

FEDERAL MARKET REFORMS NON-GRANDFATHERED PLAN PROVISIONS

Form Review / Market Conduct Examination Compliance Checklist

Note: Grandmothered plans are a type of non-grandfathered plan. However, under a non-enforcement policy, many (but not all) of the Affordable Care Act (ACA) federal market reform requirements from which grandfathered plans are exempted under the law are not enforced against these plans. This chart is specific to non-grandfathered health plans that are subject to the 2014 ACA market reforms, as well as the No Surprises Act (NSA) and other Consolidated Appropriations Act, 2021 (CAA, 2021) federal market reform provisions.

Disclaimer: This document contains a summary of Federal statutes, regulations and guidance ONLY and DOES NOT constitute legal advice. Please view those materials directly for additional guidance. All information contained in the document is up-to-date as of August 9, 2023.

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Rating Factors: PHS Act § 2701	
Regulation:	45 CFR § 147.102
Market:	Individual & Small Group Markets; Large Group IF offered through Exchange
Statute Applicability Date(s):	Small group & individual markets: plans beginning on or after January 1, 2014. Large group Market: for coverage offered through an Exchange starting in 2017, in states where permitted.
Summary of Provision:	Fair health insurance premiums. With respect to the premium rate charged for a particular plan or coverage, only rating factors allowed: <ol style="list-style-type: none"> 1. Family (generally per-member build-up; 3-covered child cap under age 21); 2. Geographic rating area; 3. Age (3:1); and 4. Tobacco use (1.5:1).
Resources:	CCIIO Website: Overview: Final Rule for Health Insurance Market Reform State Specific Rating Areas

Guaranteed Availability: PHS Act § 2702	
Regulation:	45 CFR § 147.104
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2014.
Summary of Provision:	Each issuer that offers 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. An issuer may restrict enrollment to open or special enrollment periods (the latter requires issuers to offer enrollment periods for qualifying life events).
Notes:	<p>In the <u>group</u> market, an employer may purchase coverage at any time during the year (see 45 CFR § 147.104(b)(1)).</p> <p>In the small group market, the issuer may decline to offer coverage outside of a limited annual enrollment period (Nov. 15-Dec. 15) to a plan sponsor unable to comply with employer contribution or group participation rules (see 45 CFR § 147.104(b)(1)(i)(B)).</p> <p>In the small group market, and in the large group market if such coverage is offered through a Small Business Health Options Program (SHOP), coverage becomes effective consistent with the dates described in 45 CFR § 155.726.</p> <p>In the <u>individual</u> market, coverage becomes effective consistent with the dates in 45 CFR § 155.410 and 45 CFR § 155.420, and coverage must be available, unless otherwise permitted, during specified annual, limited open, and special open enrollment periods (see 45 CFR § 147.104(b) and 45 CFR § 155.420).</p> <p>Per 45 CFR § 147.104(b)(3), issuers must provide special enrollment rights for qualifying events as defined under 29 U.S.C. § 1163.</p> <p>There are special rules for network plans limiting eligibility for enrollment at 45 CFR § 147.104(c).</p> <p>Application of financial capacity limits can be found at 45 CFR § 147.104(d).</p>

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	<p>Additionally, the issuer may deny coverage if it has demonstrated to the applicable state authority (if required by the state authority) that it lacks the financial reserves necessary to offer additional coverage, provided it applies denials uniformly without regard to health status.</p> <p>However, if making this demonstration then the issuer is barred from offering coverage for 180 days or, until it demonstrates to the applicable state authority, if required under applicable state law, that it has sufficient financial resources to underwrite additional coverage.</p>
Resources:	<p>CCIIO Website: Overview: Final Rule for Health Insurance Market Reform</p> <p>FAQs: FAQ on Qualified Health Plans and Guaranteed Availability Standards</p>

Guaranteed Renewability: PHS Act § 2703	
Regulation:	45 CFR § 147.106
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2014.
Summary of Provision:	<p>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 unless:</p> <ol style="list-style-type: none"> 1. Nonpayment of premiums or employer contributions; 2. Fraud; 3. Violation of participation or contribution rules; 4. Discontinuation of plan; 5. Enrollees' movement outside service area; or 6. Association membership ceases.
Notes:	<p>There are specific rules for when an issuer is discontinuing a particular product or discontinuing all coverage. In both cases, the discontinuation must be in accordance with state law made after written notice to enrollees (90 days for a particular product, or 180 days for all coverage).</p> <p>If the issuer is discontinuing a particular product then it must give the option of enrolling in other coverage offered in the same market. Additionally, the discontinuance must be applied without considering claims or health status factors of existing or prospective participants. If the issuer is discontinuing all coverage then it may not offer health insurance in the same market and state for 5 years.</p> <p>There are exceptions for uniform modification of coverage. Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan or an individual in the following:</p> <ol style="list-style-type: none"> 1. Large group market; 2. Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with state law and is effective uniformly among group health plans with that product; and 3. Individual market if the modification is consistent with State law and is effective uniformly for all individuals with that product.
Resources:	<p>CCIIO Website: Overview: Final Rule for Health Insurance Market Reform</p> <p>Renewal and Product Discontinuation Notices in the Individual Market</p>

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	<p>Safe Harbor for Individual Market Product Discontinuation Notices in 2022 Benefit Year</p> <p>FAQs: Uniform Modification and Plan/Product Withdrawal FAQ</p>
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Preexisting Condition Exclusions: PHS Act § 2704	
Regulation:	45 CFR § 147.108
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	<p>Effective for children (enrollees under 19 years of age) for plan year in the Individual market or policy years beginning on or after September 23, 2010.</p> <p>Effective for adults for plan years in the Individual and group markets or policy years beginning on or after January 1, 2014.</p>
Summary of Provision:	A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion (as defined in 45 CFR § 144.103).
Notes:	Under 45 C.F.R § 144.103, a preexisting condition exclusion is defined to include any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage.

Special Enrollment Periods: PHS Act § 2704(f)	
Regulation:	45 CFR § 146.117
Market Type:	Group Health plans, Group Market
Statute Applicability Date(s):	Plan years beginning after June 30, 1997
Summary of Provision:	<p>A group health plan or health insurance issuer offering group health insurance in connection with a group health plan must allow eligible employees or their dependents to enroll in coverage if they had health insurance coverage at the time that a group health plan was offered to them but lost the coverage because they exhausted COBRA, or lost eligibility or employer contributions to the previous plan. The individual must request special enrollment within 30 days of exhausting or losing coverage and, if required by the group health plan or issuer, state in writing that enrollment in another plan is their only reason for not enrolling previously.</p> <p>If a plan offers coverage to dependents, then it must allow the dependents and spouse of an enrollee or eligible employee to enroll in the plan within 30 days of marriage, adoption, or birth.</p> <p>A group health plan must permit eligible individuals and their dependents who are otherwise eligible for coverage to request enrollment within 60 days of losing Medicaid or CHIP eligibility or becoming eligible for employment premium assistance. (NOTE: This provision appears in PHS Act § 2704(f)(3), but is not codified in 45 CFR § 146.117).</p>
Notes:	Regulations require that employees receive a notice of special enrollment at or before the time they are first offered the opportunity to enroll in the group health plan.

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	Under the guaranteed availability requirements at 147.104(b)(3), a health insurance issuer in the group and individual market must establish special enrollment periods for qualifying events as defined under section 603 of ERISA. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law.
Resources:	FAQs: Affordable Care Act Implementation FAQs – Set 35

Discrimination in general: PHS Act § 2705	
Discrimination Based on Health Status	
Regulation:	45 CFR § 146.121 and 45 CFR § 147.110
Market Type:	Group Health Plans, Individual & Group Markets (note: 45 CFR § 146.121, applies to group market plans, and pursuant to 45 CFR § 147.110, to individual market plans)
Statute Applicability Date(s):	Plan or policy years beginning after June 30, 1997 and extended to individual market plans effective January 1, 2014.
Summary of Provision:	<p>A group health plan or group or individual health insurance issuer may not establish any rule for eligibility (including continued 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:</p> <ul style="list-style-type: none"> • health status; • medical condition, including both physical and mental illnesses (as defined in 45 CFR § 144.103); • claims experience; • receipt of health care; • medical history; • genetic information (as defined in 45 CFR § 146.122(a)); • evidence of insurability (as defined in 45 CFR § 146.121(a)(2)); or • disability. <p>However, group health plans and group health insurance issuers may offer discounts or rebates for certain health promotion and disease prevention programs.</p>
Notes:	<p>Issuer may not establish any rule for eligibility based on a health factor – rules for eligibility include, but are not limited to, rules relating to:</p> <ul style="list-style-type: none"> • enrollment; • effective date of coverage; • waiting periods; • late and special enrollment; • eligibility for benefit packages; • benefits; • continued eligibility; and • terminating coverage under the plan. <p><u>More favorable treatment for individuals with adverse health factors is permitted.</u></p>
Resources:	FAQs: Affordable Care Act Implementation FAQs – Set 5 (see Q12-15)
Genetic Information & Non-Discrimination Act (GINA): PHS Act § 2705(b)(3), (c) – (e) and PHS Act § 2753	
Regulation:	45 CFR §§ 146.121(a)(1)(vi)), 146.122 , and 147.110
Market Type:	Group Health Plans, Individual & Group Markets

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Statute Applicability Date(s):	Plan or policy years beginning on or after May 21, 2009.
Summary of Provision:	<p>GINA amended the PHS Act to generally prohibit an issuer offering health insurance coverage in the individual market, an issuer offering health insurance coverage in connection with a group health, and group health plans from:</p> <ul style="list-style-type: none"> • Denying coverage based on family history or genetic information; • Setting or increasing the group premium or contribution amounts based on family history or genetic information; • Requesting or requiring an individual or family member to undergo a genetic test; and • Requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes. Underwriting purposes include determinations of eligibility, premium amounts, pre-existing condition exclusions, or other activities related to the creation, renewal or replacement of a health insurance contract or health benefits.¹ <p>However, there are exceptions to these rules. Health care professionals that are providing health care services may request genetic tests. Plans and issuers may request, but not require, genetic tests pursuant to research complying with federal, local, and state law which is not used for underwriting purposes. Additionally, a plan or issuer may obtain genetic information if incidental to requesting, requiring, or purchasing non-genetic information.</p>
Notes:	Protections of genetic information extend to a fetus carried by a pregnant individual or, if an individual or family member is utilizing assisted reproductive technologies, their legally held embryo.
Resources:	<p>Additional Regulatory Provisions: 29 CFR Part 1635</p> <p>CCIO Website: Genetic Information Nondiscrimination Act (GINA): OHRP Guidance (2009) (Content last reviewed March 21, 2016)</p> <p>FAQs: Frequently Asked Questions Regarding the Genetic Information Nondiscrimination Act</p>
Wellness Programs: PHS Act § 2705(j)	
Regulation:	45 CFR § 146.121
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Generally, Plan years beginning on or after July 1, 2007 for wellness programs. Programs of health promotion or disease prevention under subsection (j) of PHS Act 2705 plan years beginning on or after January 1, 2014.
Summary of Provision:	<p>Group health plans and issuers offering health insurance coverage in the individual or group market may offer discounts or rebates to encourage health promotion and disease prevention.</p> <p>Generally, it is prohibited to discriminate based on a health factor, however, there is an exception provided for certain wellness programs that discriminate in benefits (including cost-sharing mechanisms) and/or premiums or contributions based on a health factor. The regulations divide wellness programs into two categories:</p> <ul style="list-style-type: none"> • participatory wellness programs; and • health-contingent wellness programs

¹ See PHS Act § 2791(d)(19) (42 U.S.C. § 300gg-91(d)(19)).

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	<p>Participatory wellness programs do not condition rebates or discounts on health status factors and participation is made available to all similarly situated individuals. Such programs include reimbursements for fitness center membership, attending health education seminars, and participation in diagnostic testing or smoking cessation programs. Individual market health insurance issuers may offer only participatory wellness programs, and cannot offer health-contingent wellness programs. Such programs are not an exception to the prohibition against discrimination based on a health factor, because they do not discriminate based on a health factor.</p> <p>Health-contingent wellness programs condition rebates and discounts on individuals satisfying health status standards. The amount of a reward or penalty may not exceed 30% of the combined employer and employee premium contributions, though the tri-Departments may increase the amount to 50% to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use. The program must be reasonably designed to promote health or prevent disease and not operate as a subterfuge for discrimination. Eligible individuals must have opportunity to qualify once a year and the full award must be available to all similarly situated individuals.</p>
Notes:	<p>Health-contingent wellness programs must provide reasonable alternative standards for individuals for whom it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, and for individuals for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard.</p> <p>PHS Act § 2705(l) establishing the 10-State individual market Wellness Program Demonstrations that would have allowed issuers in such states to offer health-contingent wellness programs was never implemented. (See CMS Bulletin: Opportunity for States to Participate in a Wellness Program)</p>
Resources:	<p>Statutory Provisions: PHS Act § 2705(l)</p> <p>Incentives for Nondiscriminatory Wellness Programs in Group Health Plans</p> <p>FAQs: Affordable Care Act Implementation FAQs – Set 5 (see Q12-15) Affordable Care Act Implementation FAQs – Set 18 (see Q8-10) Affordable Care Act Implementation FAQs – Set 25 Affordable Care Act Implementation FAQs – Set 29 (see Q11)</p> <p>Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation FAQs - Set 43</p> <p>Affordable Care Act Implementation FAQs - Set 50</p> <p>Frequently Asked Questions on Health Insurance Market Reforms and Wellness Programs</p>

Non-Discrimination in Health Care: PHS Act § 2706

Regulation: No implementing regulation

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Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2014.
Summary of Provision:	Prohibits plans and issuers from discriminating against providers acting within the scope of their license or certification under applicable state law. However, this section does not require the plan or issuer to contract with any provider willing to abide by the plan or issuer's terms and conditions. Further, group health plans, health insurance issuers, or the Secretary are not prevented from establishing varied reimbursement rates based on quality and performance metrics.
Resources:	Statutory Provisions: 42 USC § 300gg-5 FAQs: Affordable Care Act Implementation FAQs – Set 27

Essential Health Benefits (EHB): PHS Act § 2707	
EHB In General	
Regulation:	45 CFR §§ 147.150, 156.100, et seq.
Market Type:	Individual & Small Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2014.
Summary of Provision:	<p>For plan or policy years (PY) beginning on or after January 1, 2014, individual and small group market health insurance coverage must provide EHBs, which include items and services within at least the following 10 categories:</p> <ol style="list-style-type: none"> 1. Ambulatory patient services; 2. Emergency services; 3. Hospitalization; 4. Maternity and newborn care; 5. Mental health and substance use disorder services, including behavioral health treatment; 6. Prescription drugs; 7. Rehabilitative and habilitative services and devices; 8. Laboratory services; 9. Preventive and wellness services and chronic disease management; and 10. Pediatric services, including oral and vision care. <p>HHS regulations (45 CFR 156.100, et seq.) define EHB based on State-specific EHB-benchmark plans. In PYs 2014 through 2016, the EHB-benchmark plan is a plan that was sold in 2012. For PYs 2017, 2018, and 2019, each State's EHB-benchmark plan is based on a plan that was sold in 2014. For PY 2020 and after, States have greater flexibility pursuant to 45 CFR 156.111, which provides new options for States to update their EHB-benchmark plans, if they so choose.</p> <p>All non-grandfathered group health plans and non-grandfathered individual and group health insurance coverage must limit cost-sharing for EHB furnished for individuals to the amount incurred in self-only coverage in PY 2014, increased by the premium adjustment percentage in each subsequent year. Plans must limit cost-sharing for the whole enrollment group to twice the limit of self-only cost-sharing.</p> <p>If a health insurance issuer offers coverage in any level of coverage specified under ACA § 1302(d), the issuer must also offer such coverage in that level as a plan in</p>

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	which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21.
Notes:	The maximum out-of-pocket (MOOP) limit is only required to be applied to EHBs.
Resources:	<p>CCIIO Website:</p> <p>Information on Essential Health Benefits (EHB) Benchmark Plans</p> <p>Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage</p> <p>FAQs:</p> <p>Frequently Asked Questions on Essential Health Benefits Bulletin</p> <p>FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)</p> <p>Affordable Care Act Implementation FAQs – Set 12 (see Q1-2)</p> <p>Affordable Care Act Implementation FAQs – Set 18 (see Q2-5, 12)</p> <p>Affordable Care Act Implementation FAQs – Set 27</p> <p>Affordable Care Act Implementation FAQs – Set 46</p> <p>Affordable Care Act Implementation FAQs-Set 55 (See Q5)</p>
EHB-Benchmark Plans	
Regulation:	45 CFR §§ 156.111, 156.115
Market Type:	Individual & Small Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2014.
Summary of Provision:	<p>Each state has an EHB-benchmark plan which serves as the standardized set of EHBs for plans required to offer EHBs in the state.</p> <p>Plans/issuers must provide benefits that are substantially equal to the EHB-benchmark plan. When designing plans that are substantially equal to the EHB-benchmark plan, issuers may need to conform plan benefits, including coverage and limitations, to comply with current requirements and limitations, including prohibitions on annual and/or lifetime dollar limits on EHBs, requirements on coverage limits, requirements for discriminatory plan designs, prescription drug coverage by category and class, excluded benefits, habilitative services and devices, mental health parity, preventive services, and state-required benefits.</p> <p>Plans/issuers may substitute EHB benefits if:</p> <ul style="list-style-type: none"> • the new benefit is actuarially equivalent to the replaced benefit (submit certification); the substitution is within the same EHB category; and • it is not substituting prescription drug benefits.
Notes:	<p>For plan years 2020 through 2023, no State opted to permit issuers to substitute benefits between benefit categories, pursuant to 45 CFR 156.115(b)(2)(ii).</p> <p>The following benefits are excluded from EHB even though an EHB-benchmark plan may cover them: routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and/or non-medically necessary orthodontia. Please also note that although the EHB-benchmark plan may cover abortion services (see 45 CFR § 156.115(c)), no health plan is required to cover abortion services as part of the requirement to cover EHB. Nothing in this provision impedes an issuer's ability to choose to cover abortion services or limits a State's ability to either prohibit or require these services under State law.</p>

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	With the exception of coverage for pediatric services, a plan may not exclude an enrollee from coverage in an entire EHB category, regardless of whether such limits exist in the EHB-benchmark plan (see 45 CFR § 156.115(a)(2)).
Resources:	CCIIO Website: Information on Essential Health Benefits (EHB) Benchmark Plans (select “Current EHB-Benchmark Plan Documents by State” under “Navigation”)

Prohibition on Excessive Waiting Periods: PHS Act § 2708	
Regulation:	45 CFR § 147.116
Market Type:	Group Health Plans & Group Market
Statute Applicability Date(s):	Plan years beginning on or after January 1, 2014.
Summary of Provision:	A group health plan or group health insurance issuer shall not apply any waiting period that exceeds 90 days. A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective.
Resources:	FAQs: Affordable Care Act Implementation FAQs – Set 16 (see Q2)

Clinical Trials: PHS Act § 2709	
Regulation:	No implementing regulation
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2014.
Summary of Provision:	Plans and issuers that cover a “qualified individual” may not do any of the following: <ul style="list-style-type: none"> • Deny the individual from participating in a specified approved clinical trial; • Deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection to the individual’s participation in the trial (to the extent provided within the plan’s network, if applicable); or • Discriminate against the individual on the basis of his/her participation in the trial. <p>However, if an in-network provider is participating in the trial and willing to accept the qualified individual in the trial, then the plan or issuer may require the qualified individual to participate through the in-network provider.</p>
Notes:	Per PHS Act § 2709(b), a qualified individual is someone eligible to participate in an approved clinical trial under the trial terms, requires treatment of cancer or life-threatening disease, and a referring health care provider who participates in the plan concludes that the individual’s participation in the trial is appropriate, or the individual provides information establishing that participation is appropriate. Per PHS Act § 2709(d), an approved clinical trial is an FDA investigational new drug application trial, an FDA drug trial exempt from having an investigational new drug application, or a stud funded by the NIH, CDC, AHRQ, CMS, and in certain situations the DOD, VA, or DOE.

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	Per PHS Act § 2709(a)(2), routine patient costs include all items and services that are consistent with plan coverage and typically covered for qualified individuals that are not enrolled in a clinical trial. As further explained in guidance, these costs do not include the investigational item, device, or service itself, items and services provided solely for data collection and analysis, services clearly inconsistent with widely accepted standards of care for a diagnosis, and out-of-network items and services when the plan does not cover out-of-network benefits. (see Affordable Care Act Implementation FAQs – Set 31).
Resources:	Statutory Provisions: 42 USC § 300gg-8 FAQs: Affordable Care Act Implementation FAQs – Set 15 (see Q3) Affordable Care Act Implementation FAQs – Set 31 (see Q5-6)

Disclosure of Information: PHS Act § 2709	
Regulation:	45 CFR § 146.160
Market Type:	Individual & Small Group Markets
Statute Applicability Date(s):	June 1, 1997
Summary of Provision:	<p>Issuers are required to make a reasonable disclosure to the employer, as part of its solicitation and sales materials, and at the request of the employer, of the availability of the following information:</p> <ul style="list-style-type: none"> • The issuer’s right to change premium rates and factors that affect changes in premium rates. • The benefits and premiums available under all health insurance coverage for which the employer is qualified. The renewability of coverage. • Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage. • Any affiliation periods applied by HMOs. • The geographic areas service by HMOs. <p>Additionally, issuers must provide the benefits and premiums available under all health insurance coverage for which the employer is qualified, under applicable state law.</p> <p>The information must be described in language that is understandable by the average small employer, with a level of detail that is sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.</p>
Notes:	<p>Disclosure of Information is included in this section because the HIPAA provisions were re-designated by the ACA.</p> <p>An issuer is not required to disclose any information that is proprietary and trade secret information under applicable law.</p>

Annual & Lifetime Limits: PHS Act § 2711	
Regulation:	45 CFR § 147.126
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2014.

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Summary:	<p>Group health plans and group and individual health insurance coverage cannot have annual dollar amount or lifetime dollar amount limitations on covered essential health benefits.</p> <p>In accordance with 45 CFR 147.126, annual or lifetime dollar limits cannot be applied to the essential health benefits as of 2014. Annual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits.</p> <p>Restricted annual dollar limits on coverage of EHBs were permitted for plan years beginning before January 1, 2014.</p> <p>Lifetime dollar limits on coverage of EHBs are prohibited.</p>
Notes:	<p>Issuers are not prohibited from using annual dollar limits or lifetime dollar limits for specific covered benefits that are <u>not</u> EHBs.</p> <p>If the limit is not a dollar limit (e.g., a visit limit), the annual dollar limit prohibition would not be triggered, unless the visit limit has a specified dollar amount for each visit. Any such non-dollar limit must comply with EHB requirements.</p> <p>If the limit is not a dollar limit (e.g., a visit limit), the lifetime dollar limit prohibition would not be triggered.</p>
Resources:	<p>CCIIO Website:</p> <p>Annual Limits</p> <p>Waivers for Annual Limits and Exemption for Health Reimbursement Arrangements</p> <p>FAQs:</p> <p>Affordable Care Act Implementation FAQs – Set 18 (see Q2-5)</p>

Rescissions: PHS Act § 2712	
Regulation:	45 CFR § 147.128
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after September 23, 2010.
Summary of Provision:	<p>Coverage may not be rescinded, unless the individual or (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms or the plan or coverage.</p> <p>A discontinuation or cancellation with retroactive effect due to non-payment of premiums is not a rescission.</p> <p>A health insurance issuer or group health plan is required to provide thirty (30) days' advance written notice prior to rescinding coverage. The enrollee may appeal this decision under 45 CFR § 147.136.</p>
Resources:	<p>FAQs:</p> <p>Affordable Care Act Implementation FAQs – Set 2 (see Q7)</p> <p>Affordable Care Act Implementation FAQs – Set 31 (see Q3)</p>

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Preventive Health Services: PHS Act § 2713	
Coverage of preventive health services without imposing cost-sharing requirements	
Regulation:	45 CFR §§ 147.130, 147.131, 147.132, 147.133
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after September 23, 2010.
Summary of Provision:	<p>Health insurance issuers and group health plans must provide coverage for all of the following items and services, and may not impose any cost sharing requirements with respect to those services:</p> <ul style="list-style-type: none"> • Evidence-based items or services that have in effect a rating of A or B in the current USPSTF recommendations with respect to the individual involved; • For infants, children, and adolescents, evidence-informed preventive care and screenings provided for by HRSA guidelines; • For women, such additional preventive care and screenings not described in connection with the USPSTF, as provided for in comprehensive guidelines supported by HRSA; and • Immunizations for routine use in children, adolescents, and adults with recommendation from Advisory Committee on Immunization Practices (ACIP) of the CDC with respect to the individual involved. <p>The issuer is generally not required to cover recommended preventive services delivered by out-of-network providers, and <u>may</u> impose cost-sharing requirements for such providers.</p>
Notes:	<p>While nothing 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 45 CFR § 147.130(a)(3)(i). Additional information can be found in Q3 of the Affordable Care Act Implementation FAQs – Set 12.</p> <p>See 45 CFR § 147.130(a)(2) for when an office visit is billed separately from the preventive service provided.</p> <p>Guidance strongly encourages plans or issuers to defer to the determination of the attending provider, and make available an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome so the individual or their provider (or other individual acting as the individual’s authorized representative) can obtain coverage for the medically necessary service or product without cost sharing as required under PHS Act section 2713 and its implementing regulations and guidance. The Departments will determine whether a plan’s or issuer’s exceptions process is easily accessible, transparent, sufficiently expedient, and not unduly burdensome based on all the relevant facts and circumstances, including whether and how the plan or issuer notifies providers, participants, beneficiaries, or enrollees of the exceptions process, and the steps the individual or their provider (or other individual acting as a patient's authorized representative) must take to utilize the exceptions process. Additional information can be found in Q9 of the Affordable Care Act Implementation FAQs – Set 54.</p> <p>USPSTF-recommended OTC drugs should be covered without cost-sharing if prescribed by a doctor. Additional information can be found in Q4 of the Affordable Care Act Implementation FAQs – Set 12</p>

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	<p>The issuer may not impose cost-sharing for polyp removal performed during a screening colonoscopy. However, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service. Additional information can be found in Q5 of the Affordable Care Act Implementation FAQs – Set 12 and Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency.</p> <p>If the applicable guidelines/recommendations for a preventive service do not identify the frequency, method, treatment, or setting for which such service should be available without cost-sharing requirements, a health insurance issuer <u>may</u> rely on reasonable medical management techniques and relevant evidence to make the determinations.</p> <p>Section 3203 of the CARES Act requires group health plans and health insurance issuers offering group or individual health insurance coverage to cover qualifying coronavirus preventive services without cost-sharing requirements. see FAQs About Affordable Care Act Implementation Part 50 and Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency.</p>
Resources:	<p>CCIIO Website: Prevention</p> <p>FAQs: Affordable Care Act Implementation FAQs – Set 2 (see Q8) Affordable Care Act Implementation FAQs – Set 5 (see Q1) Affordable Care Act Implementation FAQs – Set 12 (see Q3-20) Affordable Care Act Implementation FAQs – Set 18 (see Q1) Affordable Care Act Implementation FAQs – Set 19 (see Q5) Affordable Care Act Implementation FAQs – Set 31 Affordable Care Act Implementation FAQs – Set 34 Affordable Care Act Implementation FAQs – Set 47 Affordable Care Act Implementation FAQs – Set 48 Affordable Care Act Implementation FAQs – Set 50 Affordable Care Act Implementation FAQs – Set 54</p> <p>Additional Resources: U.S. Preventative Services Task Force – A & B Recommendations CDC Child & Adolescent Immunization Schedule HRSA Women’s Preventive Services Guidelines Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency</p>

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Changes in recommendations or guidelines	
Regulation:	45 CFR § 147.130(b)
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after September 23, 2010.
Summary of Provision:	A plan or issuer that is required to provide coverage of any items or services specified in any recommendation or guideline that specifies the required preventive services on the first day of a plan year, must provide coverage through the end of the plan year even if recommendation or guideline changes.
Notes:	
Resources:	

Coverage of Dependent Children until 26 Years of Age: PHS Act § 2714	
Regulation:	45 CFR § 147.120
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after September 23, 2010.
Summary of Provision:	<p>Extension of dependent children coverage until 26 years of age</p> <p>Issuers that issue policies providing for dependent coverage, as well as group health plans providing for dependent coverage, for children must continue to make such coverage available to married and unmarried dependent children up to age 26.</p>
Notes:	<p>The plan or issuer does not have to provide coverage to dependent childrens' spouses or children.</p> <p>Dependent eligibility can only be defined in terms of the relationship between the child and the subscriber. Requirements for eligibility cannot include:</p> <ul style="list-style-type: none"> • Financial dependency; • Residency • Student status; or • Employment <p>Terms of dependent coverage cannot vary based on age. <u>For example:</u> plans cannot impose a premium surcharge for dependent children over 18. Note that this does not prohibit plans from imposing age rating, pursuant to PHS Act § 2701 and 45 CFR § 147.102.</p>
Resources:	<p>CCIIO Website:</p> <p>Coverage for Young Adults</p> <p>Young Adults and the Affordable Care Act</p> <p>FAQs:</p> <p>Affordable Care Act Implementation FAQs - Set 1 (see Q14)</p> <p>Affordable Care Act Implementation FAQs - Set 5 (see Q5)</p>

Summary of Benefits and Coverage (SBC): PHS Act § 2715	
Regulation:	45 CFR § 147.200
Market Type:	Group Health Plans, Individual & Group Markets

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Statute Applicability Date(s):	March 23, 2012.
Summary of Provision:	<p>Plans and issuers must provide a Summary of Benefits and Coverage (SBC) to applicants prior to application, enrollees prior to enrollment, and policyholders at the time of issuing (or renewing) the policy.</p> <p>The SBC provides information on a plan’s benefits in a uniform format for easy comparison. Specifically, the SBC provides uniform definitions of insurance and medical terms, a standardized description of coverage, cost-sharing, limitations, and renewability provisions, examples of common benefits scenarios (such as pregnancy), and other information.</p>
Notes:	<p>Please see separate checklist for handling SBC reviews. The appearance, language, and layout must follow specific guidelines and templates</p> <p><i>In addition</i>, under PHS Act § 2715(d)(4), the plan must give enrollees 60 days’ advance notice before any material modification in coverage.</p>
Resources:	<p>CCIIO Website:</p> <p>Summary of Benefits and Coverage and Uniform Glossary Guidance</p> <p>Summary of Benefits & Coverage Uniform Glossary</p> <p>SBC Materials and Supporting Documents (Authorized for use for plan or policy years that begin on or after January 1, 2021; includes templates, sample language, and coverage examples calculations)</p> <p>Fact Sheets and FAQs:</p> <p>Summary of Benefits and Coverage and Uniform Glossary Fact Sheet</p> <p>Affordable Care Act Implementation FAQs - Set 7</p> <p>Affordable Care Act Implementation FAQs - Set 8</p> <p>Affordable Care Act Implementation FAQs - Set 9</p> <p>Affordable Care Act Implementation FAQs - Set 10</p> <p>Affordable Care Act Implementation FAQs - Set 14</p> <p>Affordable Care Act Implementation FAQs - Set 19</p> <p>Affordable Care Act Implementation FAQs - Set 24</p> <p>Affordable Care Act Implementation FAQs - Set 30</p> <p>Affordable Care Act Implementation FAQs - Set 41</p> <p>FAQs on the Applicability Date of the Updated Summary of Benefits and Coverage Template, Calculator, and Related Materials</p>

Provision of Additional Information: PHS Act § 2715A	
Regulation:	45 CFR §§ 147.210
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	September 23, 2010.

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Summary of Provision:	<p>Plans and issuers must provide the below information to the HHS Secretary, applicable state insurance commissioner, the public, and, if offering insurance on an exchange, to the applicable exchange:</p> <ul style="list-style-type: none"> • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to any out-of-network coverage • Information on enrollee and participant rights • Other information required by Secretary <p>QHP issuers must ensure that individuals may learn of cost-sharing arrangements in a timely manner and even without internet access.</p>
Notes:	<p>Requirements are listed in ACA § 1311(e)(3) and PHS Act § 2715A extended these to the individual and Group Markets.</p> <p>The information must be provided in plain language that the intended audience and those with limited English proficiency can readily understand and use.</p>
Resources:	<p>Additional Regulatory Provisions: 77 FR 18309</p>
Transparency in Coverage – Price Comparison Tool	
Regulation:	45 CFR § 147.211
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	<p>Plan or policy years beginning on or after January 1, 2023 for the 500 items and services identified in preamble.</p> <p>Plan or policy years beginning on or after January 1, 2024 for all covered items and services.</p>
Summary of Provision:	Requires plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request.
Resources:	<p>Additional Resources: Transparency in Coverage website</p> <p>FAQs: Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 FAQs</p>

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Transparency in Coverage – Machine-readable files	
Regulation:	45 CFR § 147.212
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	<p>Plan or policy years beginning on or after January 1, 2022.</p> <ul style="list-style-type: none"> • Departments deferred enforcement of the requirement that plans and issuers publish machine-readable files relating to in-network provider rates and out-of-network allowed amounts to July 1, 2022. • Departments deferred enforcement of the requirement that plans and issuers publish machine-readable files relating to prescription drug pricing pending further rulemaking.
Summary of Provision:	Requires plans/issuers in the group and individual markets to disclose on a public website information regarding in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files.
Resources:	<p>Additional Resources:</p> <p>Transparency in Coverage website</p> <p>GitHub Technical Assistance</p> <p>FAQs:</p> <p>Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 FAQs</p> <p>Affordable Care Act Implementation FAQs-Set 55 (August 19, 2022)</p>

Medical Loss Ratio: PHS Act § 2718	
Regulation:	45 CFR Part 158
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	January 1, 2011.
Summary of Provision:	<p>Health insurance issuers offering group or individual health insurance coverage must report:</p> <ul style="list-style-type: none"> • the ratio of incurred claims and expenses for quality improvement activities to earned premium, as adjusted for state and federal taxes, fees, and assessments. <p>Issuers must provide rebates to enrollees if:</p> <ul style="list-style-type: none"> • In the large group market, they spend less than 85% of premiums on claims and activities that improve health care quality • In the individual and small group markets, they spend less than 80% of premiums on claims and activities that improve health care quality
Notes:	Self-funded plans are not subject to MLR requirements.

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Appeals: PHS Act § 2719	
Internal claims appeals and external review	
Regulation:	45 CFR § 147.136
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	<p>For adverse benefit determinations and rescissions of coverage, September 23, 2010.</p> <p>The requirements related to external review of No Surprises Act compliance matters are applicable for plan years beginning on or after January 1, 2022.</p>
Summary of Provision:	<p>Group health plan and health insurance issuers must provide a description of available claims procedures, internal appeals and external review processes, and information regarding how to initiate an appeal as part of the Summary Plan Description (SPD) (or policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to enrollees), and how to provide this information in a culturally and linguistically appropriate manner.</p> <p>These provisions establish for group health plans and health insurance issuers requirements governing the submission of benefit claims, issuing adverse benefit determinations (ABDs), the internal appeals process for an ABD (including whether a plan or issuer has one or two levels of internal appeals available), and external review processes.</p> <p>The issuer must also describe the exceptions available to exhausting the internal claims and appeals process (“deemed exhaustion”) such as:</p> <ul style="list-style-type: none"> • Issuer waives internal appeal; • Urgent care situations where simultaneous expedited internal and external review may occur; or • Failure to comply with all requirements of internal appeals process except in cases where the violation was: <ul style="list-style-type: none"> ○ De minimis; ○ Non-prejudicial; ○ Attributable to good cause/matters beyond issuer’s control; ○ In context of ongoing good-faith exchange of information; or ○ Not reflective of a practice of non-compliance. <p>If a plan denies payment after considering the final internal appeal, the ACA permits a consumer to take another step. Consumers may choose to have an independent review organization (an outside independent decision-maker) decide whether to uphold or overturn the plan’s decision. This additional check is often referred to as an “external review.” Regulations provide for three different ways to process external reviews. In some states, consumers will use their state’s external review process. This method is for states determined by the federal government to have an external review process that meets the federal consumer protection standards. If the state’s process does not meet the federal consumer protection standards, issuers must offer to consumers one of two federally-sanctioned processes: The accredited Independent Review Organization (IRO) Contracting Process; or the HHS-Administered Federal External Review Process. More information can be found here.</p>

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Notes:	<p>Health insurance issuers in all states must participate in an external review process that meets minimum consumer protection standards outlined in the Affordable Care Act.</p> <p>Use the State External Appeals Review Processes List to determine if plans and issuers in the state are subject to a state external review process or a Federal external review process (FERP).</p> <p>For example:</p> <ul style="list-style-type: none"> • In Missouri, Oklahoma, and Wyoming issuers follow the state’s external review processes as they meet the minimum federal standards for a State external review process. • In Texas and Alabama, the minimum federal standards for a State external review process have not been met. As a result, a FERP applies. Plans and issuers in these states can elect to use the HHS administered process for external reviews or can contract directly with independent review organizations to conduct external reviews. <p>If an applicable state external review process cannot accommodate review of NSA compliance matters, HHS is offering states, starting on January 1, 2022, the opportunity to refer adverse benefit determinations by issuers of insured coverage that involve NSA compliance matters to the Federal HHS-administered external review process. See CMS Bulletin titled Guidance for States, Plans, and Issuers on State External Review Processes Regarding Requirements in the NSA</p>
Resources:	<p>CCIIO Website External Appeals Guidance</p> <p>External Appeal Fact Sheets and FAQs</p> <p>FAQs Affordable Care Act Implementation FAQs- Set 1 (see Q7-14)</p> <p>Additional Resources: Regulations for External Reviews of No Surprises Act Compliance Matters Guidance for States, Plans, and Issuers on State External Review Processes</p>
Notice of right to appeal	
Regulation:	45 CFR § 147.136(e)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after September 23, 2010.
Summary of Provision:	<p>The issuer must provide the written notice of the right to appeal in a culturally and linguistically appropriate manner and must also 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 (CLAS).</p> <p>The issuer must also provide, upon request, a notice in any applicable non-English language.</p> <p>Additionally, the issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language</p>

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	clearly indicating how to access the language services provided by the issuer.
Notes:	Applicable non-English language is determined by a threshold percentage of 10% or more of the population in a county who are literate only in the same non-English language based on the American Community Survey (ACS).
Resources:	CCIIO Website: CLAS County Data: January 2016* (*most recent document available) FAQs: Affordable Care Act Implementation FAQs – Set 8 (see Q13)
Notice of appeal determination	
Regulation:	45 CFR §147.136(b)(2)(ii)(E)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after September 23, 2010.
Summary of Provision:	<p>The issuer must provide a written or electronic notification of a plan’s benefit determination. Content of notification must include:</p> <ul style="list-style-type: none"> • Enough information to identify the claim involved; • Reason(s); • Reference to specific plan provision(s); and • A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the corresponding treatment code and its meaning. <p>Issuers must provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination (ABD).</p> <p>Issuers must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act § 2793 to assist individuals with the internal claims and appeals and external review processes.</p>
Resources:	CCIIO Website: External Review For Group Health Plans Guidance

Patient Protections: PHS Act § 2719A	
NOTE: The No Surprises Act added section 2799A–1 of the PHS Act, which expand the patient protections related to emergency services under section 2719A of the PHS Act, in part, by providing additional consumer protections related to balance billing and section 2799A-7 of the PHS Act, which recodifies other provisions under section 2719A of the PHS Act. The No Surprises Act amended section 2719A of the PHS Act to include a sunset provision effective for plan and policy years beginning on or after January 1, 2022, when the new protections under the No Surprises Act take effect. The regulations cited at 45 CFR 149.138 sunset effective for plan and policy years beginning on or after January 1, 2022.	
Choice of health care professional	
Regulation(s):	45 CFR § 147.138(a)(1)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	PHS Act § 2719A effective plan or policy years beginning on or after September 23, 2010; sunset by PHS Act § 2799A-7 for plan or policy years beginning on or after January 1, 2022. See requirements under No Surprises Act provision § 2799A-7 for plan years and policy years beginning on or after January 1, 2022.

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Summary of Provision:	If the issuer or group health plan requires or allows for designation of a primary care provider (PCP), then the issuer shall permit each individual to designate any participating primary care provider who is available to accept such individual.
Notes:	<p>If a PCP is mandated and the individual fails to designate a PCP, the plan may designate one until the individual does so.</p> <p>There is no prohibition on reasonable and appropriate geographic limitations with respect to PCP selection, in accordance with plan or coverage terms, underlying provider contracts, and applicable state law.</p> <p>The No Surprises Act recodified the patient protections regarding choice of health care professional from section 2719A(a), (c), and (d) of the PHS Act at new section 2799A-7 of the PHS Act.</p>
Resources:	<p>CCIIO Website:</p> <p>Patient's Bill of Rights</p> <p>Protecting Your Choice of Health Care Providers</p>
Choice of pediatrician as primary care provider –	
Regulation(s):	45 CFR § 147.138(a)(2)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	PHS Act § 2719A effective plan or policy years beginning on or after September 23, 2010; sunset by PHS Act § 2799A-7 for plan or policy years beginning on or after January 1, 2022. See requirements under No Surprises Act provision § 2799A-7 for plan years and policy years beginning on or after January 1, 2022.
Summary of Provision:	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.
Notes:	If a PCP is mandated and the individual fails to designate a PCP, the plan may designate one until the individual does so.
Resources:	<p>CCIIO Website:</p> <p>The Affordable Care Act's New Patient's Bill of Rights</p>
Direct access to obstetrical and gynecological care	
Regulation(s):	45 CFR § 147.138(a)(3)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	PHS Act § 2719A effective plan or policy years beginning on or after September 23, 2010; sunset by NSA § 102(e) for plan or policy years beginning on or after January 1, 2022. See requirements under No Surprises Act provision § 2799A-7 for plan years and policy years beginning on or after January 1, 2022.
Summary of Provision:	<p>An issuer or group health plan that provides coverage for OB/GYN care and requires the designation of a PCP must comply with the following:</p> <ul style="list-style-type: none"> • may not require prior authorization or a referral for a female patient to see a participating provider specializing in OB/GYN care; • Must permit OB/GYN providers to directly refer for or order OB/GYN-related items and services without approval of another provider, including a PCP.
Notes:	If no OB/GYN care is provided, the issuer does not have to comply with this provision.
Resources:	CCIIO Website:

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	The Affordable Care Act's New Patient's Bill of Rights
Notice requirement	
Regulation(s):	45 CFR § 147.138(a)(4)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	PHS Act § 2719A effective plan or policy years beginning on or after September 23, 2010; sunset by NSA § 102(e) for plan or policy years beginning on or after January 1, 2022. See requirements under No Surprises Act provision § 2799A-7 for plan years and policy years beginning on or after January 1, 2022.
Summary of Provision:	<p>If the plan requires the designation of a PCP, it must provide notices regarding the above requirements to each participant or primary subscriber of a policy, which can be in the Summary Plan Description (SPD).</p> <p>Notice must be included whenever a new SPD/policy/certificate is issued.</p>
Coverage of emergency services	
Regulation(s):	45 CFR § 147.138(b) .
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	PHS Act § 2719A effective plan or policy years beginning on or after September 23, 2010; sunset by NSA § 102(e) for plan or policy years beginning on or after January 1, 2022. See requirements under No Surprises Act provision § 2799A-1 for plan years and policy years beginning on or after January 1, 2022.
Summary of Provision:	<p>If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services:</p> <ul style="list-style-type: none"> • Without the need for a prior authorization determination, even if the emergency services are provided on an out-of-network basis; • Without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect the services; and • If such services are provided by an out-of-network provider, without imposing administrative requirements or coverage limitations that are more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; • If the emergency services are provided by out-of-network providers/facilities, by complying with the following cost sharing requirements, <ul style="list-style-type: none"> ○ Copayment amount or coinsurance rate imposed with respect to an emergency service for an enrollee received out-of-network cannot exceed the cost-sharing requirement that would have been imposed if the services were provided in-network. The participant, beneficiary, or enrollee may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan/issuer is required to pay (the greatest of the three amounts as noted below). <ul style="list-style-type: none"> ▪ The amount negotiated with in-network providers for emergency service furnished, excluding any in-network copayment/coinsurance imposed. If there is more than one amount negotiated with in-network providers for the emergency service, the median of these amounts. ▪ The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as usual, customary, and

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	<p>reasonable amount), excluding any in-network copayment/coinsurance imposed.</p> <ul style="list-style-type: none"> ▪ The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 <i>et. seq</i>) for the emergency service, excluding any in-network copayment/coinsurance imposed.
Notes:	See regulation for definition of “emergency services” and for requirements for payment of emergency services on or after January 1, 2022. 45 CFR § 149.110(c) .
Resources:	Additional Resources: EMTALA Resource Page (CMS)

Benefits for mothers and newborns: PHS Act § 2725 & PHS Act § 2751	
Regulation:	45 CFR § 146.130 and §148.170
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 1998.
Summary of Provision:	<p>If a plan or issuer provides benefits for hospital lengths of stay in connection with child birth then issuers may <i>NOT</i>:</p> <ul style="list-style-type: none"> • Restrict benefits for hospital length of stay to less than 48 hours after vaginal delivery or 96 hours after cesarean section, unless the provider decides to dismiss the mother or infant earlier in consultation with the mother. • Require prior authorization for the length of stay • Deny eligibility to the mother or newborn for the purposes of avoiding the length of stay or prior authorization requirements • Provide payments or rebates to encourage mothers to accept less than minimum protections • Penalize the provider for following length of stay requirements • Incentivize the provider to act inconsistently with requirements • Restrict benefits for any portion of the length of stay in a manner that is less favorable than benefits provider for any preceding length of stay <p>Plans/issuers must provide notice of the above benefits in plan or insurance materials.</p>
Notes:	<p>Other provisions in the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA).</p> <p>Plans and issuers must follow state law if requiring a longer minimum length of stay, coverage in accordance with the guidelines of established professional medical associations, or hospital lengths of stay left to the discretion of attending physician in consultation with the mother</p> <p>If delivery occurs outside a hospital, then the 48/96 hours begin when the mother or newborn is admitted as an inpatient in connection with childbirth</p> <p>Plans/issuers may impose cost-sharing on the 48/96 hour stay if not greater than the amount imposed on any preceding portion of the stay</p>
Resources:	CCIO Website: Newborns’ and Mothers’ Health Protection Act Fact Sheet

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Mental health parity: PHS Act § 2726	
Applicability and exemptions	
Regulation:	45 CFR § 146.136
Market Type:	Individual & Group Markets (NOTE: MHPAEA initially was applicable only to self-insured group health plans sponsored by large employers, and to large group health insurance coverage. The ACA expanded MHPAEA requirements to apply to individual market health insurance coverage and, through the application of the essential health benefits requirement under the ACA, applies it to small group health insurance coverage.
Statute Applicability Date(s):	Plan or policy years beginning on or after July 1, 2014.
Summary of Provision:	<p>Mental health parity requirements apply to group health plans (plans) or issuers offering health insurance coverage in connection with a group health plan (issuers) offering both medical/surgical benefits (M/S) and mental health or substance use disorder benefits (MH/SUD), unless:</p> <ul style="list-style-type: none"> • An exemption applies • The plan is maintained pursuant to an unexpired collective bargaining agreement ratified prior to October 3, 2008 • A self-funded, non-Federal governmental plan has opted out of compliance with the requirements under MHPAEA. Note: The Consolidated Appropriations Act, 2023 (CAA, 2023), enacted on December 29, 2022, included, in Division FF, Subtitle C, Chapter 3, section 1321, a sunset provision for the MHPAEA opt-out election for self-funded, non-Federal governmental group health plans. Such plans cannot initiate a new MHPAEA opt-out election on or after December 29, 2022 and generally, may not renew existing MHPAEA opt-out elections on or after June 27, 2023 (180 days after enactment of the CAA, 2023). There is an exception for self-funded, non-Federal governmental group health plans with multiple collective bargaining agreements (CBAs) of varying lengths that have a MHPAEA opt-out election in effect on December 29, 2022 that expires on or after June 27, 2023, to allow renewal until the expiration of the last applicable CBA.
Notes:	<p>PHS Act 2791(e) defines large and small employers.</p> <p>MHPAEA does not apply directly to small group health insurance coverage. Its requirements are applied indirectly to small group health insurance coverage in connection with the ACA's EHB requirements.</p>
Resources:	<p>CCIIO Website: The Mental Health Parity and Addiction Equity Act (MHPAEA) Website</p> <p>MHPAEA Fact Sheets</p> <p>FAQs: FAQs about MHPAEA and CAA, 2021 - Part 45</p> <p>Additional Resources: Department of Labor Mental Health and Substance Use Disorder Parity Website</p>
Annual and Lifetime dollar limits	
Regulation:	45 CFR § 146.136(a) and (b)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after July 1, 2014.

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Summary of Provision:	<p>If a plan or issuer provides both medical/surgical benefits (M/S) and mental health or substance use disorder benefits (MH/SUD) and</p> <ul style="list-style-type: none"> • Imposes no limits on M/S or includes limits that apply to less than 1/3 of M/S, then the plan/issuer may not impose limits on MH/SUD. • Imposes limits on $\geq 2/3$ of M/S, then plans/issuers must either not apply the limit to both M/S and MH/SUD in a manner that does not distinguish between the limit on M/S and the limit on MH/SUD or apply a limit to MH/SUD that is no less than the M/S limit • Imposes varying limits on different categories of M/S, then follow the Secretary's rules that take into account the weighted average of aggregate lifetime or annual limits.
Resources:	<p>CCIO Website: MHPAEA Fact Sheets</p>
Financial requirements and treatment limitations	
Regulation:	45 CFR § 146.136(a) and (c)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after July 1, 2014.
Summary of Provision:	<p>If a plan or issuer provides both medical/surgical benefits (M/S) and mental health or substance use disorder benefits (MH/SUD) then they must:</p> <ul style="list-style-type: none"> • Apply financial requirements to MH/SUD that are no more restrictive than the predominant financial requirements applied to substantially all M/S benefits in the same classification • Not enact any cost-sharing requirements that apply only to MH/SUD benefits • Apply treatment limitations to MH/SUD that are no more restrictive than the predominant treatment limitations applied to substantially all M/S benefits in the same classification • Not enact treatment limitations that are applicable only to MH/SUD benefits • Provide medical necessity criteria for MH/SUD and reasons for claim denials to current or potential participant, beneficiary, and provider upon request • If the plan or issuer allows out-of-network coverage for M/S, allow out-of-network coverage for MH/SUD
Notes:	<p>Treatment limitations are any limits placed on the scope or duration of a course of treatment. For example, a number of physician office visits allowed a year.</p> <p>The analysis for financial limits and for quantitative treatment limitations proceeds as follows:</p> <p><u>Step 1: Classification</u></p> <ul style="list-style-type: none"> • Divide M/S and MH/SUD into one of the following classifications: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; prescription drugs. • NOTE: Each outpatient classification may be subclassified into office visits, and all other outpatient visits. • NOTE: Benefits furnished on an in-network basis may be broken down into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to M/S or MH/SUD. • NOTE: If a plan (or health insurance coverage) applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) (relating to requirements for nonquantitative treatment

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	<p>limitations) and without regard to whether a drug is generally prescribed with respect to M/S or with respect to MH/SUD, the plan (or health insurance coverage) satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits.</p> <ul style="list-style-type: none"> • Compare MH/SUD to the M/S in the same classification or subclassification only <p>Step 2: “Substantially all” test:</p> <ul style="list-style-type: none"> • Determine which limitation or requirement to analyze. For example, analyze copayments • Determine whether that limitation or requirement applies to at least 2/3 of M/S in the classification. If it does not, plan or issuer cannot apply that limit or requirement to MH/SUD in that same classification. If it does, proceed to Step 3. <p>Step 3: “Predominant” test:</p> <ul style="list-style-type: none"> • Determine the level of limitation or requirement. For example, a \$20 copay • Determine the level of (e.g., \$20) the limitation or requirement (e.g., copay) that applies to more than ½ of M/S benefits that are subject to the limitation or requirement <p>If a restriction/limitation applies to at least 2/3 of M/S in a classification, then the level of the restriction/limitation that may apply to MH/SUD in that same classification can be no more restrictive than the level that applies to more than ½ of M/S in that classification that are subject to the restriction/limitation.</p>
Cumulative financial requirements and quantitative treatment limitations	
Regulation(s):	45 CFR § 146.136(a) and (c)(3)(v)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after July 1, 2014.
Summary of Provision:	A plan/issuer may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for MH/SUD in a classification that accumulates separately from any established for M/S in the same classification.
Notes:	For example, the plan/issuer may not impose a separate deductible for MH/SUD and M/S for emergency services.
Non-quantitative treatment limitations (NQTLs)	
Regulation:	45 CFR § 146.136(a) and (c)(4)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after July 1, 2014.
Summary of Provision:	A group health plan (or health insurance coverage) may not impose an NQTL with respect to MH/SUD in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S in the classification.
Notes:	<p>NQTLs include, but are not limited to:</p> <ul style="list-style-type: none"> • Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; • Formulary design for prescription drugs;

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	<ul style="list-style-type: none"> Standards for provider admission to participate in a network, including reimbursement rates; Plan methods for determining usual, customary, and reasonable charges; Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and Exclusions based on failure to complete a course of treatment
Resources:	<p>CCIIO Website: The Mental Health Parity and Addiction Equity Act (MHPAEA) Website</p> <p>FAQs: MHPAEA Fact Sheets</p> <p>MHPAEA and CAA, 2021 Implementation FAQs - Part 45</p>
Medical necessity criteria	
Regulation:	45 CFR § 146.136(d)(1) and (d)(2)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after July 1, 2014.
Summary of Provision:	<p>The plan administrator or issuer must make available the criteria for medical necessity determinations under the coverage with respect to MH/SUD to any current or potential participant, beneficiary, or contracting provider upon request.</p> <p>The plan administrator or issuer must make the reason for any denial of reimbursement or payment made for services with respect to MH/SUD to any participant or beneficiary.</p>
Notes:	Plans and issuers are required to make available the criteria for medical necessity determinations to providers, but are not required to make available the reason for any denial or payment for MH/SUD services to providers.
Exemptions	
Regulation:	45 CFR § 146.136(f) and (g)
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	Plan year beginning on or after July 1, 2014.
Summary of Provision:	<p>Small business exemption: Self-insured small group plans (less than 50 employees), including those offered by employers with a single employee, are exempt from mental health parity requirements. NOTE: This exception does not apply to insured small group health plans, as the health insurance issuers of such plans must comply with MHPAEA through the EHB requirement.</p> <p>Cost exemption: Plans and issuers may be exempt from mental health parity requirements for one plan year if they can demonstrate to the HHS Secretary the findings of a licensed actuary that compliance with parity increases the actual total costs of M/S and MH/SUD coverage by 2% in the first plan year that MHPAEA applies to the plan or coverage. For any subsequent exemption year, the applicable percentage is 1%. NOTE: This exception does not apply to non-grandfathered health insurance coverage in the individual or small group market that must comply with MHPAEA through the EHB requirement.</p>

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Coverage for reconstructive surgery following mastectomies: PHS Act § 2727 & PHS Act § 2752	
Regulation:	No implementing regulation
Market Type:	Group health plans, Individual & Group Markets
Statute Applicability Date(s):	October 21, 1998.
Summary of Provision:	<p>If a beneficiary or enrollee is receiving benefits in connection with a mastectomy and elects breast reconstruction then the plan or issuer must cover</p> <ul style="list-style-type: none"> • All stages of reconstruction of the breast where mastectomy performed • Surgery and reconstruction of the other breast for symmetry • Prosthesis and physical complications of mastectomy, including lymphedemas <p>The plan or issuer may not deny eligibility solely for the purpose of avoiding these requirements or penalize or incentivize the provider to encourage violations of this section.</p> <p>Additionally, plans and issuers must provide written notice of these benefits annually and upon enrollment</p>
Notes:	<p>The Women’s Health and Cancer Rights Act of 1998 created these protections in the group and individual market.</p> <p>The PHS Act cross-references the relevant ERISA section.</p> <p>The plan or issuer may apply deductibles and coinsurance, but no more than those established for other benefits and must provide written notice to each participant and beneficiary of these requirements.</p>
Resources:	<p>Statutory Provisions:</p> <p>42 USC § 300gg-52</p> <p>29 USC § 1185b (ERISA)</p> <p>CCIIO Website:</p> <p>Women’s Health and Cancer Rights Act (WHCRA) Website</p>

Coverage of Dependent Students on Medically Necessary Leave of Absence: PHS Act § 2728	
Regulation:	No implementing regulation
Market Type:	Group health plans, Individual & Group Markets
Statute Applicability Date(s):	Section applicable with respect to plan years beginning on or after the date that is one year after Oct. 9, 2008, and to medically necessary leaves of absence beginning during such plan years, see section 2(d) of Pub. L. 110-381, set out as a note under section 9813 of Title 26, Internal Revenue Code.
Summary of Provision:	<p>If a dependent child of an enrollee takes a leave of absence from a postsecondary institution which a physician verifies as medically necessary and causes the dependent to lose their eligibility under the health plan then the plan or issuer may not terminate the dependents coverage for one year or, if earlier,) the date on which the coverage would otherwise terminate under the terms of the plan or health insurance coverage.</p> <p>Additionally, the plan or issuer must provide the same benefits to the dependent as would apply without the leave of absence. However, if the plan’s coverage terms change, then the plan or issuer may apply those changes to the dependent’s coverage during the leave of absence.</p>

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Notes:	The plan or issuer must include, with any notice regarding a requirement for certification of student status for coverage under the plan or coverage, a description of the terms of this provision for continued coverage during medically necessary leaves of absence, in language which is understandable to the typical plan participant.
Resources:	Statutory Provisions: 42 USC § 300gg-28

Student Health Insurance Plans: ACA § 1560(c)	
Regulation:	45 CFR § 147.145
Market Type:	Individual Market
Statute Applicability Date(s):	Policy years beginning on or after July 1, 2012.
Summary of Provision:	<p>Student health insurance coverage is a type of individual health insurance coverage and is subject to individual market requirements except for the following provisions:</p> <ol style="list-style-type: none"> 1. Guaranteed Availability: PHS Act § 2702 – not required to accept individuals who are not students or dependents of students; not required to offer coverage on an open enrollment or calendar year basis. 2. Guaranteed Renewability: PHS Act § 2703 – not required to renew or continue in force coverage for individuals who are no longer students or dependents of students. 3. Single risk pool: ACA §1312(c)- may establish one or more separate risk pools for an institution of higher education, if the distinction among groups who forms the risk pool is based on a bona fide school-related classification and not based on a health factor. <p>Student Administrative health fees are not cost-sharing for purposes of PHS Act § 2713 which requires that certain preventive services be covered without cost sharing.</p> <p>Note special notice requirements.</p>
Resources:	CCIIO Website: Improving Health Insurance Protections for Students Student Health Plans and the Affordable Care Act

Disclosure to enrollees of Individual Market Coverage: PHS Act § 2746	
Regulation:	No implementing regulation
Market Type:	Individual Market: Individual Health Insurance Coverage & Short-term Limited Duration Insurance
Statute Applicability Date(s):	December 27, 2021
Summary of Provision:	Issuers offering individual health insurance coverage or short-term limited duration insurance coverage must disclose to enrollees any amount of direct or indirect compensation provided to an agent or broker for plan selection and enrollment services prior to the enrollee finalizing plan selection. The disclosure must also be included on documentation confirming the individual’s enrollment

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	and the issuer must annually report to the HHS Secretary any such compensation prior to the beginning of open enrollment.
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Information on Prescription Drugs: PHS Act § 2729	
Regulation:	No implementing regulation
Market Type:	Individual & Group Markets
Statute Applicability Date(s):	October 10, 2018.
Summary of Provision:	<p>Plans and issuers may not directly or indirectly penalize or restrict a pharmacy that informs enrollees of any out-of-pocket cost differences between purchasing a drug through the plan or purchasing the drug without a plan.</p> <p>Plans and issuers must also ensure that any contracted pharmacy benefits management service does not apply any such restrictions or penalties.</p>

Premium Review Process: PHS § 2794	
Regulation:	45 CFR Part 154
Market Type:	Individual & Small Group Markets
Statute Applicability Date(s):	Rates filed or effective on or after July 1, 2011
Summary of Provision:	Issuers offering health insurance coverage in the individual and small group markets must submit information on rate changes to the HHS Secretary, including justifications for unreasonable premium increases, and post the justifications on a public website.
Resources:	Statutory Provisions: 42 USC § 300gg-94 2023 Unified Rate Review Instructions 2023 Final Rate Review Bulletin

No Surprises Act: Preventing Surprise Medical Bills: PHS Act § 2799A-1	
Surprise Billing	
Regulation:	45 CFR Part 149
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022.
Summary of Provision:	<p>Implements provisions of the No Surprises Act that establish standards for group health plans, health insurance issuers offering group or individual health insurance coverage, health care providers and facilities, and providers of air ambulance services with respect to surprise medical bills, transparency in health care coverage, and additional patient protections.</p> <p>Also implements provisions of the No Surprises Act that establish an independent dispute resolution process, and standards for certifying independent dispute resolution entities; a Patient-Provider Dispute Resolution Process and standards for certifying Selected Dispute Resolution entities.</p>
Resources:	No Surprise Website

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	<p>CCIIO Website:</p> <p>Requirements Related to Surprise Billing Part I Fact Sheet (July 1, 2021)</p> <p>Requirements Related to Surprise Billing Part II Fact Sheet (September 30, 2021)</p> <p>Affordable Care Act Implementation FAQs-Set 55 (August 19, 2022)</p>
Coverage of Emergency Services	
Regulation:	45 CFR § 149.110
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022. Prior to January 1, 2022 Coverage of Emergency Services requirements can be found under 45 CFR § 147.138(b) .
Summary of Provision:	<p>If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to emergency services in the emergency department of a hospital or in an independent freestanding emergency department, then the plan or issuer must cover those services without regard to whether the provider is a participating provider and without prior authorization.</p> <p>Cost-sharing for emergency services furnished by an out-of-network provider must not be greater than what would apply if the services were provided by an in-network provider. Such cost-sharing payments are counted toward any in-network deductible or out-of-pocket maximums.</p> <p>Cost-sharing obligation for items or services provided by a nonparticipating provider is calculated based on the recognized amount as determined by an All-Payer Model Agreement (APMA), or if there is no applicable APMA, specified state law, or if there is no applicable specified state law, the lesser of billed charges or the qualifying payment amount (QPA) as described and calculated at 45 CFR 149.140(c).</p> <p>The plan or issuer must process the claim, and if the plan determines that it covers the claim, the plan must send the initial payment or notice of denial of payment to the provider or facility within 30 calendar days after a clean bill for the services is transmitted by the provider or facility to the plan or issuer.</p> <p>An open negotiation period may be initiated within 30 business days beginning on the day the OON provider receives either an initial payment or a notice of denial of payment for the item or service from the plan, issuer, or carrier.</p>
Notes:	<p>Emergency services include certain services in an emergency department of a hospital or an independent freestanding emergency department, as well as post-stabilization services in certain instances.</p> <p>Emergency Department includes an outpatient hospital department that provides emergency services.</p>
Resources:	<p>CCIIO Website:</p> <p>Requirements Related to Surprise Billing Part I Fact Sheet (July 1, 2021)</p> <p>Federal Independent Dispute Resolution (IDR) Process Guidance (April 2022)</p>
Coverage of Non-Emergency Services by Non-participating Provider at Participating Facilities	
Regulation:	45 CFR § 149.120
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022.

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Summary of Provision:	<p>Consumer protections that apply to emergency services also apply to non-emergency services provided by a non-participating provider related to a patient visit at an in-network facility, unless the provider satisfies certain notice and consent requirements. A group health plan or health insurance issuer offering group or individual health insurance coverage that provides or covers any benefits with respect to nonemergency services must cover the items and services when furnished by a nonparticipating provider.</p> <p>The plan or issuer must:</p> <ol style="list-style-type: none"> 1. Not impose a cost-sharing requirement for the items and services that is greater than if such services were provided by an participating provider (or facility, as applicable, for emergency services); and 2. Calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the lower of the billed amount or the qualifying payment amount, in instances where an All Payer Model Agreement or a specified state law does not apply to determine the cost-sharing amount. 3. Send initial payment or denial of payment to provider (or facility, as applicable, for emergency services) no later than 30 calendar days after a clean bill for services is transmitted 4. Count cost sharing toward in-network deductible and in-network out-of-pocket maximums <p>The plan or issuer must pay the provider the difference between in-network cost-sharing amount and the out-of-network rate, which in many cases will be determined through negotiation or through the Independent Dispute Resolution process (see below).</p> <p>The plan or issuer must provide certain information in writing (electronically or in paper) with each initial payment or notice of denial of payment as outlined in 45 CFR § 149.140(d).</p>
Resources:	<p>CCIIO Website: Requirements Related to Surprise Billing Part I Fact Sheet (July 1, 2021)</p> <p>Additional Resources: CY 2022 Fee Guidance for the Federal Independent Dispute Resolution Process under the NSA (September 30, 2021)</p>

Payment of IDR determinations	
Regulation:	45 CFR § 149.510(c)(4)(ix)
Market Type:	Group health plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022.
Summary of Provision:	<p>The amount of the offer selected by the certified IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider, facility, or provider of air ambulance services not later than 30 calendar days after the determination by the certified IDR entity. If the offer selected by the certified IDR entity is less than the sum of the initial payment and any cost sharing paid by the participant or beneficiary, the provider, facility, or provider of air ambulance services will be liable to the plan or issuer for the difference. The provider, facility, or provider of air ambulance services must pay the difference directly to the plan or issuer not later than 30 calendar days after the determination by the certified IDR entity.</p>

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Resources:	Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties (October 2022) Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties (March 2023)
Access Fees to Certain Databases	
Regulation:	45 CFR § 149.140(e)
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022.
Summary of Provision:	A group health plan or health insurance issuer offering group or individual health insurance coverage shall cover the cost for access to a database used to determine rates to apply for an item or service by reason of having insufficient information.
Resources:	Regulatory Provisions: 45 CFR § 149.140(e)
Transparency Regarding In-Network and Out-of-Network Deductibles	
Regulation:	No implementing regulation
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022.
Summary of Provision:	<p>A group health plan or health insurance issuer offering group or individual health insurance coverage shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to enrollees the following:</p> <ul style="list-style-type: none"> • Any deductible • Any out-of-pocket maximum limitation • A telephone number and Internet website address which an individual may seek consumer assistance information
Resources:	Statutory Provisions: 42 USC §300gg-111(c)(8)(e) FAQs: FAQs about ACA and CAA, 2021 Implementation - Part 49 (see Q4)

Methodology for Calculating Qualifying Payment Amount (QPA): PHS Act § 2799A-1	
Regulation:	45 CFR § 149.140
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022.
Summary of Provision:	<p>The QPA for a given item or service is generally the median contracted rate on January 31, 2019 for the same or similar item or service in the geographic region, increased for inflation.</p> <p>The median contracted rate for an item or service is determined by:</p> <ul style="list-style-type: none"> • Identifying the contracted rates of all plans of the plan sponsor (or of the administering entity, if applicable) or all coverage offered by the issuer in the same insurance market for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the

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	<p>same or similar facility type and provided in the geographic region in which the item or service is furnished. See definitions at 45 CFR 149.140.</p> <ul style="list-style-type: none"> The plan or issuer must calculate the qualifying payment amount by increasing the median contracted rate (as determined above) for the same or similar item or service under such plans or coverage, respectively, on January 31, 2019, by the combined percentage increase as published by the Department of the Treasury and the Internal Revenue Service to reflect the percentage increase in the CPI-U over 2019, such percentage increase over 2020, and such percentage increase over 2021 Additional calculation rules apply for anesthesia and air ambulance services 45 CFR 149.140(b)(2)(ii) <p>Insufficient information; newly covered items and services. In the case of a plan or issuer that does not have sufficient information to calculate the median of the contracted rates (or, in the case of a newly covered item or service, in the first coverage year for such item or service with respect to such plan or coverage if the plan or issuer does not have sufficient information) for an item or service provided in a geographic region -</p> <ul style="list-style-type: none"> For an item or service furnished during 2022 (or, in the case of a newly covered item or service, during the first coverage year for the item or service with respect to the plan or coverage), the plan or issuer must calculate the qualifying payment amount by first identifying the rate that is equal to the median of the in-network allowed amounts for the same or similar item or service provided in the geographic region in the year immediately preceding the year in which the item or service is furnished (or, in the case of a newly covered item or service, the year immediately preceding such first coverage year) determined by the plan or issuer, respectively, through use of any eligible database, and then increasing that rate by the percentage increase in the CPI-U over such preceding year.
Resources:	<p>Statutory Provisions: 42 USC § 300gg-111</p> <p>CCIIO Website: Qualifying Payment Amount Calculation Methodology</p> <p>Affordable Care Act Implementation FAQs-Set 55 (August 19, 2022)</p>

Surprise Air Ambulance Bills: PHS Act § 2799A-2	
Regulation:	45 CFR § 149.130
Market Type:	Group Health Plans, Individual & Group Markets
Effective Date(s):	Plan or policy years beginning on or after January 1, 2022
Summary of Provision:	<p>If the plan/issuer covers in-network air ambulance services and a beneficiary or enrollee uses an out-of-network air ambulance service then the plan/issuer must transmit either the initial payment or notice of denial to the air ambulance provider within 30 days of receiving the bill.</p> <p>The plan/issuer must reimburse the provider for the difference between the out-of-network rate and the cost-sharing amount.</p> <p>The out-of-network rate is either an amount set by State law, agreed to by the plan/issuer and air ambulance provider in open negotiations, or determined by the Independent Dispute Resolution Process.</p>

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	Cost-sharing for out-of-network air ambulance services must be equivalent to the cost-sharing for the in-network air ambulance services and apply to the in-network deductible.
Resources:	<p>Statutory provision: 42 USC § 300gg-112</p> <p>Fact Sheets: Air Ambulance NPRM Fact Sheet</p>

Continuity of Care: PHS Act § 2799A-3	
Regulation:	No implementing regulation
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan years beginning on or after January 1, 2022.
Summary of Provision:	<p>An individual is a continuing care patient if the individual is undergoing treatment for:</p> <ul style="list-style-type: none"> • serious and complex conditions. In the case of an acute illness, this includes a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, this includes a condition that is either life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time. • conditions requiring institutional or inpatient care • Scheduled for nonelective surgery or post-operative care • Pregnancy • Terminal illnesses <p>If, while an individual is a continuing care patient with respect to a provider or facility, the contract between the provider or facility and the plan/issuer terminates, or the contract between the individual's group health plan and health insurance issuer terminates, resulting in a loss of such benefits provided under such plan with respect to such provider or facility, the plan/issuer must notify all individuals who are continuing care patients of their continuing care status on a timely basis, inform them of their right to elect transitional care from the provider or facility, and provide an opportunity to notify the plan/issuer of any need for transitional care. Additionally, the plan/issuer must permit the patient to elect transitional care under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan or coverage had such termination not occurred, with respect to the course of treatment furnished by the provider or facility relating to the individual's status as a continuing care patient, for 90 days from the date of notice of the option to elect continuing care or, if earlier, until the date that the individual is no longer a continuing care patient.</p>

Public Disclosure of In-Network Rates and Out-of-Network Allowed Amounts and Billed Charges
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No Surprises Act – Price Comparison Tool: PHS Act § 2799A-4	
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Regulation:	No implementing regulation
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan years beginning on or after January 1, 2022.

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

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	<ul style="list-style-type: none"> Enforcement of the NSA tool was delayed to January 1, 2023 to align with the Transparency in Coverage tool enforcement date.
Summary of Provision:	The plan/issuer must offer a price comparison tool by phone and internet that allows beneficiaries and enrollees to compare the cost-sharing amounts they will incur for specific items or services supplied by a provider.
Notes:	
Resources:	Website: Transparency in Coverage website FAQs: Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation - Part 49 FAQs

Provider Directory Information: PHS Act § 2799A-5	
Regulation:	No implementing regulation
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan years beginning on or after January 1, 2022.
Summary of Provision:	The plan/issuer must establish a database that is available online, lists every provider and facility in a direct or indirect contractual relationship with the provider, and includes other important contact information. Information on the databases must be verified and updated every 90 days. Additionally, the plan/issuer must provide information on whether a provider is contracted with the plan/issuer in less than 1 business day and retain a record of the communication for 2 years.
Notes:	If a plan/issuer tells a beneficiary or enrollee that a provider is in-network, the beneficiary or enrollee receives services from the nonparticipating provider, and could have received the same services from a participating provider under the plan, then the cost-sharing cannot exceed the in-network rate and must apply to the in-network deductible and out-of-pocket maximum.

Other Patient Protections: PHS Act § 2799A-7	
Regulation:	45 CFR § 149.310
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Plan or policy years beginning on or after January 1, 2022. See requirements under PHS Act 2719A for requirements prior to January 1, 2022.
Summary of Provision:	<p>Choice of primary care provider: If the plan/issuer requires or provides for designation by a participant for a participating primary care provider, then the plan/issuer must permit a participant or enrollee to designate any in network primary care provider that is available to accept the individual.</p> <p>Designation of pediatrician as primary care provider: If the plan/issuer, in the case of a person who has a child who is a participant, beneficiary, or enrollee, requires or provides for the designation of a participating primary care provider for the child, the plan/issue must permit such person to designate any in network physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider.</p> <p>Patient access to obstetrical and gynecological care: If the plan/issuer provides coverage for OB/GYN care and requires the designation by a participant or enrollee of a participating primary care provider, then the plan or issuer may not</p>

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	<p>require authorization or referral by the plan/issuer or any person in the case of a female participant or enrollee who seeks coverage for OB/GYN care provided by a participating health care professional who specializes in OB/GYN. Such professional must agree to otherwise adhere to plan's/issuer's policy and procedures, including regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by plan/issuer. The plan/issuer must treat the ordering of related OB/GYN items and services by a participating health care professional who specializes in OB/GYN as the authorization of the primary care provider.</p> <p>Notice of right to designate a primary care provider: If the plan/issuer requires the designation by a participant, beneficiary, or enrollee of a primary care provider, the plan/issuer must provide a notice to each participant (in the individual market, primary subscriber) of the terms of the plan/coverage regarding designation of a primary care provider and of the rights—</p> <ul style="list-style-type: none"> • That any participating primary care provider who is available to accept the participant, beneficiary, or enrollee can be designated; • With respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and • That the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. <p>The notice must be included whenever the plan/issuer provides a participant with a summary plan description or other similar description of benefits under the plan/issuer's health coverage. In the case of individual health insurance coverage, the notice must be included whenever the issuer provides a primary subscriber with a policy, certificate, or contract of health insurance.</p> <p>Model language:</p> <p>Designation of primary care provider:</p> <p>"[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information]."</p> <p>Designation of a primary care provider for a child:</p> <p>"For children, you may designate a pediatrician as the primary care provider."</p> <p>Provide coverage for obstetric or gynecological care and require designation of primary care provider:</p> <p>"You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals</p>
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	who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].”
Resources:	FAQs: FAQs about ACA and CAA, 2021 Implementation - Part 49

Gag Clause: PHS Act § 2799A-9	
Regulation:	No implementing regulation
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	Contracts entered into December 27, 2020 or thereafter.
Summary of Provision:	<p>Group Health Plans and health insurance issuers offering group health insurance may not enter into agreements with providers, networks, third party administrators and other service providers if those agreements directly or indirectly restrict any group health plan or issuer from:</p> <ul style="list-style-type: none"> • Transmitting provider-specific cost or quality of care data to enrollees, individuals eligible to enroll, or plan sponsors • Electronically accessing de-identified claims and encounter information made accessible consistent with applicable privacy law • Sharing claims and encounter information with business associates for the purposes of plan design, plan administration, or financial, legal, and quality improvement purposes <p>Issuers offering coverage on the individual market may not enter into agreements with providers, networks, third party administrators and other service providers that directly or indirectly restrict an issuer from:</p> <ul style="list-style-type: none"> • Transmitting provider-specific cost or quality of care data to enrollees, individuals eligible to enroll, or plan sponsors • Sharing claims and encounter information with business associates for the purposes of plan design, plan administration, or financial, legal, and quality improvement purposes <p>All group health plans and issuers must annually submit attestations to the HHS, DOL and Treasury Secretaries affirming compliance with this section.</p>
Resources:	FAQs: FAQs about ACA and CAA, 2021 Implementation - Part 49

Reporting on Pharmacy Benefits and Drug Costs: PHS Act § 2799A-10	
Regulation:	45 CFR §149.710 , <i>et seq.</i>
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	December 23, 2021.
Summary of Provision:	No later than December 27, 2021, and no later than June 1 of each year thereafter, group health plans and health insurance issuers offering group or individual health insurance coverage must submit a report to the HHS, Labor, and Treasury Secretaries containing certain information on prescription drug and health care spending, including premiums, drug claims, drug costs, changes in drug costs, and prescription rebates for drugs under the plan or coverage.

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Coverage of Diagnostic Testing for COVID-19: FFCRA § 6001; CARES Act §§ 3201, 3202	
Regulation:	No implementing regulation
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	March 18, 2020.
Summary of Provision:	<p>Plans and issuers must cover without cost-sharing, prior authorization or other medical management requirements the following items and services furnished during the COVID-19 public health emergency:</p> <ul style="list-style-type: none"> • Certain in vitro diagnostic tests • Administration of these products • Items and services furnished during health care provider office visits urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product to the extent such items and services relate to the furnishing or administration of the in vitro diagnostic product or for the purposes of determining whether a patient requires an in vitro diagnostic product <p>The plan or issuer will reimburse the diagnostic test provider at a negotiated rate set before the public health emergency or, if no negotiated rate applies, the cash price listed by the provider on a public internet website.</p>
Notes:	Requirement expires at end of public health emergency
Resources:	<p>Statutory Provisions: FFCRA 6001 (see page 27)</p> <p>CCIIO Website: Coronavirus Disease 2019 (COVID-19) Guidance</p> <p>Information Related to COVID-19 Individual and Small Group Market Insurance Coverage</p> <p>FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)</p> <p>FAQs on Catastrophic Plan Coverage and the Coronavirus Disease 2019 (COVID-19)</p> <p>FAQs on the Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to Coronavirus Disease 2019 (COVID-19)</p> <p>Payment and Grace Period Flexibilities Associated with the COVID-19 National Emergency</p> <p>FAQs on Prescription Drugs and the Coronavirus Disease 2019 (COVID-19) for Issuers Offering Health Insurance Coverage in the Individual and Small Group Markets</p> <p>FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation – Part 42</p> <p>FAQs on Issuer Flexibilities for Utilization Management and Prior Authorization</p> <p>Insurance Standards Bulletin Series – Temporary Period of Relaxed Enforcement of Certain Timeframes Related to Group Market Requirements under the Public Health Service Act in Response to the COVID-19 Outbreak</p>

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	<p>Letter to Sponsors of non-Federal governmental plans – June 5, 2020</p> <p>FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation – Part 43</p> <p>FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation – Part 44</p> <p>FAQs about FFCRA and CARES Act Implementation - Part 52</p> <p>FAQs About Families First Coronavirus Response Act, Coronavirus Aid, Relief, and Economic Security Act, and Health Insurance Portability and Accountability Act Implication – Part 58</p> <p>FAQs About Affordable Care Act and Coronavirus Aid, Relief, and Economic Security Act Implementation – Part 59</p>
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Coverage of Preventive Services and Vaccines for Coronavirus: CARES Act § 3203	
Regulation:	45 CFR § 147.130
Market Type:	Group Health Plans, Individual & Group Markets
Statute Applicability Date(s):	15 business days after the date on which a relevant recommendation specified in 45 CFR § 147.130(a)(1)(v)(A) or (B) is made relating to such item, service, or immunization.
Summary of Provision:	<p>Plans and issuers must cover the qualifying coronavirus preventive services without cost sharing pursuant to section 2713(a) of the PHS Act and its implementing regulations. A qualifying coronavirus preventive service is an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is an:</p> <ul style="list-style-type: none"> • Evidence-based item or service that receives an “A” or “B” rating from the US Preventive Services Task Force • An immunization that has a recommendation from ACIP
Notes:	Certain regulatory requirements regarding coverage and reimbursement of qualifying coronavirus preventive services furnished out-of-network expired at end of the COVID-19 public health emergency. However, the statutory requirement to cover such items and services pursuant to section 2713(a) of the PHS Act does not expire.
Resources:	<p>Statutory Provisions:</p> <p>42 USC § 300gg-13</p> <p>Section 3203 of the CARES Act (see page 100)</p> <p>Regulatory Provisions:</p> <p>45 CFR § 147.130</p> <p>Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency</p>