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Federal Requirements on Private Health Insurance Plans

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Summary

A majority of Americans have health insurance from the private health insurance (PHI) market. Health plans sold in the PHI market must comply with requirements at both the state and federal levels; such requirements often are referred to as market reforms.

The first part of this report provides background information about health plans sold in the PHI market and briefly describes state and federal regulation of private plans. The second part summarizes selected federal requirements and indicates each requirement's applicability to one or more of the following types of private health plans: individual, small group, large group, and self-insured. The selected market reforms are grouped under the following categories: obtaining coverage, keeping coverage, developing health insurance premiums, covered services, cost-sharing limits, consumer assistance and other patient protections, and plan requirements related to health care providers. Many of the federal requirements described in this report were established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended); however, some were established under federal laws enacted prior to the ACA.

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A majority of Americans have health insurance from the private health insurance (PHI) market. Health plans sold in the PHI market must comply with requirements at both the state and federal levels. This report describes selected federal statutory requirements applicable to health plans sold in the PHI market. These requirements relate to the offer, issuance, generosity, and pricing of health plans, among other issues; such requirements often are referred to as *market reforms*. Many of the federal requirements described in this report were established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended); however, some were established under federal laws enacted prior to the ACA.

The first part of this report provides background information about health plans sold in the PHI market and briefly describes state and federal regulation of private plans. The second part summarizes selected federal requirements and indicates each requirement's applicability to one or more of the following types of private health plans: individual, small group, large group, and self-insured. The second part of the report includes a table summarizing the applicability of federal statutory requirements across those plan types. The **Appendix** includes **Table A-1**, which shows the applicability of federal statutory requirements across plan types pre-ACA and under current law.

Background

Private Health Plans

Whether a health plan must comply with a particular federal requirement depends on the segment of the PHI market in which the plan is sold. The *individual market* (or *non-group market*) is where individuals and families buying insurance on their own (i.e., not through a plan sponsor) may purchase health plans.

Health plans sold in the *group market* are offered through a plan sponsor, typically an employer. The group market is divided into small and large segments. For purposes of federal requirements that apply to the group market, states may elect to define *small* as groups with 50 or fewer individuals (e.g., employees) or groups with 100 or fewer individuals. The definition for *large* group builds on the small-group definition. A large group is a group with at least 51 individuals or a group with at least 101 individuals, depending on which small-group definition is used in a given state.

The reference to group markets technically applies to health plans purchased by employers and other plan sponsors from state-licensed issuers and offered to employees or other groups. Health plans obtained in this way are referred to as *fully insured*. However, health insurance coverage provided through a group also may be *self-insured*. Employers or other plan sponsors that self-insure set aside funds to pay for health benefits directly, and they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan.

For simplicity's sake, the term *plan* is used generically in this report's descriptions of federal requirements; however, **Table 1** provides detailed information about the application of federal requirements to different types of plans (e.g., individual market plans).

Regulation of Private Health Plans

States are the primary regulators of the business of health insurance, as codified by the 1945 McCarran-Ferguson Act.[1] Each state requires insurance issuers to be licensed in order to sell health plans in the state, and each state has a unique set of requirements that apply to state-licensed issuers and the plans they offer. Each state's health insurance requirements are broad in scope and address a variety of issues, and requirements vary greatly from state to state. State requirements have changed over time in response to shifting attitudes about regulation, the evolving health care landscape, and the implementation of federal policies. State oversight of health plans applies only to plans offered by state-licensed issuers. Because self-insured plans are financed directly by the plan sponsor, such plans are not subject to state law.

The federal government also regulates state-licensed issuers and the plans they offer. Federal health insurance requirements typically follow the model of federalism: federal law establishes standards, and states are primarily responsible for monitoring compliance with and enforcement of those standards. Generally, the federal standards establish a minimum level of requirements (*federal floor*) and states may impose additional requirements on issuers and the plans they offer, provided the state requirements neither conflict with federal law nor prevent the implementation of federal requirements. For example, the federal rating restriction requirement provides that certain types of health plans may vary premiums by only four factors—type of coverage (i.e., self-only or family), geographic rating area, tobacco use, and age. Some states have expanded this requirement by prohibiting issuers from varying premiums by tobacco use and age. The federal government also regulates self-insured plans, as part of federal oversight of employment-based benefits. Federal requirements applicable to self-insured plans often are established in tandem with requirements on fully insured plans and state-licensed issuers. Nonetheless, fewer federal requirements overall apply to self-insured plans compared to fully insured plans.

Federal requirements for health plans are codified in three statutes: the Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC). Although the health insurance provisions in these statutes are substantively similar, the differences reflect, in part, the applicability of each statute to private plans. The PHSA's provisions apply broadly across private plans, whereas ERISA and the IRC focus primarily on group plans.

Some types of plans are exempt from one or more federal requirements (as opposed to the requirement not being applicable to the plan). For example, in general, plans in the individual market must comply with the requirement to accept every applicant for health coverage (i.e., guaranteed issue); however, *grandfathered* health plans offered in the individual market are exempt from

Qualified Health Plans (QHP)

A QHP is a health plan that is certified by a health insurance exchange and is offered by a state-licensed issuer that complies with specified requirements (see 42 U.S.C. §18021(a)(1)(C)). A QHP is the only type of comprehensive health plan an exchange may offer, but QHPs may be offered inside and outside exchanges. A QHP issuer and a QHP must comply with all state and federal requirements that apply to state-licensed issuers and the plans they offer. In other words, the federal requirements described in this report apply to a QHP—whether offered inside or outside an exchange—the same way that the requirements apply to health plans that are not QHPs. As such, QHPs are not discussed separately from other types of health plans in this report. (For additional discussion about QHPs, see CRS Report R44065, *Overview of Health Insurance Exchanges*.)

[1] 15 U.S.C. §§1011 et seq.

complying with this requirement.[2] Plans that are exempt from one or more federal requirements are not discussed in this report.

Federal Requirements

Federal requirements applicable to health plans sold in the PHI market affect insurance offered to groups and individuals; impose requirements on sponsors of coverage; and, collectively, establish a federal floor with respect to access to coverage, premiums, benefits, cost sharing, and consumer protections. The federal requirements described in this report are grouped under the following categories: obtaining coverage, keeping coverage, developing health insurance premiums, covered services, cost-sharing limits, consumer assistance and other patient protections, and plan requirements related to health care providers.[3]

Federal requirements do not apply uniformly to all types of health plans. For example, plans offered in the individual and small-group markets must comply with the federal requirement to cover the essential health benefits (EHB; see "Coverage of Essential Health Benefits," below); however, plans offered in the large-group market and self-insured plans do not have to comply with this requirement. **Table 1** provides details about the specific types of plans to which the federal requirements described in this report apply: individual, small group, large group, and self-insured. Summary descriptions of the federal requirements follow the table.

Many of the federal requirements described in this report were established under the ACA, but some were established prior to the ACA. Among the requirements established prior to the ACA, some were modified or expanded under the ACA.

Table 1. Applicability of Selected Federal Requirements to Private Health Insurance Plans

		Group Market[b]			
		Fully Insured[d]			
U.S. Code[a]	**Provision**	**Large Group**[f]	**Small Group**[f]	**Self-Insured**[e]	**Individual Market**[c]
Obtaining Coverage					
42 U.S.C. §300gg-1	Guaranteed Issue	√	√	N.A.	√
42 U.S.C. §300gg-4(a)	Prohibition on Using Health Status for Eligibility Determinations	√	√	√	√
42 U.S.C. §300gg-14	Extension of Dependent Coverage	√	√	√	√

[2] A grandfathered health plan refers to an existing plan in which at least one individual has been enrolled since enactment of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) on March 23, 2010. Grandfathered plans are subject to fewer federal requirements than non-grandfathered plans. A plan may maintain grandfathered status if it undergoes only minimal changes to employer contributions, access to coverage, benefits, or cost sharing. A plan that undergoes more extensive changes may lose its grandfathered status. For additional information about grandfathered plans, see Kaiser Family Foundation, "FAQ: Grandfathered Health Plans," at https://khn.org/news/grandfathered-plans-faq/.

[3] Consumers typically have two different categories of spending related to health coverage. *Premiums* refer to the cost of purchasing the health plan in the first place. *Cost-sharing requirements* are the amounts an insured consumer pays for health care services included under his or her health plan. A plan's cost-sharing requirements may include deductibles, co-payments, and coinsurance.

		Group Market[b]			
		Fully Insured[d]			
U.S. Code[a]	**Provision**	**Large Group**[f]	**Small Group**[f]	**Self-Insured**[e]	**Individual Market**[c]
42 U.S.C. §300gg-16 26 U.S.C. §105(h)	Prohibition of Discrimination Based on Salary	√[g]	√[g]	√[g]	N.A.
42 U.S.C. §300gg-7	Waiting Period Limitation	√	√	√	N.A.
Keeping Coverage					
42 U.S.C. §300gg-2	Guaranteed Renewability	√	√	N.A.	√
42 U.S.C. §300gg-12	Prohibition on Rescissions	√	√	√	√
29 U.S.C. §1161- §1168	COBRA Continuation Coverage[h]	√	√[i]	√	N.A.
Developing Health Insurance Premiums					
42 U.S.C. §300gg-4(b)	Prohibition on Using Health Status as a Rating Factor	√	√	√	√
42 U.S.C. §300gg	Rating Restrictions	N.A.	√	N.A.	√
42 U.S.C. §300gg-94	Rate Review	N.A.	√	N.A.	√
42 U.S.C. §18032	Single Risk Pool	N.A.	√	N.A.	√
Covered Services					
42 U.S.C. §300gg-25	Minimum Hospital Stay After Childbirth	√	√	√	√
42 U.S.C. §300gg-26	Mental Health Parity	√	N.A.	√[j]	√
42 U.S.C. §300gg-27	Reconstruction After Mastectomy	√	√	√	√
42 U.S.C. §300gg-3, 4	Nondiscrimination Based on Genetic Information	√	√	√	√
42 U.S.C. §300gg-28	Coverage for Students Who Take a Medically Necessary Leave of Absence	√	√	√	√
42 U.S.C. §18022	Coverage of Essential Health Benefits	N.A.	√	N.A.	√
42 U.S.C. §300gg-13	Coverage of Preventive Health Services Without Cost Sharing	√	√	√	√
42 U.S.C. §300gg-3	Coverage of Preexisting Health Conditions	√	√	√	√
42 U.S.C. §300gg-4	Wellness Programs	√	√	√	N.A.

		Group Market[b]			
		Fully Insured[d]			
U.S. Code[a]	Provision	Large Group[f]	Small Group[f]	Self-Insured[e]	Individual Market[c]
Cost-Sharing Limits					
42 U.S.C. §18022	Limits for Annual Out-of-Pocket Spending	√	√	√	√
42 U.S.C. §18022	Minimum Actuarial Value Requirements	N.A.	√	N.A.	√
42 U.S.C. §300gg-11	Prohibition on Lifetime Limits	√	√	√	√
42 U.S.C. §300gg-11	Prohibition on Annual Limits	√	√	√	√
Consumer Assistance and Other Patient Protections					
42 U.S.C. §300gg-15	Summary of Benefits and Coverage	√	√	√	√
42 U.S.C. §300gg-18	Medical Loss Ratio	√	√	N.A.	√
42 U.S.C. §300gg-19	Appeals Process	√	√	√	√
42 U.S.C. §300gg-19a	Patient Protections	√	√	√	√
42 U.S.C. §300gg-8	Nondiscrimination Regarding Clinical Trial Participation	√	√	√	√
Plan Requirements Related to Health Care Providers					
42 U.S.C. §300gg-5	Nondiscrimination Regarding Health Care Providers	√	√	√	√
42 U.S.C. §300gg-17	Reporting Requirements Regarding Quality of Care	√	√	√	√

Source: Congressional Research Service (CRS) analysis of federal statutes.

Notes: N.A. indicates that the requirement is not applicable to that type of health plan. The requirements listed in the table do not comprise a comprehensive list of all federal requirements and standards that apply to all health plans.

a. Some requirements listed in this table also may be found in other sections of the *U.S. Code.*

b. Health insurance may be provided to a group of people that are drawn together by an employer or other organization, such as a trade union. Such groups generally are formed for purpose other than obtaining insurance, such as employment. When insurance is provided to a group, it is referred to as *group coverage* or *group insurance*. In the group market, the entity that purchases health insurance on behalf of a group is referred to as the *plan sponsor*.

c. Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurance issuer in the individual (or non-group) health insurance market.

d. A fully insured health plan is one in which the plan sponsor purchases health coverage from a state-licensed issuer; the issuer assumes the risk of paying the medical claims of the sponsor's enrolled members.

e. *Self-insured plans* refer to health coverage that is provided directly by the organization sponsoring coverage for its members (e.g., a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering

medical claims. In general, the size of a self-insured employer does not affect the applicability of federal requirements.

f. States may elect to define large groups as groups with more than 50 individuals or more than 100 individuals. The definition of a small group is a group with either 50 or fewer individuals or 100 or fewer individuals, depending on a state's definition of a large group.

g. Fully insured plans are subject to the nondiscrimination requirement codified at 42 U.S.C. §300gg-16 (and incorporated by reference into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code). Self-insured plans are subject to the nondiscrimination requirement codified at 26 U.S.C. §105(h). The nondiscrimination requirement for fully insured plans is not in effect as of the date of this report, but the requirement for self-insured plans is in effect.

h. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272.

i. Employers with fewer than 20 employees are not required to comply with COBRA's coverage continuation requirement.

j. Self-insured plans sponsored by small employers (50 or fewer employees) are exempt from the mental health parity requirement.

Obtaining Coverage

Guaranteed Issue

Certain types of health plans must be offered on a guaranteed-issue basis.[4] In general, *guaranteed issue* is the requirement that a plan accept every applicant for coverage, as long as the applicant agrees to the terms and conditions of the insurance offer (e.g., the premium). Individual plans are allowed to restrict enrollment to open and special enrollment periods.[5] Plans offered in the group market must be available for purchase at any time during a year.[6]

Plans that otherwise would be required to offer coverage on a guaranteed-issue basis are allowed to deny coverage to individuals and employers in certain circumstances, such as when a plan demonstrates that it does not have the network capacity to deliver services to additional enrollees or the financial capacity to offer additional coverage.

Prohibition on Using Health Status for Eligibility Determinations

Plans are prohibited from basing applicant eligibility on health status-related factors.[7] Such factors include health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factor determined appropriate by the Secretary of Health and Human Services (HHS).

[4] 42 U.S.C. §300gg-1.

[5] The annual open enrollment periods in the individual market are the same inside and outside health insurance exchanges. The dates for the annual open enrollment period are issued in regulations at 45 C.F.R. §155.410. Qualifying events for special enrollment periods are defined in §603 of the Employee Retirement Income Security Act of 1974 (ERISA; P.L. 93-406) and in 45 C.F.R. §155.420(d).

[6] Regulations provide an exception for plans offered in the small-group market. The plans may limit enrollment to an annual period from November 15 through December 15 of each year if the plan sponsor does not comply with provisions relating to employer-contribution or group-participation rules, pursuant to state law.

[7] 42 U.S.C. §300gg-4(a).

Extension of Dependent Coverage

If a plan offers dependent coverage, the plan must make such coverage available to a child under the age of 26.[8] Plans that offer dependent coverage must make coverage available for both married and unmarried adult children under the age of 26, but plans do not have to make coverage available to the adult child's children or spouse (although a plan may voluntarily choose to cover these individuals).

Prohibition of Discrimination Based on Salary

The sponsors of health plans (e.g., employers) are prohibited from establishing eligibility criteria based on any full-time employee's total hourly or annual salary.[9] Eligibility rules are not permitted to discriminate in favor of higher-wage employees. Additionally, sponsors are prohibited from providing benefits under a plan that discriminates in favor of higher-wage employees (i.e., a sponsor must provide all the benefits it provides to higher-wage employees to all other full-time employees).

Self-insured plans currently are required to comply with these requirements; however, fully insured plans are not. The requirement for fully insured plans was established under the ACA, and the Departments of HHS, Labor, and the Treasury have determined that fully insured plans do not have to comply with this requirement until after regulations are issued. As of the date of this report, regulations have not been issued.[10]

Waiting Period Limitation

Plans are prohibited from establishing waiting periods longer than 90 days.[11] A *waiting period* refers to the time that must pass before coverage can become effective for an individual who is eligible to enroll under the terms of the plan. In general, if an individual can elect coverage that becomes effective within 90 days, the plan complies with this provision.

Keeping Coverage

Guaranteed Renewability

Guaranteed renewability is a requirement to renew an individual's plan at the option of the policyholder or to renew a group plan at the option of the plan sponsor. Plans that must comply with guaranteed renewability may discontinue the plan only under certain circumstances.[12] For example, a plan may discontinue coverage if the individual or plan sponsor fails to pay premiums or if an individual or plan sponsor performs an act that constitutes fraud in connection with the coverage.

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[8] 42 U.S.C. §300gg-14.

[9] Fully insured plans are subject to the nondiscrimination requirement codified at 42 U.S.C. §300gg-16 (and incorporated by reference into ERISA and the Internal Revenue Code). Self-insured plans are subject to the nondiscrimination requirement codified at 26 U.S.C. §105(h).

[10] Internal Revenue Service (IRS), "Affordable Care Act Nondiscrimination Provisions Applicable to Insured Group Health Plans," Internal Revenue Notice 2011-1, January 10, 2011.

[11] 42 U.S.C. §300gg-7.

[12] 42 U.S.C. §300gg-2.

Prohibition on Rescissions

The practice of *rescission* refers to the retroactive cancellation of medical coverage after an enrollee has become sick or injured. In general, rescissions are prohibited, but they are permitted in cases where the covered individual committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan.[13] A cancellation of coverage in this case requires that a plan provide at least 30 calendar days' advance notice to the enrollee.

COBRA Continuation Coverage[14]

Plan sponsors that have at least 20 employees are required to continue to offer coverage under certain circumstances (*qualifying events*) to certain employees and their dependents (*qualified beneficiaries*) who otherwise would be ineligible for such coverage.[15] Generally, plan sponsors must provide access to continuation coverage to qualified beneficiaries for up to 18 months (or longer, under certain circumstances) following a qualifying event. Beneficiaries may be charged up to 102% of the premium for such coverage.

Developing Health Insurance Premiums

Prohibition on Using Health Status as a Rating Factor

Plans are prohibited from varying premiums for *similarly situated individuals* based on the *health status-related factors* of the individuals or their dependents.[16] Such factors include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), and disability. However, plans may offer premium discounts or rewards based on enrollee participation in wellness programs.[17]

Rating Restrictions

Plans must use adjusted (or modified) community rating rules to determine premiums.[18] Adjusted community rating prohibits the use of health factors in the determination of premiums but allows premium variation based on other factors. The four factors by which premiums may vary are described below.

- **Type of Enrollment.** Plans may vary premiums based on whether only the individual or the individual and any number of his/her dependents enroll in the plan (i.e., self-only enrollment or family enrollment).[19]

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[13] 42 U.S.C. §300gg-12.

[14] This requirement was established under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272), and coverage received under this requirement is typically referred to as COBRA coverage.

[15] 29 U.S.C. §1161-§1168. An example of a qualifying event is termination from a job.

[16] 42 U.S.C. §300gg-4(b). For information about identifying *similarly situated individuals*, see 45 C.F.R. §146.121(d).

[17] See "Wellness Programs" in this report for more details.

[18] 42 U.S.C. §300gg.

[19] In most states, plans may vary premiums based on only self-only or family enrollment; however, in states that do not permit rating variation for age and tobacco, plans may use state-established uniform family tiers. For example, such a state may allow plans to vary premiums for self-only, self plus one, and family. For more information, see Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information & Insurance Oversight (CCIIO), "Market Rating Reforms: State-Specific Rating Variations," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-

- **Geographic Rating Area.** States are allowed to establish one or more geographic rating areas within the state for the purposes of this provision. The rating areas must be based on one of the following geographic boundaries: (1) counties, (2) three-digit zip codes,[20] or (3) metropolitan statistical areas (MSAs) and non-MSAs.[21]
- **Tobacco Use.** Plans are allowed to charge a tobacco user up to 1.5 times the premium that they charge an individual who does not use tobacco.
- **Age.** Plans may not charge an older individual more than three times the premium that they charge a 21-year-old individual. Each state must use a uniform age rating curve to specify the rates across age bands. For plan years beginning on or after January 1, 2018, plans must use one age band for individuals aged 0-14 years, one-year age bands for individuals aged 15-63 years, and one age band for individuals aged 64 years and older.[22]

Rate Review

Under the rate review program, proposed annual health insurance rate increases that meet or exceed a federal default threshold are reviewed by a state or the Centers for Medicare & Medicaid Services (CMS).[23] The federal default threshold for plan years beginning in 2019 is 15%.[24] States have the option to apply for state-specific thresholds.[25]

Plans subject to review are required to submit to CMS and the relevant state a justification for the proposed rate increase prior to its implementation, and CMS and the state must publicly disclose the information. The rate review process does not establish federal authority to deny implementation of a proposed rate increase; it is a sunshine provision designed to publicly expose rate increases determined to be unreasonable.

Insurance-Market-Reforms/state-rating.html.

[20] A three-digit zip code refers to the first three digits of a five-digit zip code. A three-digit zip code represents a larger geographical area than a five-digit zip code, as all five-digit zip codes that share the same first three numbers are included in the three-digit zip code.

[21] The Office of Management and Budget (OMB) establishes delineations for various statistical areas, including metropolitan statistical areas (MSAs). The most recent delineations are available at Executive Office of the President, OMB, "Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas," OMB Bulletin No. 17-01, August 15, 2017, at https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/bulletins/2017/b-17-01.pdf.

[22] To see the age rating curve and age bands for plan years beginning in 2018, see CMS, CCIIO, "Market Rating Reforms: State Specific Age Curve Variations," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html#age.

[23] 42 U.S.C. §300gg-94. CMS identifies whether states have effective rate review systems. In states with effective rate review systems, the state conducts review; in states that do not have effective rate review systems, CMS conducts the review.

[24] The federal default threshold was 10% in previous years. It was modified by Department of Health and Human Services, "HHS Notice of Benefit and Payment Parameters for 2019," 83 *Federal Register* 16930, April 17, 2018.

[25] For more information, see CMS, CCIIO, "State-Specific Threshold Proposals," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/sst.html.

Single Risk Pool

A risk pool is used to develop rates for coverage. A health insurance issuer must consider all enrollees in plans offered by the issuer to be members of a single risk pool.[26] Specifically, an issuer must consider all enrollees in individual plans offered by the issuer to be members of a single risk pool; the issuer must have a separate risk pool for all enrollees in small-group plans offered by the issuer. (However, states have the option to merge their individual and small-group markets; if a state does so, an issuer will have a single risk pool for all enrollees in its individual and small-group plans.) An issuer must consider the medical claims experience of enrollees in all plans offered by the issuer in a single risk pool when developing rates for the plans.

Covered Services

Minimum Hospital Stay After Childbirth

Plans are prohibited from restricting the length of a hospital stay for childbirth for either the mother or newborn child to less than 48 hours for vaginal deliveries and to less than 96 hours for caesarian deliveries.[27]

Mental Health Parity

Plans that provide coverage for mental health and substance use disorder services must offer coverage for those services at parity with medical and surgical services, specifically in the following four areas: annual and lifetime limits, treatment limitations, financial requirements, and in- and out-of-network covered benefits.[28]

Reconstruction After Mastectomy

Plans that provide coverage for mastectomies also must cover prosthetic devices and reconstructive surgery.[29]

Nondiscrimination Based on Genetic Information

Health insurance issuers are prohibited from (1) using genetic information to deny coverage, adjust premiums, or impose a preexisting-condition exclusion; (2) requiring or requesting genetic testing; and (3) collecting or acquiring genetic information for insurance underwriting purposes.[30]

Coverage for Students Who Take a Medically Necessary Leave of Absence

Plans are prohibited from terminating the health coverage of an applicable student who takes a medical leave of absence from a postsecondary educational institution or other change in enrollment that causes the student to lose access to health coverage.[31] The leave of absence must

[26] 42 U.S.C. §18032.

[27] 42 U.S.C. §300gg–25.

[28] 42 U.S.C. §300gg–26.

[29] 42 U.S.C. §300gg–27.

[30] 42 U.S.C. §300gg–3,4.

[31] 42 U.S.C. §300gg–28.

be medically necessary and must begin while the student is suffering from a serious illness or injury. These requirements are colloquially referred to as *Michelle's Law*.

Coverage of Essential Health Benefits

Plans must cover the essential health benefits (EHB).[32] The benefits that comprise the EHB are not defined in federal law; rather, the law lists 10 broad categories from which benefits and services must be included.[33] The HHS Secretary is tasked with further defining the EHB. To date, the HHS Secretary has directed each state to select an EHB benchmark plan to serve as the basis for the state's EHB.[34]

The EHB requirement does not prohibit states from maintaining or establishing state-mandated benefits. State-mandated benefits enacted on or before December 31, 2011, are considered part of the EHB. However, any state that requires plans to cover benefits beyond the EHB and what was mandated by state law prior to 2012 must assume the total cost of providing those additional benefits.[35] In other words, states must defray the cost of any mandated benefits enacted after December 31, 2011.

Coverage of Preventive Health Services Without Cost Sharing

Plans generally are required to provide coverage for certain preventive health services without imposing cost sharing.[36] The preventive services include the following minimum requirements:[37]

- evidence-based items or services that have in effect a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF);[38]
- immunizations that have in effect a recommendation for routine use from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

[32] 42 U.S.C. §18022.

[33] The 10 categories are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[34] For information about the process for defining the essential health benefits (EHB) in each state that is in place for plan years beginning before 2020, see CRS Report R44163, *The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)*. On April 17, 2018, HHS issued a final rule that modifies the process for defining the EHB for plan years beginning in 2020. For more information, see Department of Health and Human Services, "HHS Notice of Benefit and Payment Parameters for 2019," 83 *Federal Register* 16930, April 17, 2018.

[35] Technically, states only have to defray the cost of additional benefits for *qualified health plans* (QHPs). See the text box at the beginning of this report for information about QHPs. The final rule mentioned in footnote 34 did not change the overall requirement that states defray costs of mandated benefits depending on date the mandate was enacted, but the rule did add additional clarifications to this requirement that are related to broader changes to the process for states to select their EHB benchmark plans.

[36] 42 U.S.C. §300gg-13.

[37] The complete list of recommendations and guidelines required to be covered under regulations at 45 C.F.R. §147.130 is available at HealthCare.gov, "Health Benefits and Coverage: Preventive Health Services," at http://www.healthcare.gov/coverage/preventive-care-benefits/.

[38] The United States Preventive Services Task Force (USPSTF) is an independent panel of private-sector experts in primary care and prevention that assesses scientific evidence of the effectiveness of a broad range of clinical preventive services. For additional information about USPSTF, see U.S. Preventive Services Task Force at http://www.uspreventiveservicestaskforce.org.

- evidence-informed preventive care and screenings (for infants, children, and adolescents) provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- additional preventive care and screenings for women not described by the USPSTF, as provided in comprehensive guidelines supported by HRSA.[39]

Additional services other than those recommended by the USPSTF may be offered but are not required to be covered without imposing cost sharing.

A plan with a network of providers is not required to provide coverage for an otherwise required preventive service if the service is delivered by an out-of-network provider, and the plan may impose cost-sharing requirements for a recommended preventive service delivered out of network. Additionally, if a recommended preventive service does not specify the frequency, method, treatment, or setting for the service, then the plan can determine coverage limitations by relying on established techniques and relevant evidence.

Coverage of Preexisting Health Conditions

Plans are prohibited from excluding coverage for preexisting health conditions.[40] In other words, plans may not exclude benefits based on health conditions for any individual.[41] A *preexisting health condition* is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Wellness Programs

Plans are allowed to establish premium discounts or rebates or to modify cost-sharing requirements in return for adherence to a wellness program.[42] If a wellness program is made available to all *similarly situated individuals*, and it either does not provide a reward or provides a reward based solely on participation, then the program complies with federal law without having to satisfy any additional standards.[43] If a program provides a reward based on an individual meeting a certain standard relating to a health factor, then the program must meet additional requirements specified in federal regulations and the reward must be capped at 30% of the cost of employee-only coverage under the plan. However, the Secretaries of HHS, Labor, and the Treasury have the discretion to increase the reward up to 50% of the cost of coverage if the increase is determined to be appropriate.[44]

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[39] The Health Resources and Service Administration (HRSA) published its guidelines related to women's preventive services in August 2011; see HRSA, "Women's Preventive Services Guidelines," at http://www.hrsa.gov/womensguidelines/. These guidelines include, among other services, coverage for all Food and Drug Administration-approved contraceptive methods and sterilization procedures. The requirement to cover contraceptive services has been a source of controversy and the subject of several challenges in the courts, including the Supreme Court. See CRS Legal Sidebar LSB10012, *New Interim Final Rules Expand Options for Employers with Religious or Moral Objections to Contraceptive Coverage*.

[40] 42 U.S.C. §300gg-3.

[41] Prior to the ACA, some plans were allowed to exclude benefits for preexisting conditions during what was referred to as an *exclusion period*. This is different from a waiting period (see the "Waiting Period Limitation" section of this report).

[42] 42 U.S.C. §300gg-4.

[43] For information about identifying *similarly situated individuals*, see 45 C.F.R. §146.121(d).

[44] As long as the wellness programs meet applicable standards, premium discounts or rebates do not violate the federal

Cost-Sharing Limits

Limits on Annual Out-of-Pocket Spending

Plans must comply with annual limits on out-of-pocket spending.[45] The limits apply only to in-network coverage of the EHB.[46] In 2018, the limits cannot exceed $7,350 for self-only coverage and $14,700 for coverage other than self-only. In 2019, those limits will be $7,900 and $15,800, respectively.

The self-only limit applies to each individual, regardless of whether the individual is enrolled in self-only coverage or coverage other than self-only. For instance, if an individual is enrolled in a family plan and incurs $8,000 in cost sharing, the plan is responsible for covering the individual's costs above $7,350 in 2018.[47]

Minimum Actuarial Value Requirements

Plans must tailor cost sharing to comply with one of four levels of actuarial value.[48] *Actuarial value* (AV) is a summary measure of a plan's generosity, expressed as the percentage of total medical expenses that are estimated to be paid by the issuer for a standard population and set of allowed charges.[49] In other words, AV reflects the relative share of cost sharing that may be imposed. On average, the lower the AV, the greater the cost sharing for enrollees overall.

Federal law requires each level of plan generosity to be designated according to a precious metal and to correspond to an AV. Regulations allow plans to fall within a specified AV range and still comply with each of the four levels. See **Table 2** for details.

Table 2. Actuarial Value Requirements

(for plan years beginning on or after January 1, 2018)

Precious Metal	Actuarial Value	Allowable Range
Bronze	60%	56%-62%[a]
Silver	70%	66%-72%
Gold	80%	76%-82%
Platinum	90%	86%-92%

prohibition against using health factors to determine rates, as described above in "Prohibition on Using Health Status as a Rating Factor."

[45] 42 U.S.C. §18022.

[46] Certain types of plans—self-insured plans and plans offered in the large-group market—must comply with this requirement but do not have to offer the EHB. The Department of Health and Human Services (HHS) has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirement.

[47] For additional information about the annual out-of-pocket limit, see HHS, "Embedded Self-Only Annual Limitation on Cost Sharing FAQs," May 8, 2015, at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/hhs-guidance-embedded-self-only-annual-limitation-on-cost-sharing-faqs.pdf.

[48] 42 U.S.C. §18022.

[49] Actuarial value (AV) is only one component that addresses the value of any given benefit package. AV, by itself, does not address other important features of coverage, such as total (dollar) value, network adequacy, and premiums.

Sources: 42 U.S.C. §18022 and 45 C.F.R. §156.140(c).

Note:

a. If a bronze plan either (1) covers at least one major service, other than preventive services, before the deductible, or (2) is considered a health savings account-qualified high-deductible health plan, then the allowable range for the bronze plan is 56% - 65%.

Prohibition on Lifetime Limits and Annual Limits

Plans are prohibited from setting lifetime and annual limits on the EHB.[50] Lifetime and annual limits are dollar limits on how much the plan spends for covered health benefits either during the entire period an individual is enrolled in the plan (lifetime limits) or during a plan year (annual limits). Plans are permitted to place lifetime and annual limits on covered benefits that are not considered EHBs, to the extent that such limits are otherwise permitted by federal and state law.

Consumer Assistance and Other Patient Protections

Summary of Benefits and Coverage

Plans are required to provide a summary of benefits and coverage (SBC) to individuals at the time of application, prior to the time of enrollment or reenrollment, and when the insurance policy is issued.[51] The SBC must meet certain requirements with respect to the included content and the presentation of the content.[52] The SBC may be provided in paper or electronic form. Enrollees must be given notice of any material changes in benefits no later than 60 days prior to the date that the modifications would become effective. Plans also must provide a uniform glossary of terms commonly used in health insurance coverage (e.g., coinsurance) to enrollees upon request.

Medical Loss Ratio

Plans are required to submit a report to the HHS Secretary concerning the percentage of premium revenue spent on medical claims (*medical loss ratio*, or MLR).[53] The MLR calculation includes adjustments for quality improvement expenditures, taxes, regulatory fees, and other factors. Plans in the individual and small-group markets must meet a minimum MLR of 80%; for large groups, the minimum MLR is 85%. States are permitted to increase the percentages, and the HHS Secretary may lower a state percentage for the individual market if HHS determines that the application of a minimum MLR of 80% would destabilize the individual market within the state.[54] Plans whose MLR falls below the specified limit must provide rebates to policyholders on a pro rata basis. Any required rebates must be paid to policyholders by August of that year.

[50] 42 U.S.C. §300gg-11.

[51] 42 U.S.C. §300gg-15.

[52] For more information about the summary of benefits and coverage's content and presentation, see CMS, CCIIO, "Summary of Benefits & Coverage & Uniform Glossary," at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html.

[53] 42 U.S.C. §300gg-18. For more information about the medical loss ratio (MLR), see CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, by Suzanne M. Kirchhoff.

[54] To view a list of state requests for an MLR adjustment, see CMS, CCIIO, "Ensuring the Affordable Care Act Serves the American People," at http://cciio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html.

Appeals Process

Plans must implement an effective appeals process for coverage determinations and claims.[55] At a minimum, plans must

- have an internal claims appeals process;
- provide notice to enrollees regarding available internal and external appeals processes and the availability of any applicable assistance; and
- allow an enrollee to review his or her file, present evidence and testimony, and receive continued coverage pending the outcome.

Patient Protections

Plans are subject to three requirements relating to the choice of health care professionals.[56] First, plans that require or allow an enrollee to designate a participating primary care provider are required to permit the designation of any participating primary care provider who is available to accept the individual. Second, the same provision applies to pediatric care for any child who is a plan participant. Third, plans that provide coverage for obstetrical or gynecological care cannot require authorization or referral by the plan or any person (including a primary care provider) for a female enrollee who seeks obstetrical or gynecological care from an in-network health care professional who specializes in obstetrics or gynecology.

Plans also must comply with one requirement relating to benefits for emergency services.[57] If a plan covers services in an emergency department of a hospital, the plan is required to cover those services without the need for any prior authorization and without the imposition of coverage limitations, irrespective of the provider's contractual status with the plan. If the emergency services are provided out of network, the cost-sharing requirement will be the same as the cost sharing for an in-network provider.

Nondiscrimination Regarding Clinical Trial Participation

Plans are subject to nondiscrimination and other provisions with respect to *qualified individuals'* access to and costs associated with clinical trials.[58] Specifically, plans cannot

- prohibit qualified individuals from participating in an approved clinical trial;
- deny, limit, or place conditions on the coverage of routine patient costs associated with participation in an approved clinical trial; or
- discriminate against qualified individuals on the basis of their participation in approved clinical trials.[59]

[55] 42 U.S.C. §300gg-19.

[56] 42 U.S.C. §300gg-19a.

[57] 42 U.S.C. §300gg-19a.

[58] For purposes of this provision, a *qualified individual* is an individual who (1) is eligible to participate in an approved clinical trial for treatment of cancer or other life-threatening disease or condition and (2) has a referring health care provider who either has concluded that the individual's participation is appropriate or provides medical and scientific information establishing that participation in a clinical trial would be appropriate.

[59] 42 U.S.C. §300gg-8.

Plan Requirements Related to Health Care Providers

Nondiscrimination Regarding Health Care Providers

Plans are not allowed to discriminate, with respect to participation under the plan, against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.[60] Federal law does not require that a plan contract with any health care provider willing to abide by the plan's terms and conditions, and it also does not prevent a plan or the HHS Secretary from establishing varying reimbursement rates for providers based on quality or performance measures.

Reporting Requirements Regarding Quality of Care

The HHS Secretary was required to develop quality reporting requirements for use by specified plans, concluding no later than two years after enactment of the ACA.[61] The Secretary was to develop these requirements in consultation with experts in health care quality and other stakeholders. The Secretary also was required to publish regulations governing acceptable provider reimbursement structures not later than two years after ACA enactment. Not later than 180 days after these regulations were promulgated, the U.S. Government Accountability Office (GAO) was required to conduct a study regarding the impact of these activities on the quality and cost of health care. To date, the Secretary has not published the required regulations; therefore, the required GAO report has not been published.

However, the Department of Labor (DOL), Employee Benefits Security Administration, published a proposed rule on July 21, 2016, that would make modifications to current annual reporting requirements for pension and other employee benefit plans under ERISA Titles I and IV.[62] Under these requirements, plans would report on the financial condition and operations of the plan, among other things, using standardized forms (Form 5500 Annual Return/Report or the Form 5500-SF). This rule proposes that a group health plan in compliance with these reporting requirements would satisfy the quality reporting requirements in PHSA Section 717, as incorporated in ERISA.

Once the reporting requirements are implemented, plans will submit annually, to the HHS Secretary (and to DOL and the Department of the Treasury) and to enrollees, a report addressing whether plan benefits and reimbursement structures do the following:

- improve health outcomes through the use of quality reporting, case management, care coordination, and chronic disease management;
- implement activities to prevent hospital readmissions, improve patient safety, and reduce medical errors; and
- implement wellness and health promotion activities.

The HHS Secretary is required to make these reports available to the public and is permitted to impose penalties for noncompliance.

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[60] 42 U.S.C. §300gg-5.

[61] 42 U.S.C. §300gg-17. These plans include non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage.

[62] Department of Labor, Employee Benefits Security Administration, "Annual Reporting and Disclosure," Proposed Rule, 81 *Federal Register* 47495, July 21, 2016.

Wellness and health promotion activities include personalized wellness and prevention services, specifically efforts related to smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention. These services may be made available by entities (e.g., health care providers) that conduct health risk assessments or provide ongoing face-to-face, telephonic, or web-based intervention efforts for program participants.[63]

[63] With respect to guns, a wellness or promotion activity cannot require disclosure or collection of any information in relation to (1) the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the property of an individual or (2) the lawful use, possession, or storage of a firearm or ammunition by an individual. A health plan issued in accordance with the law is prohibited from increasing premium rates; denying health insurance coverage; and reducing or withholding a discount, rebate, or reward offered for participation in a wellness program on the basis of or reliance on the lawful ownership, possession, use, or storage of a firearm or ammunition.

Appendix. Applicability of Federal Requirements Pre-ACA and Under Current Law

Table A-1. Applicability of Selected Federal Requirements to Private Health Insurance Plans, Pre-ACA and Under Current Law

I Individual	S Small Group	L Large Group	SI Self-Insured		
	Pre-ACA		**Current Law**		
OBTAINING COVERAGE	I	Guaranteed issue for HIPAA eligibles moving from the group market to the individual market[a]	I	↗Expanded: guaranteed issue to all persons seeking coverage in the individual market ★New requirements: prohibition on using health status for eligibility determinations; extension of dependent coverage	
	S	Guaranteed issue for all small groups Prohibition on using health status for eligibility determinations	S	✓Still apply: guaranteed issue for all small groups; prohibition on using health status for eligibility determinations ★New requirements: extension of dependent coverage; prohibition of discrimination based on salary;[b] waiting-period limitation	
	L	Prohibition on using health status for eligibility determinations	L	✓Still applies: prohibition on using health status for eligibility determinations ★New requirements: guaranteed issue; extension of dependent coverage; prohibition of discrimination based on salary; waiting-period limitation	
	SI	Prohibition on using health status for eligibility determinations Prohibition of discrimination based on salary	SI	✓Still apply: prohibition on using health status for eligibility determinations; prohibition of discrimination based on salary ★New requirements: extension of dependent coverage; waiting period limitation	
KEEPING COVERAGE	I	Guaranteed renewability	I	✓Still applies: guaranteed renewability ★New requirement: prohibition on rescissions	
	S	Guaranteed renewability COBRA continuation coverage[c]	S	✓Still apply: guaranteed renewability; COBRA continuation coverage[c] ★New requirement: prohibition on rescissions	

I Individual	S Small Group	L Large Group	SI Self-Insured
	L	Guaranteed renewability COBRA continuation coverage	L	✓Still apply: guaranteed renewability; COBRA continuation coverage ★New requirement: prohibition on rescissions
	SI	COBRA continuation coverage	SI	✓Still applies: COBRA continuation coverage ★New requirement: prohibition on rescissions
DEVELOPING HEALTH INSURANCE PREMIUMS	I	N.A.	I	★New requirements: prohibition on using health status as a rating factor; rating restrictions; rate review; single risk pool requirement
	S	Prohibition on using health status as a rating factor	S	✓Still applies: prohibition on using health status as a rating factor ★New requirements: rating restrictions; rate review; single risk pool requirement
	L	Prohibition on using health status as a rating factor	L	✓Still applies: prohibition on using health status as a rating factor
	SI	Prohibition on using health status as a rating factor	SI	✓Still applies: prohibition on using health status as a rating factor
COVERED SERVICES	I	Prohibition against coverage exclusions for preexisting conditions for HIPAA eligibles moving from the group market to the individual market Mandated benefits[d]	I	↗Expanded: prohibition against coverage exclusions for preexisting health conditions to all persons in the individual market ✓Still applies: mandated benefits[d] ★New requirements: mental health parity; coverage of essential health benefits (EHB); coverage of preventive health services without cost sharing
	S	Limitation of coverage exclusions for preexisting conditions for individuals moving from one group health plan to another or from the individual market to a group health plan[e] Mandated benefits[d] Wellness programs	S	↗Expanded: prohibition against coverage exclusions for preexisting health conditions to all persons in the small-group market ✓Still apply: mandated benefits;[d] wellness programs ★New requirements: coverage of EHB; coverage of preventive health services without cost sharing

I Individual	S Small Group	L Large Group	SI Self-Insured
	L	Limitation of coverage exclusions for preexisting conditions for individuals moving from one group health plan to another or from the individual market to a group health plan Mandated benefits[d] Mental health parity Wellness programs	L ↗Expanded: prohibition against coverage exclusions for preexisting health conditions to all persons in the large-group market ✓Still apply: mandated benefits;[d] mental health parity; wellness programs ★New requirement: coverage of preventive health services without cost sharing
	SI	Limitation of coverage exclusions for preexisting conditions for individuals moving from one group health plan to another or from the individual market to a group health plan Mandated benefits[d] Wellness programs Mental health parity[f]	SI ↗Expanded: prohibition against coverage exclusions for preexisting health conditions to all persons in self-insured plans ✓Still apply: mandated benefits;[d] mental health parity;[f] wellness programs ★New requirement: coverage of preventive health services without cost sharing
COST-SHARING LIMITS	I	N.A.	I ★New requirements: limits for annual out-of-pocket spending; minimum actuarial value requirements; prohibition on lifetime limits; prohibition on annual limits
	S	N.A.	S ★New requirements: limits for annual out-of-pocket spending; minimum actuarial value requirements; prohibition on lifetime limits; prohibition on annual limits
	L	N.A.	L ★New requirements: limits for annual out-of-pocket spending; prohibition on lifetime limits; prohibition on annual limits
	SI	N.A.	SI ★New requirements: limits for annual out-of-pocket spending; prohibition on lifetime limits; prohibition on annual limits
CONSUMER ASSISTANCE AND OTHER PATIENT PROTECTIONS	I	N.A.	I ★New requirements: summary of benefits and coverage; medical loss ratio; appeals process; patient protections; nondiscrimination regarding clinical trial participation

I Individual	S Small Group	L Large Group	SI Self-Insured
	S	Appeals process Requirements to provide summary plan descriptions and summary of any material modifications to a plan	S	↗Expanded: appeals process; expanded requirements for plans to provide summary information by adding the summary of benefits and coverage requirement ★New requirements: medical loss ratio; patient protections; nondiscrimination regarding clinical trial participation
	L	Appeals process Requirements to provide summary plan descriptions and summary of any material modifications to a plan	L	↗Expanded: appeals process; expanded requirements for plans to provide summary information by adding the summary of benefits and coverage requirement ★New requirements: medical loss ratio; patient protections; nondiscrimination regarding clinical trial participation
	SI	Appeals process Requirements to provide summary plan descriptions and summary of any material modifications to a plan	SI	↗Expanded: appeals process; expanded requirements for plans to provide summary information by adding the summary of benefits and coverage requirement ★New requirements: patient protections; nondiscrimination regarding clinical trial participation
PLAN REQUIREMENTS RELATED TO HEALTH CARE PROVIDERS	I	N.A.	I	★New requirements: nondiscrimination regarding health care providers; reporting requirements regarding quality of care
	S	N.A.	S	★New requirements: nondiscrimination regarding health care providers; reporting requirements regarding quality of care
	L	N.A.	L	★New requirements: nondiscrimination regarding health care providers; reporting requirements regarding quality of care
	SI	N.A.	SI	★New requirements: nondiscrimination regarding health care providers; reporting requirements regarding quality of care

Source: Congressional Research Service (CRS) analysis of federal statutes.

Notes: N.A. indicates the no federal requirements in the category are applicable to that type of health plan. The requirements listed in the table do not comprise a comprehensive list of all federal requirements and standards that apply to all health plans.

a. The Health Insurance Portability and Accountability Act of 1996 (HIPPA; P.L. 104-191) provided that an individual leaving a group health plan who met certain conditions was guaranteed the availability of a plan to purchase in the individual market and such a plan would not exclude coverage for preexisting conditions. To be a HIPAA-eligible individual, an individual must have had at least 18 months of prior coverage that was not interrupted by a gap of 63 or more days in a row and the last day of prior coverage must have been in a group health plan, a governmental plan, or a church plan. The individual must have elected and exhausted any available COBRA continuation coverage or similar state continuation coverage upon leaving the group

health plan. A HIPAA-eligible individual cannot be eligible for any other group health plan or for Medicare or Medicaid.

b. Fully insured plans are subject to the nondiscrimination requirement codified at 42 U.S.C. §300gg-16 (and incorporated by reference into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code). Self-insured plans are subject to the nondiscrimination requirement codified at 26 U.S.C. §105(h). The nondiscrimination requirement for fully insured plans was established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and is not in effect as of the date of this report. The requirement for self-insured plans was established prior to the ACA and is in effect.

c. Employers with fewer than 20 employees are not required to comply with COBRA's coverage-continuation requirement.

d. The mandated benefits are minimum hospital stay after childbirth, reconstruction after mastectomy, nondiscrimination based on genetic information, and coverage for students who take a medically necessary leave of absence.

e. HIPAA provided that group health plans could not impose a limitation period on a preexisting condition that is longer than 12 months (18 months for late enrollees) for individuals with prior creditable coverage. For individuals moving from one group health plan to another, or from the individual market to a group health plan, the new plan must reduce any preexisting condition limitation period by one month for every month that such individuals had creditable coverage under a previous plan, provided that they enroll when first eligible and had no break in previous coverage of 63 or more continuous days.

f. Self-insured plans sponsored by small employers (50 or fewer employees) are exempt from the mental health parity requirement.

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