians with lower household income under § 155.350(a) of this subchapter (subject to the special rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the zero cost sharing plan variation of the selected QHP with all cost sharing eliminated described in § 156.420(b)(1).

(3) If the individual is determined by the Exchange to be eligible for cost-

sharing reductions for Indians regardless of household income under § 155.350(b) of this subchapter (subject to the special rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the limited cost sharing plan variation of the selected QHP with the prohibition on cost sharing for benefits received from the Indian Health Service and certain other providers described in § 156.420(b)(2).

(4) If the individual is determined by the Exchange not to be eligible for cost-sharing reductions (including eligibility under the special rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the selected QHP with no cost-sharing reductions.

#### § 156.420 Plan variations.

(a) *Submission of silver plan variations.* For each of its silver health plans that an issuer seeks to offer or to continue to offer in the individual market on an Exchange, the issuer must submit annually to the Exchange for certification prior to each benefit year the standard silver plan and three variations of the standard silver plan, as follows—

(1) For individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 94 percent plus or minus the de minimis variation for a silver plan variation;

(2) For individuals eligible for cost-sharing reductions under § 155.305(g)(2)(ii) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 87 percent plus or minus the de minimis variation for a silver plan variation; and

(3) For individuals eligible for cost-sharing reductions under § 155.305(g)(2)(iii) of this subchapter, a

variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 73 percent plus or minus the de minimis variation for a silver plan variation (subject to § 156.420(h)).

(b) *Submission of zero and limited cost sharing plan variations.* For each of its health plans at any level of coverage that an issuer seeks QHP certification for the individual market on an Exchange, the issuer must submit to the Exchange for certification the health plan and two variations of the health plan, as follows—

(1) For individuals eligible for cost-sharing reductions under § 155.350(a) of this subchapter, a variation of the health plan with all cost sharing eliminated; and

(2) For individuals eligible for cost-sharing reductions under § 155.350(b) of this subchapter, a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through referral under contract health services.

(c) *Benefit and network equivalence in silver plan variations.* A standard silver plan and each silver plan variation thereof must cover the same benefits and providers, and require the same out-of-pocket spending for benefits other than essential health benefits. Each silver plan variation is subject to all requirements applicable to the standard silver plan (except for the requirement that the plan have an AV as set forth in § 156.140(b)(2)).

(d) *Benefit and network equivalence in zero and limited cost sharing plan variations.* A QHP and each zero cost sharing plan variation or limited cost sharing plan variation thereof must cover the same benefits and providers, and require the same out-of-pocket spending for benefits other than essential health benefits. A limited cost sharing plan variation must have the same cost sharing on items or services not described in paragraph (b)(2) of this section as the QHP with no cost-sharing reductions. Each zero cost sharing plan variation or limited cost sharing plan variation is subject to all requirements applicable to the QHP (except for the requirement that the plan have an AV as set forth in § 156.140(b)).

(e) *Decreasing cost sharing in higher AV silver plan variations.* The cost sharing required of enrollees under any silver plan variation of a standard silver plan for an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding cost sharing required in the standard silver plan or any other silver plan variation thereof with a lower AV.

(f) *Minimum AV differential between 70 percent and 73 percent silver plan variations.* Notwithstanding any permitted de minimis variation in AV for a health plan or permitted de minimis variation for a silver plan variation, the AVs of a standard silver plan and the silver plan variation thereof described in paragraph (a)(3) of this section must differ by at least 2 percentage points.

**§ 156.425 Changes in eligibility for cost-sharing reductions.**

(a) *Effective date of change in assignment.* If the Exchange notifies a QHP issuer of a change in an enrollee's eligibility for cost-sharing reductions (including a change in the individual's eligibility under the special rule for family policies set forth in § 155.305(g)(3) of this subchapter due to a change in eligibility of another individual on the same policy), then the QHP issuer must change the individual's assignment such that the individual is assigned to the applicable standard plan or plan variation of the QHP as required under § 156.410(b) as of the effective date of eligibility required by the Exchange.

(b) *Continuity of deductible and out-of-pocket amounts.* In the case of a change in assignment to a different plan variation (or standard plan without cost-sharing reductions) of the same QHP in the course of a benefit year under this section, the QHP issuer must ensure that any cost sharing paid by the applicable individual under previous plan variations (or standard plan without cost-sharing reductions) for that benefit year is taken into account in the new plan variation (or standard plan without cost-sharing reductions) for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

**§ 156.430 Payment for cost-sharing reductions.**

(a) *Estimates of value of cost-sharing reductions for purposes of advance payments.* (1) For each health plan that an issuer offers, or intends to offer, in the individual market on an Exchange as a QHP, the issuer must provide to the

Exchange annually prior to the benefit year, for approval by HHS, an estimate of the dollar value of the cost-sharing reductions to be provided over the benefit year. The estimate must:

(i) If the QHP is a silver health plan, identify separately the per member per month dollar value of the cost-sharing reductions to be provided under each silver plan variation identified in § 156.420(a)(1), (2), and (3);

(ii) Regardless of the level of coverage of the QHP, identify the per member per month dollar value of the cost-sharing reductions to be provided under the zero cost sharing plan variation;

(iii) Be accompanied by supporting documentation validating the estimate; and

(iv) Be developed using the methodology specified by HHS in the applicable annual HHS notice of benefit and payment parameters.

(2) If an issuer seeks advance payments for the cost-sharing reductions to be provided under the limited cost sharing plan variation of a health plan it offers, or seeks to offer, in the individual market on the Exchange as a QHP at any level of coverage, the issuer must provide to the Exchange annually prior to the benefit year, for approval by HHS, an estimate of the per member per month dollar value of the cost-sharing reductions to be provided over the benefit year under such limited cost sharing plan variation. The estimate must:

(i) Be accompanied by supporting documentation validating the estimate; and

(ii) Be developed using the methodology specified by HHS in the annual HHS notice of benefit and payment parameters.

(3) HHS's approval of the estimate will be based on whether the estimate is made consistent with the methodology specified by HHS in the annual HHS notice of benefit and payment parameters.

(b) *Advance payments.* A QHP issuer will receive periodic advance payments based on the approved advance estimates provided under paragraph (a) of this section and the actual enrollment in the applicable plan variation.

(c) *Submission of actual amounts.* A QHP issuer must submit to HHS, in the manner and timeframe established by HHS, the following—

(1) In the case of a benefit for which the QHP issuer compensates the applicable provider in whole or in part on a fee-for-service basis, the total allowed costs for essential health benefits charged for an enrollee's policy for the benefit year, broken down by what the issuer paid, what the enrollee

paid, and the amount reimbursed to the provider by the QHP issuer for the amount that the enrollee would have paid under the standard QHP without cost-sharing reductions; and

(2) In the case of a benefit for which the QHP issuer compensates the applicable provider in any other manner, the total allowed costs for essential health benefits charged for an enrollee's policy for the benefit year, broken down by what the issuer paid, what the enrollee paid, and what the enrollee would have paid under the standard QHP without cost-sharing reductions.

(d) *Reconciliation of amounts.* HHS will perform periodic reconciliations of any advance payments of cost-sharing reductions provided to a QHP issuer under paragraph (b) of this section against—

(1) The actual amount of cost-sharing reductions provided to enrollees and reimbursed to providers by the QHP issuer for benefits for which the QHP issuer compensates the applicable providers in whole or in part on a fee-for-service basis; and

(2) The actual amount of cost-sharing reductions provided to enrollees for benefits for which the QHP issuer compensates the applicable providers in any other manner.

(e) *Payment of discrepancies.* If the actual amounts of cost-sharing reductions described in paragraphs (d)(1) and (2) of this section are—

(1) More than the amount of advance payments provided and the QHP issuer has timely provided the actual amounts of cost-sharing reductions as required under paragraph (c) of this section, HHS will reimburse the QHP issuer for the difference; and

(2) Less than the amount of advance payments provided, the QHP issuer must repay the difference to HHS in the manner and timeframe specified by HHS.

(f) *Cost-sharing reductions during special periods.* (1) Notwithstanding the reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will not be eligible for reimbursement of any cost-sharing reductions provided following a termination of coverage effective date with respect to a grace period as described in § 155.430(b)(2)(ii)(A) or (B) of this subchapter. However, the QHP issuer will be eligible for reimbursement of cost-sharing reductions provided prior to the termination of coverage effective date. Advance payments of cost-sharing reductions will be paid to a QHP issuer prior to a determination of termination (including during any grace period, but the QHP issuer will be

required to repay any advance payments made with respect to any month after any termination of coverage effective date during a grace period).

(2) Notwithstanding the reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the termination (or the late determination thereof) is the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will not be eligible for advance payments and reimbursement for cost-sharing reductions provided during the period following the termination of coverage effective date and prior to the determination of the termination.

(3) Subject to the requirements of the reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the reason for the termination (or late determination thereof) is not the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during such period.

(4) Subject to the requirements of the reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during any period of coverage pending resolution of inconsistencies in information required to determine eligibility for enrollment under § 155.315(f) of this subchapter.

**§ 156.440 Plans eligible for advance payments of the premium tax credit and cost-sharing reductions.**

Except as noted in paragraph (a) through (c) of this section, the provisions of this subpart apply to qualified health plans offered in the individual market on the Exchange.

(a) *Catastrophic plans.* The provisions of this subpart do not apply to catastrophic plans as described in § 156.155.

(b) *Stand-alone dental plans.* The provisions of this subpart, to the extent relating to cost-sharing reductions, do not apply to stand-alone dental plans. The provisions of this subpart, to the extent relating to advance payments of

the premium tax credit, apply to stand-alone dental plans.

(c) *Child-only plans.* The provisions of this subpart apply to child-only QHPs, as described in § 156.200(c)(2).

**§ 156.460 Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.**

(a) *Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.* A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must—

(1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit;

(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and

(3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.

(b) *Delays in payment.* A QHP issuer may not refuse to commence coverage under a policy or terminate coverage on account of any delay in payment of an advance payment of the premium tax credit on behalf of an enrollee if the QHP issuer has been notified by the Exchange under § 155.340(a) of this subchapter that the QHP issuer will receive such advance payment.

**§ 156.470 Allocation of rates and claims costs for advance payments of cost-sharing reductions and the premium tax credit.**

(a) *Allocation to additional health benefits for QHPs.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each health plan at any level of coverage offered, or proposed to be offered in the individual market on an Exchange, an allocation of the rate and the expected allowed claims costs for the plan, in each case, to:

(1) EHB, other than services described in § 156.280(d)(1), and

(2) Any other services or benefits offered by the health plan not described in paragraph (a)(1) of this section.

(b) *Allocation to additional health benefits for stand-alone dental plans.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each stand-alone dental plan offered, or proposed to be offered, in the individual

market on the Exchange, a dollar allocation of the expected premium for the plan, to:

(1) The pediatric dental essential health benefit, and

(2) Any benefits offered by the stand-alone dental plan that are not the pediatric dental essential health benefit.

(c) *Allocation standards for QHPs.* The issuer must ensure that the allocation described in paragraph (a) of this section—

(1) Is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies;

(2) Reasonably reflects the allocation of the expected allowed claims costs attributable to EHB (excluding those services described in § 156.280(d)(1));

(3) Is consistent with the allocation applicable to State-required benefits to be submitted by the issuer under § 155.170(c) of this subchapter, and the allocation requirements described in § 156.280(e)(4) for certain services; and

(4) Is calculated under the fair health insurance premium standards described at 45 CFR 147.102, the single risk pool standards described at 45 CFR 156.80, and the same premium rate standards described at 45 CFR 156.255.

(d) *Allocation standards for stand-alone dental plans.* The issuer must ensure that the dollar allocation described in paragraph (b) of this section—

(1) Is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies;

(2) Is consistent with the allocation applicable to State-required benefits to be submitted by the issuer under § 155.170(c) of this subchapter;

(3) Is calculated under the fair health insurance premium standards described at 45 CFR 147.102, except for the provision related to age set forth at § 147.102(a)(1)(ii); the single risk pool standards described at 45 CFR 156.80; and the same premium rate standards described at 45 CFR 156.255 (in each case subject to paragraph (d)(4) of this section); and

(4) Is calculated so that the dollar amount of the premium allocable to the pediatric dental essential health benefit for an individual under the age of 19 years does not vary, and the dollar amount of the premium allocable to the pediatric dental essential health benefit for an individual aged 19 years or more is equal to zero.

(e) *Disclosure of attribution and allocation methods.* An issuer of a health plan at any level of coverage or a stand-alone dental plan offered, or proposed to be offered in the individual

market on the Exchange must submit to the Exchange annually for approval, an actuarial memorandum, in the manner and timeframe specified by HHS, with a detailed description of the methods and specific bases used to perform the allocations set forth in paragraphs (a) and (b), and demonstrating that the allocations meet the standards set forth in paragraphs (c) and (d) of this section, respectively.

#### PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

41. The authority citation for part 157 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1311, 1312, 1321, 1411, 1412, Pub. L. 111-148, 124 Stat. 199.

42. Section 157.20 is amended by adding the definitions for "Federally-facilitated SHOP," "Full-time employee," and "Large employer" in alphabetical order to read as follows:

##### § 157.20 Definitions.

\* \* \* \* \*

*Federally-facilitated SHOP* has the meaning given to the term in § 155.20 of this subchapter.

*Full-time employee* has the meaning given to the term in § 155.20 of this subchapter.

*Large employer* has the meaning given to the term in § 155.20 of this subchapter.

\* \* \* \* \*

#### PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

43. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 U.S.C. 300gg-18), as amended.

44. Section 158.110 is amended by revising paragraph (b) to read as follows:

##### § 158.110 Reporting requirements related to premiums and expenditures.

\* \* \* \* \*

(b) *Timing and form of report.* The report for each of the 2011, 2012, and 2013 MLR reporting years must be submitted to the Secretary by June 1 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary. Beginning with the 2014 MLR reporting year, the report for each MLR reporting year must be submitted to the Secretary by July 31 of the year following the end of an MLR reporting year, on a form and

in the manner prescribed by the Secretary.

\* \* \* \* \*

45. Section 158.130 is amended by adding paragraph (b)(5) to read as follows:

##### § 158.130 Premium revenue.

\* \* \* \* \*

(b) \* \* \*

(5) Account for the net payments or receipts related to risk adjustment, risk corridors, and reinsurance programs under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, 18062, 18063.

46. Section 158.140 is amended by adding paragraph (b)(4)(ii) and revising paragraph (b)(5)(i) to read as follows:

##### § 158.140 Requirements for clinical services provided to enrollees.

\* \* \* \* \*

(b) \* \* \*

(4) \* \* \*

(ii) Net payments or receipts related to risk adjustment, risk corridors, and reinsurance programs under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, 18062, 18063.

(5) \* \* \*

(i) Affiliated issuers that offer group coverage at a blended rate may choose whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula that must be defined by the issuer prior to January 1 of the MLR reporting year, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate.

\* \* \* \* \*

47. Section 158.162 is amended by revising paragraph (b)(1)(vii) and adding paragraph (b)(1)(viii) to read as follows:

##### § 158.162 Reporting of Federal and State taxes.

\* \* \* \* \*

(b) \* \* \*

(1) \* \* \*

(vii) Payments made by a Federal income tax exempt issuer for community benefit expenditures as defined in paragraph (c) of this section, limited to the highest of either:

(A) Three percent of earned premium;

or

(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the issuer's

earned premium in the applicable State market.

(viii) In lieu of reporting amounts described in paragraph (b)(1)(vi) of this section, an issuer that is not exempt from Federal income tax may choose to report payment for community benefit expenditures as described in paragraph (c) of this section, limited to the highest premium tax rate in the State for which the report is being submitted multiplied by the issuer's earned premium in the applicable State market.

\* \* \* \* \*

48. Section 158.221 is amended by revising paragraph (c) to read as follows:

##### § 158.221 Formula for calculating an issuer's medical loss ratio.

\* \* \* \* \*

(c) *Denominator.* The denominator of an issuer's MLR must equal the issuer's premium revenue, as defined in § 158.130, excluding the issuer's Federal and State taxes and licensing and regulatory fees, described in §§ 158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, described in § 158.130(b)(5).

49. Section 158.232 is amended by revising paragraph (c)(1)(i) and paragraph (d) introductory text to read as follows:

##### § 158.232 Calculating the credibility adjustment.

\* \* \* \* \*

(c) \* \* \*

(1) \* \* \*

(i) The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be the lesser of: the deductible applicable to each of the individual family members; or the overall family deductible for the subscriber and subscriber's family divided by two (regardless of the total number of individuals covered through the subscriber).

\* \* \* \* \*

(d) *No credibility adjustment.* Beginning with the 2013 MLR reporting year, the credibility adjustment for and MLR based on partially credible experience is zero if both of the following conditions are met:

\* \* \* \* \*

50. Section 158.240 is amended by revising paragraphs (c) and (d) to read as follows:

##### § 158.240 Rebating premium if the applicable medical loss ratio standard is not met.

\* \* \* \* \*

(c) *Amount of rebate to each enrollee.*  
(1) For each MLR reporting year, an

issuer must rebate to the enrollee the total amount of premium revenue, as defined in § 158.130 of this part, received by the issuer from the enrollee, after subtracting Federal and State taxes and licensing and regulatory fees as provided in §§ 158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance as provided in § 158.130(b)(5), multiplied by the difference between the MLR required by § 158.210 or § 158.211, and the issuer's MLR as calculated under § 158.221.

(2) For example, an issuer must rebate a pro rata portion of premium revenue if it does not meet an 80 percent MLR for the individual market in a State that has not set a higher MLR. If an issuer has a 75 percent MLR for the coverage it offers in the individual market in a State that has not set a higher MLR, the issuer must rebate 5 percent of the premium paid by or on behalf of the enrollee for the MLR reporting year after subtracting taxes and fees and accounting for payments or receipts related to reinsurance, risk adjustment and risk corridors. In this example, an enrollee may have paid \$2,000 in premiums for the MLR reporting year. If the issuer received net payments related to reinsurance, risk adjustment and risk corridors of \$200, the gross earned

premium would be \$2,200. If the Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in §§ 158.161(a), 158.161(a)(1), and 158.162(b)(1) are \$150 and the net payments related to reinsurance, risk adjustment and risk corridors that must be accounted for in premium revenue as described in §§ 158.130(b)(5), 158.221 and 158.240 are \$200, then the issuer would subtract \$150 and \$200 from gross premium revenue of \$2,200, for a base of \$1,850 in premium. The enrollee would be entitled to a rebate of 5 percent of \$1,850, or \$92.50.

(d) *Timing of rebate.* For each of the 2011, 2012, and 2013 MLR reporting years, an issuer must provide any rebate owing to an enrollee no later than August 1 following the end of the MLR reporting year. Beginning with the 2014 MLR reporting year, an issuer must provide any rebate owing to an enrollee no later than September 30 following the end of the MLR reporting year.

51. Section 158.241 is amended by revising paragraph (a)(2) to read as follows:

§ 158.241 Form of rebate.

(a) \* \* \*  
(2) For each of the 2011, 2012, and 2013 MLR reporting years, any rebate

provided in the form of a premium credit must be provided by applying the full amount due to the first month's premium that is due on or after August 1 following the MLR reporting year. If the amount of the rebate exceeds the premium due for August, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited. Beginning with the 2014 MLR reporting year, any rebate provided in the form of a premium credit must be provided by applying the full amount due to the first month's premium that is due on or after September 30 following the MLR reporting year. If the amount of the rebate exceeds the premium due for October, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited.

\* \* \* \* \*

Dated: November 28, 2012.  
Marilyn Tavenner,  
Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 28, 2012.  
Kathleen Sebelius,  
Secretary, Department of Health and Human Services.

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## Part V

### Department of Health and Human Services

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45 CFR Parts 147, 155, and 156

Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule

(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 an AV of 90 percent.

(c) *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  $\pm 2$  percentage points.

**§ 156.145 Determination of minimum value.**

(a) *Acceptable methods for determining MV.* For the purposes of determining that an employer-sponsored plan provides MV, a group health plan may use the following methods to calculate the percentage of the total allowed costs of benefits provided under the plan or coverage:

(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 an appropriate certification by an actuary to determine MV if neither of the methods described in paragraphs (a)(1) or (2) of this section is appropriate. 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.

(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 this purpose of the options described in this subsection 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 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 shall reflect the

population covered by self-insured group health plans.

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

(a) *Annual limitation on cost-sharing.* A stand-alone dental plan covering the pediatric dental EHB under § 155.1065 of this subchapter must demonstrate to the Exchange that it has a reasonable annual limitation on cost-sharing. Such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services.

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

(1) May not use the AV calculator in § 156.135 of this subpart;

(2) Must demonstrate that the stand-alone dental plan offers the pediatric dental essential health benefit at either:

(i) A low level of coverage with an AV of 75 percent; or

(ii) A high level of coverage with an AV of 85 percent; and

(iii) Within a *de minimis* variation of  $\pm 2$  percentage points of the level of coverage in paragraphs (b)(2)(i) or (ii) of this section.

(3) The level of coverage as defined in paragraph (b)(2) of this section must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.

9. In § 156.275, revise paragraphs (c)(1), (c)(4) introductory text, and (c)(4)(i) to read as follows:

**§ 156.275 Accreditation of QHP issuers.**

\* \* \* \* \*

(c) \* \* \*  
(1) *Recognition of accrediting entity by HHS—(i) Application.* An accrediting entity may apply to HHS for recognition. An application must include the documentation described in paragraph (c)(4) of this section and demonstrate, in a concise and organized fashion how the accrediting entity meets the requirements of paragraphs (c)(2) and (3) of this section.

(ii) *Proposed notice.* Within 60 days of receiving a complete application as described in paragraph (c)(1)(i) of this section, HHS will publish a notice in the Federal Register identifying the accrediting entity making the request, summarizing HHS's analysis of whether the accrediting entity meets the criteria described in paragraphs (c)(2) and (3) of this section, and providing no less than a 30-day public comment period about whether HHS should recognize the accrediting entity.

(iii) *Final notice.* After the close of the comment period described in paragraph (c)(1)(ii) of this section, HHS will notify the public in the Federal Register of the

names of the accrediting entities recognized and those not recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs.

(iv) *Other recognition.* Effective upon completion of conditions listed in paragraphs (c)(2), (3), and (4) of this section, HHS will notify the public in the Federal Register, that the National Committee for Quality Assurance (NCQA) and URAC are recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs meeting the requirements of this section.

\* \* \* \* \*  
(4) *Documentation.* An accrediting entity applying to be recognized under the process described in (c)(1) of this section must provide the following documentation:

(i) To be recognized, an accrediting entity must provide current accreditation standards and requirements, processes and measure specifications for performance measures to demonstrate that it meets the conditions described in paragraphs (c)(2) and (3) of this section to HHS.

\* \* \* \* \*  
Dated: August 1, 2012.

Marilyn Tavenner,  
Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 14, 2012.

Kathleen Sebelius,  
Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations:

**Appendix A: List of Proposed Essential Health Benefits Benchmarks**

The purpose of this appendix is to list the proposed EHB benchmark plans for the 50 states and the District of Columbia for public review and comment. As described in the EHB Bulletin published December 16, 2011, and proposed in § 156.100 of this regulation, each state may select a benchmark plan to serve as the standard for plans required to offer EHB in the state.<sup>52</sup> HHS has also proposed that the default benchmark plan for states that do not exercise the option to select a benchmark health plan would be the largest plan by enrollment in the largest product in the state's small group market. As described in proposed § 156.110, an EHB-benchmark plan must offer coverage in each of the 10 statutory benefit categories. In the summary table that follows, we list the proposed EHB benchmark plans. Additional information on

<sup>52</sup> Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges along with certain other types of plans must cover EHBs beginning in 2014. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

From Appendix A

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State	Plan type	Issuer and plan name	Supplemented categories	Supplementary plan type	Habilitative services
			Pediatric vision .....	FEDVIP.	
Indiana .....	Plan from largest small group product.	Anthem Blue Cross and Blue Shield of Indiana Blue 5 Blue Access PPO Medical Option 6 Rx Option G.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Iowa .....	Plan from largest small group product.	Wellmark Inc. Alliance Select Copayment Plus PPO.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Kansas .....	Plan from largest small group product.	Blue Cross and Blue Shield of Kansas Comprehensive Major Medical Blue Choice PPO GF 500 deductible with Blue Rx card.	Pediatric oral .....	FEDVIP .....	No.
			Pediatric vision .....	FEDVIP.	
* Kentucky .....	Plan from largest small group product.	Anthem Health Plans of Kentucky, Inc. PPO.	Pediatric oral .....	CHIP .....	Yes.
Louisiana .....	Plan from largest small group product.	Blue Cross and Blue Shield of Louisiana GroupCare PPO.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Maine .....	Plan from largest small group product.	Anthem Health Plans of Maine Blue Choice 20 PPO with RX 10 30 50 50.	Pediatric oral .....	FEDVIP .....	Yes.
Maryland .....	Largest state employee plan.	CareFirst of Maryland, Inc. State of Maryland PPO.	Pediatric oral .....	CHIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Massachusetts .....	Plan from largest small group product.	Blue Cross Blue Shield of Massachusetts, Inc. HMO Blue 2000 Deductible.	Pediatric oral .....	CHIP .....	Yes.
Michigan .....	Largest state non-Medicaid HMO.	Priority Health PriorityHMO 100 Percent Hospital Services Plan.	Pediatric oral .....	CHIP .....	No.
			Pediatric vision .....	FEDVIP.	
Minnesota .....	Plan from largest small group product.	HealthPartners 500 25 Open Access PPO.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Mississippi .....	Plan from largest small group product.	Blue Cross and Blue Shield of Mississippi Network Blue PPO.	Pediatric oral .....	CHIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Missouri .....	Plan from largest small group product.	Healthy Alliance Life Insurance Co. (Anthem BCBS) Blue 5 Blue Access PPO Medical Option 4 Rx Option D.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Montana .....	Plan from largest small group product.	Blue Cross and Blue Shield of Montana Blue Dimensions PPO.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Nebraska .....	Plan from largest small group product.	Blue Cross and Blue Shield of Nebraska BluePride PPO.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	
Nevada .....	Plan from largest small group product.	Rocky Mountain Hospital & Medical Service, Inc. (Anthem BCBS) GenRx PPO 45 Copay.	Pediatric oral .....	FEDVIP .....	Yes.
			Pediatric vision .....	FEDVIP.	

Kentucky Health Exchange  
 Dental & Vision Subcommittee  
 January 20, 2013

