**Table A. Requirements That May Be Included in Federal Public Health Service Act (PHS Act) Market Conduct Examinations**

***Note: This list is being provided for illustrative purposes. It is not intended to be all-inclusive of the statutory or regulatory requirements that may be included as part of a Federal PHS Act Market Conduct Examination.***

| Summary of Provision | Citation(s) |
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| **Discrimination Based on Health Status**<br>Issuers[1] or group health plans may not establish any rule for eligibility of any individual to enroll for benefits under the terms of the plan or charge more in premiums or contributions for coverage because of any of the following health factors:<br>• Health status<br>• Medical condition (as defined in § 144.103)<br>• Claims experience<br>• Receipt of health care<br>• Medical history<br>• Genetic information (as defined in § 146.122(a))<br>• Evidence of insurability (as defined in § 146.121(a)(2))<br>• Disability | **45 C.F.R. § 146.121**<br>**45 C.F.R. § 147.110** |
| **Coverage for Mothers and Newborns (NMPHA)**<br>Issuers or group health plans providing benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. In addition there are requirements for early discharge of mother of newborn to be a decision made by an attending physician in consultation with the mother or newborn's representative, a prohibition on incentives to the mother or provider, a prohibition on penalizing providers, and a notice requirement.<br><br>**Note:** NMPHA may not apply in some States that satisfy specified requirements. | **45 C.F.R. § 146.130**<br>**45 C.F.R. § 148.170** |
| **Parity in Mental Health and Substance Use Disorder Benefits (MHPAEA)**<br>Issuers or group health plans that provide mental health and substance use disorder benefits are prohibited from imposing less favorable benefit limitations (e.g., financial requirements, quantitative treatment limits and non-quantitative treatment limits) for mental health and substance abuse services than on coverage for medical and surgical services. | **45 C.F.R. § 146.136(b)**<br>**45 C.F.R. § 147.160** |
| **Disclosure of Information**<br>Issuers must disclose the following in its solicitation and sales materials to employers and individuals:<br>• The issuer's right to change premium rates and factors that affect changes in premium rates<br>• Renewability of coverage<br>• Any preexisting condition exclusion | **45 C.F.R. § 146.160** |

[1] References to "issuers" in this document includes health insurance issuers that provide health insurance coverage in the individual, small group and large group markets, unless indicated otherwise.

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| • Any affiliation periods applied by HMOs<br>• Geographic areas service by HMOs | |
| **Fair Health Insurance Premiums**<br>Issuers in the individual and small group markets are allowed to vary premiums for non-grandfathered singe risk pool coverage based only on the following factors :<br>• Whether the plan or coverage covers an individual or family<br>• Geographic rating area<br>• Age (3:1)<br>• Tobacco use (1.5:1) | **45 C.F.R. § 147.102**<br>• § 147.102(a)(1) |
| **Guaranteed Availability**<br>Each issuer that offers non-grandfathered single risk pool coverage in the individual or group market in a state must accept every individual or employer, respectively, in that state that applies for coverage, with certain exceptions. | **45 C.F.R. § 147.104** |
| **Guaranteed Renewability**<br>Each issuer offering coverage in the group or individual market is required to renew or continue in force the coverage at the option of the plan sponsor or individual except for the following reasons:<br>• Nonpayment of premiums<br>• Fraud<br>• Violation of participation or contribution rules<br>• Termination of plan<br>• Enrollees' movement outside service area<br>• Association membership ceases | **45 C.F.R. § 147.106**<br>• § 147.106(a)<br>• § 147.106(b) |
| **Preexisting Condition Exclusions**<br>Issuers in the group market or group health plans may not apply pre-existing condition exclusions to any enrollee. Also extends to issuers of non-grandfathered single risk pool coverage in the individual market. | **45 C.F.R. § 147.108**<br>**45 C.F.R. § 146.111** |
| **Excessive Waiting Periods**<br>Issuers in the group market or group health plans may not apply any waiting period (as defined in PHS Act § 2704(b)(4) ) that exceeds 90 days. | **45 C.F.R. § 147.116** |
| **Lifetime Limits**<br>Issuers or group health plans may not impose lifetime limits on the dollar value of EHBs. | **45 C.F.R. § 147.126(a)(1)** |
| **Annual Limits**<br>Issuers or group health plans may not impose annual limits on the dollar value of EHBs for plan years beginning on or after January 1, 2014.<br><br>Restricted annual limits on the dollar value of EHBs were permitted for plan years beginning before January 1, 2014.<br><br>Does not apply to grandfathered plans in the individual market. | **45 C.F.R. § 147.126(a)(2)** |
| **Rescissions**<br>Issuers or group health plans may not rescind coverage, unless the individual or group performs an act, practice, or omission that constitutes fraud or intentional misrepresentation of a material fact by the enrollee. A discontinuation or cancellation with retroactive effect due to non-payment of premiums is not a rescission. | **45 C.F.R. § 147.128(a)(1)** |

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| A health insurance issuer or group health plan is required to provide thirty (30) days' advance written notice prior to rescinding coverage. | |
| **Preventive Health Services**<br>Issuers or group health plans must provide coverage for the following items and services without imposing any cost sharing requirements:<br>• Current, USPSTF A or B rated items or services with respect to the individual involved;<br>• For infants, children, and adolescents, evidence-informed preventive care screenings supported by HRSA guidelines;<br>• For women, evidence-informed preventive care screenings recommended by HRSA and not already included in recommendations by the USPSTF; and<br>• Immunizations for routine use in children, adolescents, and adults with recommendation from ACIP of the CDC.<br><br>Issuers and group health plans are not required to cover recommended preventive services delivered by out-of-network providers and may impose cost-sharing requirements for such providers.[2]<br><br>Does not apply to grandfathered plans in the individual or group markets. | **45 C.F.R. § 147.130** |
| **Appeals**<br>Issuers or group health plans for non-grandfathered coverage must provide a description of available claims procedures, internal appeals and external review processes, including information regarding how to initiate an appeal. The issuer must also describe the exceptions available to exhausting the internal review and appeals process.<br><br>The issuer or group health plan must provide oral language services, including answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language, using culturally & linguistically appropriate services. | **45 C.F.R. § 147.136** |
| **Choice of Health Care Professional**<br>For non-grandfathered coverage, if the issuer or group health plan requires or allows for designation of a primary care provider, then the issuer or group health plan must permit each individual to designate any participating primary care provider who is available to accept such individual. | **45 C.F.R. § 147.138(a)(1)** |
| **Choice of Pediatrician as Primary Care Provider**<br>For non-grandfathered coverage, if the issuer or group health plan requires or allows for designation of a PCP for a child, a person shall be permitted to designate a physician who specializes in pediatrics (allopathic or osteopathic) as a child's primary care provider, if such provider participates in the network of the plan or issuer and is available to accept the child. | **45 C.F.R. § 147.138(a)(2)** |

[2] While nothing in the interim final regulations generally requires a plan or issuer that has a network of providers to provide benefits for preventive services provided out-of-network, this provision is premised on enrollees being able to access the required preventive services from in-network providers. Thus, if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service. See ACA FAQ 12 Q3.

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| **Direct Access to Obstetrical and Gynecological Care**<br>For non-grandfathered coverage, an issuer or group health plan that provides coverage for OB/GYN care and requires the designation of a PCP: (1) may not require prior authorization or a referral for a female patient to see a participating provider specializing in OB/GYN care; and (2) must permit OB/GYN providers to directly refer for or order OB/GYN-related items and services without prior authorization or approval of another provider, including a PCP. | **45 C.F.R. § 147.138(a)(3)** |
| **Notice Requirement**<br>For non-grandfathered coverage, issuers or group health plans must provide notice of the patient protections listed in § 147.138(a)(1)-(3) to each participant of a group health plan or the primary subscriber of a policy and can be in the Summary Plan Description (SPD). The notice must be included whenever a new SPD/policy/certificate is issued. | **45 C.F.R. § 147.138(a)(4)** |
| **Coverage of Emergency Services**<br>If an issuer or group health plan covers emergency services benefits in a hospital, then those services shall be covered:<br>• Without the need for a prior authorization determination;<br>• Without regard to whether the provider furnishing such services is a participating provider with respect to such services; and<br>• If such services are provided by an out of network provider, without imposing administrative requirements or coverage limitations that are more restrictive than or cost sharing requirements that exceed those that would apply if such services were provided in-network. | **45 C.F.R. § 147.138(b)** |
| **Essential Health Benefits**<br>Issuers of non-grandfathered single risk pool compliant coverage in the individual and small group markets must provide EHBs for plan or policy years beginning in 2014, which include items and services within at least the following categories:<br>• Ambulatory patient services<br>• Emergency services<br>• Hospitalization<br>• Maternity and newborn care<br>• Mental health and substance use disorder services, including behavioral health treatment<br>• Prescription drugs<br>• Rehabilitative and habilitative services and devices<br>• Laboratory services<br>• Preventive and wellness services and chronic disease management<br>• Pediatric services, including oral and vision care | **45 C.F.R. § 147.150(a)**<br>• § 156.110 |
| **Clinical Trials**<br>Issuers in the group market that cover a "qualified individual" (as defined in § 2709(b)) may not do any of the following:<br>• Deny the individual from participating in a specified approved clinical trial;<br>• Deny (or limit or impose additional conditions on) coverage of routine patient costs (as defined in § 2709(a)(2)) for items and | **PHS Act § 2709** |

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| services furnished in connection to the individual's participation in the trial (to the extent provided within the plan's network, if applicable); or<br>• Discriminate against the individual on the basis of his/her participation in the trial.<br><br>Does not apply to grandfathered plans or transitional plans. | |
| **Dependent Coverage until 26 Years of Age**<br>Issuers or group health plans that issue policies providing for dependent coverage for children must continue to make such coverage available to married and unmarried dependents up to age 26. Issuers or group health plans may define dependent eligibility only in terms of the relationship between the dependent. | **45 C.F.R. § 147.120**<br>• § 147.120(a)<br><br>• § 147.120(b) |
| **Summary of Benefits and Coverage (SBC)**<br>Issuers or group health plans must provide a SBC, in the format and with the information prescribed, for each benefit package without charge to entities and individuals.<br><br>Issuers or group health plans that makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees or covered individuals not later than 60 days prior to the date on which the modification will become effective. | **45 C.F.R. § 147.200(a), (b)** |
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| **Women's Health and Cancer Rights Act of 1998 (WHCRA)**<br>Issuers or group health plans must cover the following treatments following a mastectomy:<br>1. All stages of reconstruction of the breast on which the mastectomy was performed;<br>2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and<br>3. Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.<br>In addition, there are enrollment and annual notice requirements and prohibitions on penalizing providers or incentives to providers.<br><br>**Note:** State preemption: WHCRA does not preempt a State law in effect on October 21, 1998 that requires coverage of at least the coverage of reconstructive breast surgery otherwise required by WHCRA. | **PHS Act § 2727 (42 U.S.C. § 300gg-27)**<br><br>**PHS Act § 2752 (42 U.S.C. § 300gg-52)** |
| **Genetic Information and Nondiscrimination Act (GINA)**<br>Prohibits issuers or group health plans from:<br>• Denying coverage based on family history or genetic information;<br>• Setting or increasing the group premium or contribution amounts based on family history or genetic information;<br>• Requesting or requiring an individual or family member to undergo a genetic test; and<br>• Requesting, requiring, or purchasing genetic information prior to or | **45 C.F.R. 146.121(c)(2)(i)**<br><br>**45 C.F.R. 146.122** |

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| in connection with enrollment, or at any time for underwriting purposes. | |
| **Wellness Program Provisions**<br>Incentives for non-discriminatory wellness programs in group health plans permitted. Plan years beginning on or after January 1, 2014, maximum reward can be up to 30 percent (i.e. Department has authority to increase the maximum reward up to 50 percent). | **45 C.F.R. 146.121** |
| **Non-Discrimination in Health Care**<br>Issuers or group health plans may not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of the provider's license or certification under applicable state law.<br><br>Does not apply to grandfathered coverage or transitional plans. | **PHS Act § 2706**<br><br>**42 U.S.C. § 300gg-5** |