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# Federal Requirements on Private Health Insurance Plans

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# Federal Requirements on Private Health Insurance Plans

A majority of Americans have private health insurance. Broadly, private health insurance includes *group plans* (largely made up of *employer-sponsored insurance*) and *non-group plans* (i.e., plans a consumer purchases directly from an insurer). Group plans may be *fully insured* or *self-insured*, and fully insured plans may be purchased in the *large-group* or *small-group markets*. (These terms are discussed in the report.)

Private health insurance plans must comply with requirements at both the state and federal levels, where applicable. Federal requirements for health plans are codified primarily in three statutes: Title XXVII of the Public Health Service Act (PHSA), Part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of 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 different types of private plans. The PHSA's provisions apply broadly across private plans, whereas ERISA and the IRC focus primarily on group plans. The Departments of Health and Human Services (HHS), Labor, and the Treasury—given their overlapping jurisdiction over private coverage—coordinate enforcement efforts with respect to these private health insurance requirements.

Federal requirements on private health insurance may apply to large-group, small-group, self-insured, and/or non-group plans. Federal requirements do not apply uniformly to all types of health plans.

The selected requirements discussed in this report are grouped into the following categories:

- **Obtaining coverage**, which refers to consumers' eligibility for coverage
- **Keeping coverage**, which refers to consumers' ability to maintain their coverage once enrolled
- **Health insurance premiums**, which refers to the amounts consumers pay for health insurance
- **Covered benefits**, which refers to the benefits that plans cover (including services such as physician visits and items such as prescription drugs)
- **Enrollee cost sharing and plan payment for benefits**, which refers to requirements relating to the amounts the enrollees pay (i.e., deductibles, coinsurance, co-payments) and the plans pay as enrollees use covered benefits
- **Health care provider interactions**, which refers to plan and consumer interactions with providers (including specified out-of-network providers)
- **Enrollee information and appeals**, which refers to plan disclosure of certain information to enrollees (and applicants) and enrollees' rights regarding appeals of coverage denials
- **Federal and public reporting requirements**, which refers to plan reporting of specified information to the federal government and/or the public disclosure of certain information

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## Introduction

A majority of Americans have private health insurance. Private health insurance plans must comply with requirements at both the state and federal levels, where applicable.

This report organizes and examines selected federal statutory requirements applicable to private health insurance plans. The first part of this report provides background information about the types of private health insurance plans and the regulation of such 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: large group, small group, self-insured, and non-group. **Table 1** summarizes the applicability of federal statutory requirements across those plan types. The selected requirements are grouped under the following categories: obtaining coverage, keeping coverage, health insurance premiums, covered benefits, enrollee cost sharing and plan payment for benefits, health care provider interactions, enrollee information and appeals, and federal and public reporting requirements.

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 other federal laws. For example, a number of market reforms were first enacted via the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191).<sup>1</sup> Over time, certain private health insurance laws have addressed specific topics, such as mental health parity,<sup>2</sup> rather than a range of market reforms. Recently, the No Surprises Act, part of the Consolidated Appropriations Act, 2021 (P.L. 116-260), included numerous new private health insurance requirements, primarily as related to surprise billing.<sup>3</sup>

## Background

### Types of Private Health Insurance Plans

Broadly, private health insurance includes *group plans* (largely made up of *employer-sponsored insurance*) and *non-group plans* (i.e., plans a consumer purchases directly from an insurer). Federal requirements on private health insurance may apply to some or all of several types of group plans (explained below) and/or to non-group plans.

Group plans refer to health benefits provided by employers and other entities (e.g., unions, associations) that sponsor such benefits. These plan sponsors can purchase coverage in the *group market* from state-licensed insurers and offer it to their employees (and their employees' dependents). Health plans obtained this way are referred to as *fully insured*. The group market is

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<sup>1</sup> Some Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) provisions were amendments or expansions of Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191) private health insurance provisions.

<sup>2</sup> See, for example, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

<sup>3</sup> Requirements summarized in this report are not grouped according to the laws establishing them. In this report, the term *surprise billing* refers to specified situations where an individual is unknowingly, and potentially unavoidably, treated by a provider outside of the consumer's health insurance plan network and, as a result, unexpectedly receives a larger bill than the individual would have received if the provider had been in the plan network. A consumer may be surprised to receive larger-than-expected medical bills for other reasons; for example, the surprise component may arise because a consumer misunderstands the terms of his or her health insurance policy and receives a bill for an unexpected amount. Such other reasons generally are outside the scope of this report and are not included in this report's usage of the term *surprise billing*.

divided into segments based on size: the small-group market and the large-group market. For purposes of federal requirements that apply to the group market, states may elect to define *small* groups or employers as those 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 has at least 51 individuals or at least 101 individuals, depending on which small-group definition a given state uses.

Instead of purchasing group plans from insurers, plan sponsors may set aside funds and pay for health benefits directly; that is, they may *self-insure*. This alternative approach to providing health benefits means that such sponsors bear the risk of covering the medical expenses generated by the individuals covered under the self-insured plan. Groups of any size may self-insure, and federal requirements on self-insured plans generally do not depend on group size.

The non-group market, also called the *individual market*, is where consumers may purchase a health plan for themselves and their dependents directly from an insurer (i.e., not through a plan sponsor). For the most part, non-group plans are fully insured, and this report discusses them as such.<sup>4</sup>

### Certain Plan Variations

Certain types of group and non-group plans, and certain other types of private health coverage arrangements, are regulated differently than the types generally described above. Selected examples of plan variations are briefly referenced here but otherwise are not included in this report.

**Governmental Employee Plans:** Although federal, state, and other governmental employers may offer group plans as private sector employers do, certain federal requirements on group plans may apply to governmental plans differently or may not apply.<sup>5</sup>

**Plans Offered by Private Insurers to Enrollees of Public Programs:** Some beneficiaries in public health coverage programs obtain their coverage through commercial insurers contracted by those programs (e.g., Medicare Advantage or Medicaid managed care plans). Such plans are subject to those programs' requirements rather than to those described in this report.

**Plans Offered on the Health Insurance Exchanges:** The non-group and small-group markets include plans sold on and off the *health insurance exchanges*. The exchanges are government-run marketplaces that facilitate the purchase of private health insurance plans called *qualified health plans* (QHPs). The QHPs must meet all requirements applicable to the non-group or small-group market segments, plus additional requirements specific to the exchanges. This report does not include QHP-specific requirements.<sup>6</sup>

**Exempted Health Coverage Arrangements:** Certain types of plans meet a federal definition of health insurance (i.e., they meet the federal definition of health insurance coverage or group health plan) but are exempt from compliance with some or all federal health insurance

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<sup>4</sup> An exception is discussed in the student health insurance coverage section in CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

<sup>5</sup> For more information, see CRS Report R43922, *Federal Employees Health Benefits (FEHB) Program: An Overview*, and the self-insured, nonfederal governmental plans section in CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

<sup>6</sup> For more information, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

requirements that otherwise would be applicable. Such plans include, for example, *grandfathered* plans, *excepted benefit* plans, and *short-term, limited-duration insurance* plans.<sup>7</sup>

## Regulation of Private Health Plans

States are the primary regulators of insurers, as codified by the 1945 McCarran-Ferguson Act (P.L. 79-15).<sup>8</sup> Each state requires insurers to be licensed in order to sell health plans in the state, and each state has a unique set of requirements that apply to insurers 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 priorities about regulation, the evolving health care landscape, and the implementation of federal policies.

Health plans offered by state-licensed insurers are subject to state health insurance requirements. Because self-insured plans are financed directly by the plan sponsor, such plans generally are not subject to such requirements.

In addition to states, the federal government regulates state-licensed insurers 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 insurers 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 Restrictions” 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, though no states are allowed to permit these types of plans to vary premiums by any additional factors.

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 with fully insured plans.

Federal requirements for health plans are codified primarily in three statutes: Title XXVII of the Public Health Service Act (PHSA), Part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of 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 different types of private plans. The PHSA’s provisions apply broadly across private plans, whereas ERISA and the IRC focus primarily on group plans. The Departments of Health and Human Services (HHS), Labor, and the Treasury—given their overlapping jurisdiction over private coverage—coordinate enforcement efforts with respect to these private health insurance requirements.<sup>9</sup>

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<sup>7</sup> For more information on these and other types of plans, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

<sup>8</sup> 15 U.S.C. §§1011 et seq. For simplicity, this report generally uses the term *insurers* to include insurance *carriers* or *issuers* and other state-licensed firms.

<sup>9</sup> With respect to health insurers, the Public Health Service Act (PHSA) allows states to be the primary enforcers of the

## Federal Requirements

This report focuses on descriptions of statutory private health insurance requirements on major medical plans and incorporates references to certain regulatory and sub-regulatory activity where necessary to understand key components of the requirements.<sup>10</sup> In general, this report does not discuss implementation of federal requirements. However, given that Congress recently enacted surprise billing and transparency requirements and the Secretaries of HHS, Labor, and the Treasury were in the process of implementing many of those requirements at the time of this report's publication, the implementation of recently enacted requirements is discussed, where appropriate.

For the most part, this report focuses on federal requirements applicable to insurers only, insurers *and* self-insured plan sponsors (e.g., employers) in their offering of coverage, and/or on the plans themselves.<sup>11</sup> Selected requirements specific to employers are included to the extent that the requirements are particularly relevant to the topics discussed in this report (e.g., “COBRA Continuation Coverage” in the “Keeping Coverage” section).<sup>12</sup>

The federal requirements described in this report are grouped into the following categories: obtaining coverage, keeping coverage, health insurance premiums, covered benefits, cost-sharing limits, requirements related to health care providers, enrollee information and appeals, and federal and public reporting requirements. Each category of requirements begins with brief, contextual information about that set of requirements. Some requirements address more than one of these categories. For example, the requirement “Nondiscrimination Based on Genetic Information” relates to obtaining coverage, health insurance premiums, and coverage of preexisting conditions). For the sake of simplicity, these types of crosscutting requirements generally are discussed only in the most relevant category (in this case, “Obtaining Coverage”).

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

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federal private health insurance requirements, but the Secretary of the Department of Health and Human Services (HHS) assumes this responsibility if the Secretary has determined that a state has failed to “substantially enforce” the federal PHSA provisions. For more information on enforcement of private health insurance requirements, see CRS Report R46637, *Federal Private Health Insurance Market Reforms: Legal Framework and Enforcement*.

<sup>10</sup> Most people with private health insurance have a major medical plan. Major medical plans provide comprehensive health benefits compared with limited benefit plans, although the specific covered benefits may vary across major medical plans. One example of a limited benefit plan is an *excepted benefit* plan, such as a dental-only or vision-only plan. For more information on these and other types of plans, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

<sup>11</sup> In this report, references to *plans* include applicable group health plans and insurers.

<sup>12</sup> This report does not include the full range of employer-focused requirements that may have some relevance to group health plans (e.g., fiduciary requirements).



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

U.S. Code <sup>a</sup>	Provision	Group <sup>b</sup>			
		Fully Insured <sup>d</sup>			Non-group <sup>c</sup>
		Large Group <sup>f</sup>	Small Group <sup>f</sup>	Self-Insured <sup>e</sup>	
<b>Obtaining Coverage</b>					
42 U.S.C. §300gg-1	Guaranteed Issue	√	√	N.A.	√
26 U.S.C. §4980H	Employer Shared Responsibility Provisions	√	N.A. <sup>g</sup>	√ <sup>g</sup>	N.A.
42 U.S.C. §300gg-4(a)	Prohibition on Using Health Status for Eligibility Determinations	√	√	√	√
42 U.S.C. §300gg-3, 4	Nondiscrimination Based on Genetic Information	√	√	√	√
42 U.S.C. §300gg-14	Extension of Dependent Coverage	√	√	√	√
42 U.S.C. §300gg-16; 26 U.S.C. §105(h)	Prohibition of Discrimination Based on Salary	√ <sup>h</sup>	√ <sup>h</sup>	√ <sup>h</sup>	N.A.
42 U.S.C. §300gg-7	Waiting Period Limitation	√	√	√	N.A.
<b>Keeping Coverage</b>					
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 <sup>i</sup>	√	√ <sup>i</sup>	√ <sup>i</sup>	N.A.
42 U.S.C. §300gg-28	Coverage for Students Who Take a Medically Necessary Leave of Absence	√	√	√	√
<b>Health Insurance Premiums</b>					
42 U.S.C. §300gg-4(b)	Prohibition on Using Health Status as a Rating Factor	√	√	√	√ <sup>k</sup>
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.	√
42 U.S.C. §300gg-18	Medical Loss Ratio	√	√	N.A.	√

U.S. Code <sup>a</sup>	Provision	Group <sup>b</sup>			
		Fully Insured <sup>d</sup>			Non-group <sup>c</sup>
		Large Group <sup>f</sup>	Small Group <sup>f</sup>	Self-Insured <sup>e</sup>	
<b>Covered Benefits</b>					
42 U.S.C. §300gg-6(a); 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-13, Stat. Note.	Coverage of COVID-19 Vaccinations and Other Qualifying Preventive Services	√	√	√	√
42 U.S.C. §300gg-8	Coverage for Individuals Participating in Approved Clinical Trials	√	√	√	√
42 U.S.C. §300gg-25	Coverage of Minimum Hospital Stay After Childbirth	√	√	√	√
42 U.S.C. §300gg-26	Mental Health Parity	√	√ <sup>l</sup>	√ <sup>l</sup>	√
42 U.S.C. §300gg-27	Coverage of Reconstruction After Mastectomy	√	√	√	√
42 U.S.C. §2000e(k) <sup>m</sup>	Coverage of Pregnancy-Related Conditions	√ <sup>n</sup>	√ <sup>n</sup>	√ <sup>n</sup>	N.A.
42 U.S.C. §300gg-3	Prohibition on Coverage Exclusions Based on Preexisting Health Conditions	√	√	√	√
<b>Enrollee Cost-Sharing and Plan Payment for Benefits</b>					
42 U.S.C. §300gg-6(b); 42 U.S.C. §18022	Maximum Annual Limitation on Cost Sharing	√	√	√	√
42 U.S.C. §300gg-6(b); 42 U.S.C. §18022	Minimum Actuarial Value Requirements	N.A.	√	N.A.	√
42 U.S.C. §300gg-11	Prohibition on Lifetime and Annual Coverage Limits	√	√	√	√
<b>Health Care Provider Interactions</b>					
42 U.S.C. §300gg-111, 112	Preventing Surprise Medical and Air Ambulance Bills	√	√	√	√
42 U.S.C. §300gg-113	Continuity of Care	√	√	√	√
42 U.S.C. §300gg-115(b)	Services Provided Based on Incorrect Provider Directory Information	√	√	√	√

U.S. Code <sup>a</sup>	Provision	Group <sup>b</sup>			
		Fully Insured <sup>d</sup>			
		Large Group <sup>f</sup>	Small Group <sup>f</sup>	Self-Insured <sup>e</sup>	Non-group <sup>c</sup>
42 U.S.C. §300gg-117	Choice of Healthcare Professionals	√	√	√	√
42 U.S.C. §300gg-5	Nondiscrimination Regarding Health Care Providers	√	√	√	√
42 U.S.C. §300gg-119	Prohibition on Gag Clauses on Price and Quality Information	√	√	√	√
<b>Enrollee Information and Appeals</b>					
42 U.S.C. §300gg-15	Summary of Benefits and Coverage and Uniform Glossary	√	√	√	√
42 U.S.C. §300gg-111(f)	Advanced Explanation of Benefits <sup>o</sup>	√	√	√	√
42 U.S.C. §300gg-111(e)	Plan Identification Card Information	√	√	√	√
42 U.S.C. §300gg-114; 42 U.S.C. §300gg-15a <sup>p</sup>	Price Comparison Tool <sup>o</sup>	√	√	√	√
42 U.S.C. §300gg-115(a)	Provider Directory Requirements	√	√	√	√
42 U.S.C. §300gg-115(c)	Disclosure of Patient Protections Against Balance Billing	√	√	√	√
42 U.S.C. §300gg-19b	Information on Prescription Drugs	√	√	√	√
42 U.S.C. §300gg-46	Disclosure to Enrollees of Individual Market Coverage	N.A.	N.A.	N.A.	√
42 U.S.C. §300gg-19	Appeals Process and External Review	√	√	√	√
<b>Federal and Public Reporting Requirements</b>					
42 U.S.C. §300gg-17	Reporting Requirements Regarding Quality of Care	√	√	√	√
42 U.S.C. §300gg-118	Reporting Requirements Regarding Air Ambulances <sup>o</sup>	√	√	√	√
42 U.S.C. §300gg-120	Reporting Requirements Regarding Pharmacy Benefits and Drug Costs	√	√	√	√
42 U.S.C. §300gg-15a <sup>q</sup>	Transparency in Coverage <sup>o</sup>	√	√	√	√

**Source:** Congressional Research Service analysis of federal statutes.

**Notes:** N.A. indicates 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. Generally, such groups form for a purpose other than obtaining insurance, such as employment. Insurance provided to a group is referred to as *group coverage* or *group insurance*. With respect to group coverage, 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 insurer in the *non-group* (or *individual*) health insurance market.
- d. A *fully insured health plan* is one in which the plan sponsor purchases health coverage from a state-licensed insurer; the insurer assumes the risk of paying the medical claims of the sponsor's enrollees.
- 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 *small groups* as groups with 50 or fewer individuals or as groups with 100 or fewer individuals. The definition for *large group* builds on the small-group definition; a large group would have at least 51 individuals or at least 101 individuals, depending on which small-group definition a given state uses.
- g. Employers with fewer than 50 employees are not required to comply with the employer shared responsibility provisions.
- h. 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.
- i. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).
- j. Employers with fewer than 20 employees are not required to comply with COBRA's coverage continuation requirement.
- k. As part of this requirement, a plan may establish premium discounts or rebates or may modify cost sharing requirements in return for adherence to a wellness plan. This does not apply to non-group plans.
- l. Fully insured small-group plans are subject to mental health parity requirements because of the incorporation of parity requirements into essential health benefit requirements. Self-insured plans sponsored by small employers (50 or fewer employees) are exempt from mental health parity requirements.
- m. Also see 29 C.F.R. §1604.10 and 29 C.F.R. §1604, Appendix to Part 1604—Questions and Answers on the Pregnancy Discrimination Act, P.L. 95-555, 92 Stat. 2076 (1978).
- n. This requirement applies to employers with 15 or more employees, whether the coverage is fully insured or self-insured.
- o. This is a recently enacted requirement and, as of the date of this report, enforcement of some or all aspects of this requirement has been deferred.
- p. Also see 45 C.F.R. §147.211.
- q. Also see 45 C.F.R. §147.212.

## Obtaining Coverage

Requirements in this section relate to consumers' eligibility for coverage.

### Guaranteed Issue

Plans must comply with the *guaranteed issue* requirement.<sup>13</sup> In general, plans must accept every applicant for such coverage, as long as the applicant agrees to the terms and conditions of the

<sup>13</sup> 42 U.S.C. §300gg-1.

insurance offer (e.g., premium). Plans may restrict enrollment to open and special enrollment periods under specified circumstances; such circumstances differ between non-group and group plans.<sup>14</sup> Eligibility for group coverage may depend on meeting a waiting period requirement.<sup>15</sup>

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.

Large-group, small-group, and non-group plans are subject to this requirement.

## Employer Shared Responsibility Provisions

The employer shared responsibility provisions (ESRP), often referred to as the *employer mandate*, generally incentivize large employers to offer adequate, affordable health insurance coverage to their full-time employees and their full-time employees' dependents.<sup>16</sup> If an applicable large employer fails to offer health insurance or offers substandard coverage to its employees, the employer may be subject to a penalty.

This requirement applies to employers with 50 or more employees, whether the coverage is fully insured or self-insured.

## Prohibition on Using Health Status for Eligibility Determinations

Plans are prohibited from basing applicant eligibility on *health status-related factors*.<sup>17</sup> 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 HHS Secretary. (A companion requirement regarding health nondiscrimination applies to premiums; see “Prohibition on Using Health Status as a Rating Factor,” below.)

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

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<sup>14</sup> Non-group plans that choose to establish an open enrollment period must apply the same period to plans inside and outside the health insurance exchanges. The open enrollment period rules applicable to exchanges are codified at 45 C.F.R. §155.410. Group plans must allow enrollment during any time of the year, with an exception for small-group plans. Small-group 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; see 45 C.F.R. §147.104(b). 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).

<sup>15</sup> A *waiting period* refers to an amount of time that must pass before an individual becomes eligible to enroll under the terms of the plan. A federal requirement specifically concerning the duration of waiting periods is discussed later in this report (see “Waiting Period Limitation”).

<sup>16</sup> 26 U.S.C. §4980H. For more information, see CRS Report R45455, *The Affordable Care Act's (ACA's) Employer Shared Responsibility Provisions (ESRP)*.

<sup>17</sup> 42 U.S.C. §300gg-4(a).

## Nondiscrimination Based on Genetic Information

Plans 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.<sup>18</sup>

Large-group, small-group, self-insured, and non-group plans are subject to these requirements.

## Extension of Dependent Coverage

If a plan offers dependent coverage to children, the plan must make such coverage available to a child under the age of 26.<sup>19</sup> 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).

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## 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.<sup>20</sup> 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).

Large-group, small-group, and self-insured plans are subject to this requirement.

## Waiting Period Limitation

Plans are prohibited from establishing waiting periods longer than 90 days.<sup>21</sup> 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 begins within 90 days of the beginning of the waiting period, the plan complies with this provision.

Large-group, small-group, and self-insured plans are subject to this requirement.

## Keeping Coverage

These requirements relate to consumers' ability to maintain their coverage once enrolled.

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<sup>18</sup> 42 U.S.C. §§300gg-3 and 300gg-4, and 45 C.F.R. §§147.110 and 146.121.

<sup>19</sup> 42 U.S.C. §300gg-14.

<sup>20</sup> 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).

<sup>21</sup> 42 U.S.C. §300gg-7.

## Guaranteed Renewability

*Guaranteed renewability* is a requirement for plans to renew coverage at the option of the policyholder or the plan sponsor for non-group plans and group plans, respectively.<sup>22</sup> Plans that must comply with guaranteed renewability may discontinue the plan only under certain circumstances. 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.

Large-group, small-group, and non-group plans are subject to this requirement.

## Prohibition on Rescissions

Plans generally are prohibited from rescinding coverage; the practice of *rescission* refers to the retroactive cancellation of coverage after an enrollee has become sick or injured.<sup>23</sup> Plans may rescind coverage if an enrollee committed fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan. Such cancellation of coverage requires a plan to provide at least 30 calendar days' advance notice to the enrollee.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## COBRA Continuation Coverage<sup>24</sup>

Certain employers are required to continue to offer coverage to certain employees and their dependents (*qualified beneficiaries*) who otherwise would be ineligible for such coverage because of certain circumstances (*qualifying events*).<sup>25</sup> 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.

This requirement applies to employers with 20 or more employees, whether the coverage is fully insured or self-insured.

## 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 leave of absence (or other change in educational enrollment) from a postsecondary educational institution that causes the student to lose student status for health coverage purposes.<sup>26</sup> The leave of absence or change in educational enrollment must be medically necessary and must begin while the student is suffering from a severe illness or injury. These requirements are colloquially referred to as *Michelle's Law*.<sup>27</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

<sup>22</sup> 42 U.S.C. §300gg-2.

<sup>23</sup> 42 U.S.C. §300gg-12.

<sup>24</sup> This requirement was established under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272). Coverage received under this requirement is typically referred to as *COBRA coverage*.

<sup>25</sup> 29 U.S.C. §§1161-1168. An example of a qualifying event is termination from a job.

<sup>26</sup> 42 U.S.C. §300gg-28.

<sup>27</sup> P.L. 110-381.

## Health Insurance Premiums

The following requirements relate to premiums, which are the amounts consumers and others pay for health coverage.<sup>28</sup>

### 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.<sup>29</sup> 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 HHS Secretary. (A companion requirement regarding health nondiscrimination applies to eligibility; see “Prohibition on Using Health Status for Eligibility Determinations,” above.)

Plans may establish premium discounts or rebates or modify cost-sharing requirements in return for adherence to a wellness program.<sup>30</sup> If a wellness program is made available to all similarly situated individuals and 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. 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 discretion to increase the reward up to 50% of the cost of coverage if the increase is determined to be appropriate.

Large-group, small-group, self-insured, and non-group plans are subject to the overall health nondiscrimination requirement. Large-group, small-group, and self-insured plans are subject to the conditions for providing discounts or rebates for wellness activities.

### Rating Restrictions

Plans must use adjusted (or modified) community rating rules to determine premiums.<sup>31</sup> Adjusted community rating prohibits the use of health factors in the determination of premiums but allows premium variation based on other factors. Premiums may vary based on the following four factors:<sup>32</sup>

<sup>28</sup> For the sake of simplicity, the use of the term *premium* in this report broadly applies not only to the final amounts paid by consumers and others for coverage but also the prices for insurance products that health insurance issuers determine as they develop final premium amounts.

<sup>29</sup> 42 U.S.C. §300gg-4(b). For information about identifying *similarly situated individuals*, see 45 C.F.R. §146.121(d).

<sup>30</sup> 42 U.S.C. §300gg-4(j).

<sup>31</sup> 42 U.S.C. §300gg.

<sup>32</sup> Federal law allows states to impose additional rating requirements, provided the state requirements neither conflict with federal law nor prevent the implementation of federal requirements. For more information about state rating requirements, 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-Insurance-Market-Reforms/state-rating.html>.



- **Type of Enrollment.** Plans may vary premiums based on whether only an individual enrolls in the plan or an individual and dependent(s) enrolls (e.g., self-only coverage, family coverage).
- **Geographic Rating Area.** Plans may vary premiums based on geographic location. States are required 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, or (3) metropolitan statistical areas (MSAs) and non-MSAs.<sup>33</sup>
- **Tobacco Use.** Plans may not charge a tobacco user more than 1.5 times the premium they charge an individual who does not use tobacco.
- **Age.** Plans may not charge an older individual more than three times the premium they charge a 21-year-old individual. All states must use a uniform age rating curve to specify the rates across age bands (with exceptions for certain states).<sup>34</sup> For plan years beginning on or after January 1, 2018, plans must use one age band for all individuals aged 0-14 years, one-year age bands for individuals aged 15-63 years, and one age band for all individuals aged 64 years and older.

Small-group and non-group plans are subject to this requirement.

## Rate Review

Under rate review, 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).<sup>35</sup> The federal default threshold is 15%.<sup>36</sup> States have the option to apply for state-specific thresholds.<sup>37</sup>

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; instead, it is a sunshine provision designed to publicly disclose rate increases that are determined to be unreasonable.

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<sup>33</sup> 45 C.F.R. §147.102(b). 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.

<sup>34</sup> For the federal default and state-specific age rating ratios, see 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>.

<sup>35</sup> 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.

<sup>36</sup> 45 C.F.R. §§154.101 and 154.200. The federal default threshold was 10% in previous years. It was modified by HHS, “HHS Notice of Benefit and Payment Parameters for 2019,” 83 *Federal Register* 16930, April 17, 2018.

<sup>37</sup> Any state that wishes to apply a higher threshold than the federal default must submit a proposal for approval to the HHS Secretary. Since states generally are allowed to enact stricter requirements compared with relevant federal provisions, states may impose a rate review threshold that is lower than the federal default on their own without approval from the Secretary. 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>.

Small-group and non-group plans are subject to this requirement.<sup>38</sup>

### Single Risk Pool

A risk pool is used to develop premiums for coverage. A health insurance issuer must consider all enrollees in specified plans offered by the issuer to comprise a single risk pool.<sup>39</sup> Specifically, an issuer must include all enrollees in non-group plans offered by the issuer in a given state in one risk pool. Similarly, an issuer must include all enrollees in small-group plans offered by the issuer in a given state in a separate risk pool. (However, states have the option to merge their non-group and small-group markets; if a state does so, an issuer will have a single risk pool for all enrollees in its non-group and small-group plans.)

Small-group and non-group plans are subject to this requirement.

### Medical Loss Ratio

A *medical loss ratio* (MLR) is the percentage of a plan's premium revenue spent on medical claims (i.e., plan payments toward enrollees' use of health care covered under the plan).<sup>40</sup> The MLR calculation includes adjustments for quality improvement expenditures, taxes, regulatory fees, and other factors. Plans are required to report to the HHS Secretary their MLRs with respect to each plan year. Plans must also meet certain minimum MLR requirements, or otherwise provide rebates to enrollees.

Non-group and small-group plans must meet a minimum MLR of 80%; for large groups, the minimum MLR is 85%. States are permitted to increase the percentages. The HHS Secretary may lower a state's percentage for the non-group market if HHS determines that application of a minimum MLR of 80% would destabilize that state's non-group market.<sup>41</sup> Plans whose MLR falls below the specified limit must provide rebates to enrollees on a pro rata basis. Any required rebates must be paid to enrollees by August of that year.

Large-group, small-group, and non-group plans are subject to this requirement.

### Covered Benefits

These requirements generally relate to benefits that plans cover (including services such as physician visits, and items such as prescription drugs). Some of these provisions include mandates to cover certain benefits; others do not mandate coverage but impose requirements related to certain benefits, to the extent they are covered.

In addition to the requirements discussed in this section, certain provisions discussed elsewhere in this report also have benefit coverage components (See, e.g., "Prohibition of Discrimination Based on Salary.")

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<sup>38</sup> 45 C.F.R. §§154.101 and 154.200.

<sup>39</sup> 42 U.S.C. §18032(c) and 45 C.F.R. §156.80.

<sup>40</sup> 42 U.S.C. §300gg-18.

<sup>41</sup> To view a list of state requests for an medical loss ratio adjustment, see CMS, CCIIO, "Ensuring the Affordable Care Act Serves the American People," at [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state\\_mlr\\_adj\\_requests](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state_mlr_adj_requests).

## Coverage of Essential Health Benefits

Plans must cover a core package of *essential health benefits* (EHB).<sup>42</sup> The benefits that comprise the EHB generally are not defined in federal law; rather, the law lists 10 broad categories in which benefits must be covered and tasks the HHS Secretary with further defining the EHB.<sup>43</sup> To date, the HHS Secretary has directed each state to select an EHB benchmark plan, within certain parameters, to serve as the basis for the state's EHB.<sup>44</sup> The benchmark plan serves as a reference for applicable plans in that state, which must provide EHB coverage that is “substantially equal” to such coverage in the benchmark plan, as specified in regulations.<sup>45</sup>

Federal regulations have provided specific requirements regarding some EHB categories.<sup>46</sup> For example, current regulation provides that an applicable health plan meets the EHB requirements for the prescription drugs category of EHB if it covers at least one drug in every U.S. Pharmacopeia category and class or the same number of prescription drugs in each category and class as the state-selected EHB benchmark plan.

Cost sharing is possible for most categories of EHB, although certain federal requirements limit cost sharing on the EHB, as discussed in “Enrollee Cost-Sharing and Plan Payment for Benefits.” Coverage and cost sharing for EHB services furnished by out-of-network providers may vary.

Small-group and non-group plans are subject to this requirement.

## Coverage of Preventive Health Services Without Cost Sharing

Plans are required to cover certain preventive health services (and items) without cost sharing. This requirement includes, at a minimum, four categories of statutorily required coverage:<sup>47</sup>

- Preventive services recommended with an A or B rating by the U.S. Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Additional preventive care and screenings for infants, children, and adolescents, as recommended by the Health Resources and Services Administration (HRSA)

<sup>42</sup> 42 U.S.C. §300gg-6; 42 U.S.C. §18022.

<sup>43</sup> The 10 categories of essential health benefits (EHB) 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.

<sup>44</sup> For more information on the process for defining the EHB in each state, as well as each state's benchmark plan, see CMS, CCIIO, “Information on Essential Health Benefits (EHB) Benchmark Plans,” at <https://www.cms.gov/ccio/resources/data-resources/ehb>.

<sup>45</sup> 45 C.F.R. §156.115(a)(1).

<sup>46</sup> See, for example, 45 C.F.R. §156.115 and 45 C.F.R. §156.122.

<sup>47</sup> 42 U.S.C. §300gg-13; 45 C.F.R. §147.130. The complete list of preventive services required to be covered, per all of the categories of recommendations, is available at HealthCare.gov, “Preventive Health Services,” at <http://www.healthcare.gov/coverage/preventive-care-benefits/>. The four categories of recommendations, as referenced above, are at U.S. Preventive Services Task Force, “A&B Recommendations,” at <https://uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>; Centers for Disease Control and Prevention, “ACIP Vaccine Recommendations and Guidelines,” at <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>; Health Resources & Services Administration (HRSA), “Bright Futures,” at <https://mchb.hrsa.gov/programs-impact/bright-futures>; and Women's Preventive Services Initiative, “Recommendations,” at <https://www.womenspreventivehealth.org/recommendations/>.

- Additional preventive care and screenings for women as recommended by HRSA<sup>48</sup>

If there are changes in recommendations or guidelines in any of these categories (e.g., the USPSTF announces a new A or B rating), plans generally are required to provide relevant coverage as of plan years that begin on or after the date that is one year after the change.<sup>49</sup>

Although cost sharing generally is prohibited for specified preventive benefits, cost sharing for office visits associated with a furnished preventive benefit may be allowed, as specified in regulation.<sup>50</sup> By regulation, plans generally are not required to cover preventive benefits without cost sharing if the benefits are furnished out of network.<sup>51</sup> 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 “reasonable medical management” techniques.<sup>52</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### Coverage of COVID-19 Vaccinations and Other Qualifying Preventive Services

Plans are required to cover Coronavirus Disease 2019 (COVID-19) vaccinations (if not otherwise covered by the federal government) and vaccine administration fees (even if the vaccines are federally covered) without consumer cost sharing. This requirement also applies to any “qualifying coronavirus preventive service,” defined as “an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019” and that is recommended by the USPSTF or ACIP, as specified.<sup>53</sup> This requirement largely mirrors the existing requirement to cover preventive services without cost sharing, described above. One difference is that this coverage requirement is effective 15 business days after a relevant USPSTF or ACIP recommendation.<sup>54</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

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<sup>48</sup> For additional information about these categories of recommendations, see the “Federal Regulation of Private Health Insurance” section of CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions*. That and subsequent sections of the report include general discussion of the preventive services coverage requirement and particular aspects of the requirement (such as coverage of contraceptive services and supplies, per HRSA recommendations on preventive services for women).

<sup>49</sup> See 45 C.F.R. §147.130(b).

<sup>50</sup> Whether cost sharing for office visits is allowed generally depends on whether the preventive service or item is the primary purpose of the visit and whether the service or item is billed or tracked separately from the office visit. See 45 C.F.R. §147.130(a)(2).

<sup>51</sup> 45 C.F.R. §147.130(a)(3).

<sup>52</sup> 45 C.F.R. §147.130(a)(4).

<sup>53</sup> 42 U.S.C. §300gg-13, Statutory Note, “Rapid Coverage of Preventive Services and Vaccines for Coronavirus.”

<sup>54</sup> For additional discussion of this requirement, see CRS Report R46359, *COVID-19 and Private Health Insurance Coverage: Frequently Asked Questions*. As that report also discusses, the Coronavirus Disease 2019 (COVID-19) vaccination coverage requirement is not time-limited, but a separate requirement regarding private health insurance coverage of COVID-19 testing is limited to the duration of the declared public health emergency. For that reason, the testing coverage requirement is not otherwise included in this report. There are no federal requirements specific to private health insurance coverage of COVID-19 treatments, but other requirements may be applicable (e.g., coverage of the EHB).

## Coverage for Individuals Participating in Approved Clinical Trials

Plans are subject to nondiscrimination and other provisions with respect to *qualified individuals*' access to and costs associated with clinical trials.<sup>55</sup> 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; and
- discriminate against qualified individuals on the basis of their participation in approved clinical trials.<sup>56</sup>

In short, for a qualified individual participating in an approved clinical trial, a plan must provide coverage for routine patient costs (all items and services that typically would be covered under the plan for a qualified individual not enrolled in a clinical trial). Plans may impose consumer cost-sharing requirements on this coverage. Coverage and cost sharing may vary for clinical trials offered through an out-of-network provider. The costs of the trial's "investigational item, device, or service itself" and other specified costs are not required to be covered by the plan.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Coverage of Minimum Hospital Stay After Childbirth

Plans that provide coverage for maternity-related hospital stays generally are prohibited from restricting coverage for the length of a hospital stay for childbirth for either the mother or the newborn child to less than 48 hours for vaginal deliveries and to less than 96 hours for caesarian deliveries.<sup>57</sup> In addition, prior authorization requirements for these stays are prohibited.<sup>58</sup> Cost sharing is allowed for maternity-related hospital stays, as long as the cost sharing for the portions of hospital stays following deliveries is not greater than cost sharing for preceding portions of such stays.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Mental Health Parity

Federal parity law does not require plans to cover mental health and substance use disorder (MH/SUD) benefits when such coverage is not otherwise required by federal or state law. However, when a plan does cover both MH/SUD benefits and medical/surgical (M/S) benefits, parity law generally prohibits the imposition of more restrictive limitations on the MH/SUD as compared with the M/S benefits.<sup>59</sup>

<sup>55</sup> 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.

<sup>56</sup> 42 U.S.C. §300gg-8.

<sup>57</sup> 42 U.S.C. §300gg-25. There is an exception to the length-of-coverage requirement when providers make earlier discharge decisions in consultation with mothers. Plans are prohibited from offering incentives or penalties to providers or mothers to encourage shorter stays.

<sup>58</sup> Some insurers include prior authorization requirements for certain covered benefits. For example, they may require enrollees to obtain prior authorization from the insurer for routine hospital inpatient care, as a condition for covering the care.

<sup>59</sup> 42 U.S.C. §300gg-26. For more information on parity requirements, see CRS Report R47402, *Mental Health Parity*

Specifically, plans are prohibited from imposing more restrictive limits on MH/SUD benefits in each of the following areas: aggregate lifetime limits and annual limits; financial requirements (e.g., co-payments); quantitative treatment limitations (e.g., number of days or visits covered); and nonquantitative treatment limitations, or NQTLs (e.g., preauthorization requirements). Regulations also have established six classifications of benefits in which parity requirements apply: (1) in-network inpatient, (2) out-of-network inpatient, (3) in-network outpatient, (4) out-of-network outpatient, (5) emergency care, and (6) prescription drugs.<sup>60</sup>

In addition, plans are required to disclose certain information to enrollees and others upon request, including the “criteria for medical necessity determinations” made with respect to MH/SUD benefits.<sup>61</sup>

Finally, plans are required to annually conduct “comparative analyses of the design and application” of their NQTLs and to make these analyses available to applicable federal and state authorities upon request.<sup>62</sup> The Secretaries of HHS, Labor, and the Treasury must annually request and review at least 20 of these analyses and follow up on any parity violations identified.

Parity requirements apply to large-group plans, self-insured plans offered by large employers, and non-group plans. Primarily by incorporation of parity requirements into EHB requirements, small-group plans also are subject to parity law. Self-insured plans offered by small employers are exempt, and there is also an exemption for plans facing certain increased costs due to parity implementation.<sup>63</sup>

## Coverage of Reconstruction After Mastectomy

Plans that provide coverage for mastectomies also must cover prosthetic devices and reconstructive surgery.<sup>64</sup> Federal guidance has provided that this coverage requirement is applicable to female and male enrollees, and the mastectomy does not need to have been connected to a cancer diagnosis.<sup>65</sup> Cost sharing is allowed if consistent with cost sharing for other covered medical/surgical benefits.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

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*and Coverage in Private Health Insurance: Federal Requirements.*

<sup>60</sup> 45 C.F.R. §146.136.

<sup>61</sup> 42 U.S.C. §300gg-26(a)(4).

<sup>62</sup> 42 U.S.C. §300gg-26(a)(8).

<sup>63</sup> Although the small employer exemption initially applied to both fully insured and self-insured plans, EHB and parity regulations have provided that plans subject to EHB requirements (including fully insured plans offered by small employers) are also subject to parity requirements. Small employers (defined for this purpose as those with 50 or fewer employees) that self-insure are still exempt from parity requirements. For discussion of these details and the separate exemption regarding increased costs, see the Department of the Treasury, Department of Labor (DOL), and HHS, “Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program,” 78 *Federal Register* 68239, November 13, 2013, starting at page 68248.

<sup>64</sup> 42 U.S.C. §300gg-27.

<sup>65</sup> See Employee Benefits Security Administration, “Compliance Assistance Guide: Health Benefits Coverage Under Federal Law.” September 2014, at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf>. Also see DOL, HHS, and Department of the Treasury, “FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, And Women’s Health And Cancer Rights Act Implementation,” April 20, 2016, at [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31\\_Final-4-20-16.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf).

## Coverage of Pregnancy-Related Conditions

Certain employers offering health insurance are required to cover “expenses for pregnancy-related conditions on the same basis as expenses for other medical conditions” for employees enrolled in group plans.<sup>66</sup> If the group plan offers coverage to employees’ spouses and dependents, the requirement to cover pregnancy-related services also applies to employees’ spouses (but not necessarily to other dependents) enrolled in the plan.

This requirement applies to employers with 15 or more employees, whether their plans are fully insured or self-insured.

## Prohibition on Coverage Exclusions Based on Preexisting Health Conditions

Plans are prohibited from excluding coverage based on an enrollee’s *preexisting health conditions*.<sup>67</sup> This requirement does not mandate coverage for any specific benefit, if a plan otherwise would not cover it. Rather, with respect to the benefits a plan does cover, the plan may not exclude coverage of those benefits based on health conditions for any enrollee.<sup>68</sup> 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.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Enrollee Cost Sharing and Plan Payment for Benefits

As enrollees receive benefits covered by a plan, the costs for those benefits are paid by the enrollee and/or by the plan, depending on the plan’s terms. In addition to setting premiums and determining covered benefits, plans set enrollees’ cost-sharing levels. Enrollee *cost sharing*, also called *out-of-pocket (OOP) costs*, generally includes deductibles, coinsurance, and co-payments, up to annual OOP limits.<sup>69</sup> The terms of the plan also specify the amounts the plan will pay providers for covered benefits.

The following requirements relate to enrollee cost sharing and/or the costs of the benefits that the plans cover. They all reference the “Coverage of Essential Health Benefits” requirement discussed in the prior section. Certain provisions discussed elsewhere in this report are also relevant to other aspects of cost sharing or plan payments to providers, such as those relating to out-of-network providers in “Health Care Provider Interactions.”

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<sup>66</sup> 42 U.S.C. §2000e; 29 C.F.R. §1604.10, and 29 C.F.R. §1604, Appendix to Part 1604—Questions and Answers on the Pregnancy Discrimination Act, P.L. 95-555, 92 Stat. 2076 (1978). See CRS Report R46785, *Federal Support for Reproductive Health Services: Frequently Asked Questions* for additional information and citations.

<sup>67</sup> 42 U.S.C. §300gg-3.

<sup>68</sup> 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).

<sup>69</sup> In general, beginning with each plan year, an enrollee pays 100% of costs for covered health care benefits until the costs meet a certain threshold amount, called a *deductible*. Exceptions apply. After reaching the deductible, the enrollee pays coinsurance (a percentage amount) or co-payments (a flat amount) for covered benefits and the plan pays the rest. If an enrollee’s spending meets an annual out-of-pocket limit, the plan generally will pay 100% of covered costs for the remainder of the plan year.

## Maximum Annual Limitation on Cost Sharing

Plans must have annual limits on enrollee OOP costs that are no higher than federally set amounts.<sup>70</sup> In other words, once an enrollee’s OOP spending has met the federal annual limit (or a plan’s own annual limit, if lower), the plan generally will pay 100% of covered applicable costs for the remainder of the plan year.

HHS adjusts the limits each year through rulemaking and/or guidance using calculations required by the ACA.<sup>71</sup> In 2023, the limits cannot exceed \$9,100 for *self-only* coverage and \$18,200 for coverage *other than self-only*.<sup>72</sup> If a consumer is solely enrolled in a plan, the self-only limit applies. If a consumer and one or more dependents are enrolled in a plan, both types of limits apply.<sup>73</sup>

The limits generally apply only to in-network coverage of the EHB.<sup>74</sup> However, certain exceptions may apply.<sup>75</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.<sup>76</sup>

## Minimum Actuarial Value Requirements

Plans must pay for covered benefits in compliance with minimum actuarial value (AV) standards. AV estimates the “percentage of total average costs for covered benefits” to be paid by a plan.<sup>77</sup> A plan’s AV must comply with one of four levels corresponding with a precious metal designation

<sup>70</sup> 42 U.S.C. §300gg-6; 42 U.S.C. §18022.

<sup>71</sup> See, for example, CMS, CCIIO, “Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2023 Benefit Year.” December 28, 2021, at <https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf>.

<sup>72</sup> See CRS Report R44065, *Overview of Health Insurance Exchanges*, Table 2, for these and prior year annual limits.

<sup>73</sup> For example, for a family of three enrolled in a plan with the 2023 limits: Once individual 1 incurs \$9,100 in cost sharing for his or her benefits as specified above (generally, on in-network EHB), the plan is responsible for 100% of the costs for such benefits for the rest of the plan year. However, if individuals 2 and 3 have incurred only \$2,000 each in cost sharing, they would still be responsible for cost sharing at that time. If any of the enrollees’ cost sharing adds up to \$18,200, then the plan would be responsible for 100% of all of the enrollees’ costs for covered benefits for the rest of the plan year. For additional information about the annual OOP limit, see CMS, CCIIO, “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>.

<sup>74</sup> 45 C.F.R. §156.130. Also see HHS, DOL, and Treasury, “Affordable Care Act Implementation FAQs – Set 18,” January 9, 2014, at [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs18](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18), including questions 2 and 4. Hereinafter referred to as Tri-Agency FAQ 18.

<sup>75</sup> See, for example, “Preventing Surprise Medical and Air Ambulance Bills.” Also see 45 C.F.R. §156.130(h) regarding prescription drug coupons.

<sup>76</sup> This requirement applies to EHB coverage, and large-group and self-insured plans are not required to cover the EHB. The Tri-Agency FAQ 18, question 2, provides that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plan) to determine whether they comply with this requirement. This is consistent with regulations implementing the separate “Prohibition on Lifetime and Annual Coverage Limits”.

<sup>77</sup> See the definition of *actuarial value* in the glossary on HealthCare.gov at <https://www.healthcare.gov/glossary/actuarial-value/>.



(i.e., platinum, gold, silver, or bronze).<sup>78</sup> The four AV levels are 90% for platinum, 80% for gold, 70% for silver, and 60% for bronze.<sup>79</sup>

Given that plans and enrollees collectively pay total costs, AV is the plan counterpart to enrollee cost-sharing expenses. The higher the AV percentage, the lower the cost sharing, on average. For example, a silver plan expects to cover approximately 70% of total costs for covered benefits. Because enrollees' use of such benefits vary, a given enrollee's actual cost sharing may be more or less than 30% of costs associated with receipt of covered benefits. AV is not a measure of plan generosity for an enrolled individual or family, nor is it a measure of premiums or benefits packages.

AV calculations include only costs associated with a plan's covered EHB that are furnished by in-network providers, unless otherwise addressed in federal or state law.<sup>80</sup>

Small-group and non-group plans are subject to this requirement.

### Prohibition on Lifetime and Annual Coverage Limits

Plans are prohibited from setting lifetime or annual dollar limits on their coverage of the EHB, generally whether provided in-network or out-of-network.<sup>81</sup> In other words, plans may not limit their spending for such benefits for any enrollee, either during the entire period an individual is enrolled in the plan (*lifetime coverage limits*) or during a plan year (*annual coverage limits*).

Plans are permitted to place lifetime and annual coverage limits on covered benefits that are not considered EHBs, to the extent that federal and state law otherwise permit such limits.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.<sup>82</sup>

### Health Care Provider Interactions

These requirements relate to plan interactions and consumer interactions with providers, including in the context of plan coverage and benefits for services furnished to enrollees by certain out-of-network providers.

Certain requirements discussed in this section relate to provisions discussed elsewhere in this report. (See, e.g., the relationship between "Provider Directory Requirements" and "Services Provided Based on Incorrect Provider Directory Information.")

### Preventing Surprise Medical and Air Ambulance Bills

Plans are required to limit consumer cost sharing and to pay providers a specified amount when enrollees receive certain out-of-network medical care.<sup>83</sup>

<sup>78</sup> 42 U.S.C. §300gg-6; 42 U.S.C. §18022.

<sup>79</sup> Regulations allow plans to fall within a specified actuarial value range and still comply with one of the four levels; see 45 C.F.R. §156.140(c)(2).

<sup>80</sup> 45 C.F.R. §§156.20 and 156.135.

<sup>81</sup> 42 U.S.C. §300gg-11; 45 C.F.R. §147.126.

<sup>82</sup> This requirement applies to EHB coverage, and large-group and self-insured plans are not required to cover the EHB. Regulations provide that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plan) to determine whether they comply with this requirement. See 45 C.F.R. §147.126(c).

<sup>83</sup> 42 U.S.C. §§300gg-111 and 300gg-112. For more information on the topic of surprise billing, including these federal requirements, see CRS Report R46856, *Surprise Billing in Private Health Insurance: Overview of Federal Consumer*

- Out-of-network emergency services (if the plan covers services in an emergency department of a hospital or an independent freestanding emergency department)
- Nonemergency services provided by an out-of-network provider at an in-network facility (when notice and consent requirements have not been satisfied)<sup>84</sup>
- Out-of-network air ambulance services

When applicable, the cost-sharing requirement for these services cannot be greater than the cost sharing that would have applied for the service had it been provided by an in-network provider.<sup>85</sup> Generally, plans are required to calculate cost-sharing amounts based on the lesser of the billed charge for the service or the plan's median in-network rate for the service.<sup>86</sup> Any cost-sharing amounts paid by enrollees must be counted toward any in-network deductibles and in-network OOP maximums.

The amount a plan is required to pay a provider for these out-of-network services is determined according to a federal payment methodology.<sup>87</sup> Under this methodology, the plan must make an initial payment (or notice of denial of payment) to the out-of-network provider for services rendered, after which the parties may negotiate to reach an agreed-upon payment amount. If negotiations are unsuccessful, the parties may use an independent dispute resolution process, wherein an arbitrator determines the final payment amount. However, if a state has its own surprise billing law that pertains to a given plan type, provider type, and service, the state law methodology would apply. In addition, if a state has an all-payer model agreement, the amount designated under the agreement would apply.

In addition to the requirements above regarding out-of-network emergency benefits, plans must comply with additional requirements relating to benefits for emergency services.<sup>88</sup> If a plan covers services in an emergency department of a hospital or emergency services in an independent freestanding emergency department, the plan is required to cover those services without the need for any prior authorization, without coverage limitations or requirements for out-of-network providers and facilities that are more restrictive than the limitations or requirements that apply to in-network emergency providers and facilities, and regardless of any other term or condition of the plan (with limited exceptions).

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Continuity of Care

Plans are required to satisfy certain requirements when *continuing care patients* receive services from a provider that initially was in network but subsequently became out of network during the

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### *Protections and Payment for Out-of-Network Services.*

<sup>84</sup> For notice and consent requirements, see 42 U.S.C. §300gg-132(d).

<sup>85</sup> With covered, out-of-network air ambulance services specifically, the cost-sharing requirement must be *the same* as the cost sharing for an in-network provider.

<sup>86</sup> For applicable emergency services and covered nonemergency services provided by an out-of-network provider at an in-network facility, if the service is provided in a state that has an applicable surprise billing law or an all-payer model agreement, the cost-sharing amount is to be calculated in accordance with such law or agreement. See definition of *recognized amount* at 45 C.F.R. 149.30, as referenced by 45 C.F.R. 149.110(b)(3)(iii). For air ambulance services, see 45 C.F.R. 149.130(b)(2).

<sup>87</sup> For more information on the federal payment methodology, see CRS In Focus IF12073, *Surprise Billing: Independent Dispute Resolution Process*.

<sup>88</sup> 42 U.S.C. §300gg-111(a)(1).

course of treatment (i.e., as a result of the termination of the contractual relationship between the plan and provider).<sup>89</sup> In these situations, plans must

- notify the continuing care patient of the termination and the enrollee's right to elect continued transitional care from the now-out-of-network provider;
- provide the continuing care patient with an opportunity to notify the plan of his or her need for transitional care; and
- permit the continuing care patient to continue his or her course of treatment from the now out-of-network provider for, at most, 90 days and under the same terms and conditions as applied when the provider was in network.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Services Provided Based on Incorrect Provider Directory Information**

Plans must limit consumer cost sharing for covered, out-of-network services provided to enrollees who relied on incorrect provider network information.<sup>90</sup> If an enrollee receives a covered service from an out-of-network provider that the enrollee thought was in network due to incorrect information from the plan, the cost-sharing requirement cannot be greater than the cost sharing that would have applied had the service been provided by an in-network provider. In addition, plans must count any of these out-of-network cost-sharing amounts toward any in-network deductibles and in-network OOP maximums.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Choice of Healthcare Professionals**

Plans are subject to three requirements relating to the choice of health care professionals.<sup>91</sup> 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, plans that require or allow an enrollee to designate a participating primary care provider for an enrolled child are required to permit the designation of a participating physician who specializes in pediatrics as the child's primary care provider. 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.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Nondiscrimination Regarding Health Care Providers**

Plans may not discriminate, with respect to participation under the plan, against any health care provider that is acting within the scope of that provider's license or certification under applicable state law.<sup>92</sup> Federal law does not require that a plan contract with any health care provider willing

<sup>89</sup> 42 U.S.C. §300gg-113. For purposes of this provision, a *continuing care patient* is an individual who satisfies one of the following criteria: (1) is undergoing treatment for a serious and complex condition; (2) is undergoing institutional or inpatient care; (3) is scheduled to undergo nonelective surgery; (4) is pregnant and undergoing a course of treatment for the pregnancy; or (5) is or was determined to be terminally ill and is receiving treatment for such illness.

<sup>90</sup> 42 U.S.C. §300gg-115(b).

<sup>91</sup> 42 U.S.C. §300gg-117.

<sup>92</sup> 42 U.S.C. §300gg-5.

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.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Prohibition on Gag Clauses on Price and Quality Information**

Plans are prohibited from entering into agreements with providers and other selected entities that would directly or indirectly prevent the plan from

- disclosing provider-specific cost or quality of care information to referring providers, enrollees, plan sponsors, or individuals eligible to enroll in the plan;
- electronically accessing de-identified claims and encounter data for each enrollee;<sup>93</sup> and
- sharing such information with a business associate, consistent with applicable privacy regulations.<sup>94</sup>

Plans are required to annually attest to the Departments of HHS, Labor, and the Treasury that the plans are in compliance with this requirement.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Enrollee Information and Appeals**

Requirements in this section relate to plan disclosure of certain information to enrollees (and applicants, as specified) and to enrollees' rights regarding appeals of coverage denials.

In addition to the requirements discussed below, certain provisions discussed elsewhere in this report also have enrollee information and appeals components (see, e.g., "Mental Health Parity").

### **Summary of Benefits and Coverage and Uniform Glossary**

Plans are required to provide a *summary of benefits and coverage* (SBC) to individuals at the time of application, by the first day of coverage (if there are changes since the time of application), prior to the time of renewal, and otherwise upon request.<sup>95</sup> The SBC must meet certain requirements with respect to the included content and the presentation of the content (e.g., it must include uniform definitions of health insurance terms and a description of the coverage and cost sharing for specified categories of benefits). Plans may provide the SBC in paper or electronic form. Plans must notify enrollees of any material modifications (e.g., 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.

Large-group, small-group, self-insured, and non-group plans are subject to these requirements.

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<sup>93</sup> This component of the requirement applies to group health plans only.

<sup>94</sup> 42 U.S.C. §300gg-119. The term *business associate* is defined at 45 C.F.R. §160.103.

<sup>95</sup> 42 U.S.C. §300gg-15; 45 C.F.R. §147.200.

## Advanced Explanation of Benefits

When an enrollee schedules to receive medical care from a provider and seeks to have the care covered by a plan, providers are required to provide a good-faith estimate of expected charges for such care to the enrollee's plan.<sup>96</sup> Upon receipt of this estimate, plans are required to develop a notification, referred to as an *advance explanation of benefits*, and provide it to the enrollee within designated timeframes.<sup>97</sup> The advance explanation of benefits must contain specified pieces of information, including the provider's network status, the provider's good-faith estimate of expected charges, the plan's estimated payment toward the expected charges, the enrollee's estimated cost sharing, an estimate of the amounts accumulated toward the enrollee's deductible and OOP limit, whether the scheduled care is subject to a medical management technique,<sup>98</sup> and a disclaimer that the information in the advance explanation of benefits comprises estimates that are subject to change.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement. The Departments of HHS, Labor, and the Treasury have deferred enforcement of this requirement until the departments undertake notice and comment rulemaking.<sup>99</sup> As of the date of this report, regulations have not been issued.

## Plan Identification Card Information

Plans are required to include the following on any physical or electronic enrollee plan identification cards: any deductible applicable to the plan, any OOP maximum limitation applicable to the plan, and a consumer assistance telephone number and website.<sup>100</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Price Comparison Tool

Plans are required to disclose certain price comparison information to enrollees through a self-service tool on a website; by telephone; and, upon request, in paper.<sup>101</sup> Price comparison information includes but is not limited to an estimate of the enrollee's cost sharing for covered items and services furnished by any provider, amounts accumulated, in-network rates, and out-of-network allowed amounts.<sup>102</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement. Plans must disclose price comparison information for 500 specified items or services for plan years that begin on or after January 1, 2023. This list expands to all services for plan years that begin on or after January 1, 2024.<sup>103</sup>

<sup>96</sup> Good-faith cost estimates are required to be provided when care is scheduled at least three business days in advance (or upon request of the enrollee). 42 U.S.C. §300gg-136.

<sup>97</sup> 42 U.S.C. §300gg-111(f).

<sup>98</sup> The term *medical management technique* includes concurrent review, prior authorization, and step-therapy or fail-first protocols. 42 U.S.C. §300gg-111(f)(1)(F).

<sup>99</sup> DOL, HHS, and Treasury, "FAQs Part 49."

<sup>100</sup> 42 U.S.C. §300gg-111(e).

<sup>101</sup> 42 U.S.C. §300gg-114, 42 U.S.C. §300gg-15a, and 45 C.F.R. §147.211.

<sup>102</sup> 45 C.F.R. §147.211.

<sup>103</sup> DOL, HHS, and Treasury, "FAQs Part 49."

## Provider Directory Requirements

Plans are required to establish and adhere to certain provider directory standards.<sup>104</sup> These standards require plans to establish a public, online database that contains provider directory information for each provider with which they have a direct or indirect relationship. The standards also require plans to establish a process to verify and update this information at least once every 90 days. In addition, they require plans to establish a protocol to respond to enrollees who request information (via phone or electronically) about a provider’s network status. Federal law also requires that print directories include language indicating the date on which the information was accurate and noting that enrollees should consult the online database or the plan to obtain the most current provider directory information.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Disclosure of Patient Protections Against Balance Billing

Plans are required to disclose information on federal surprise billing requirements;<sup>105</sup> applicable state requirements addressing out-of-network provider charges, where appropriate; and the appropriate state and federal agencies that an individual can contact if a provider is believed to have violated such requirements.<sup>106</sup> This information must be made publicly available, posted on a public website of the plan, and included on each explanation of benefits for out-of-network emergency services and covered, nonemergency services provided by an out-of-network provider at an in-network facility.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Information on Prescription Drugs

Plans (including the pharmacy benefit managers contracted with them) are prohibited from restricting pharmacies from informing health plan enrollees of the difference in OOP costs they would pay for a prescription drug using their health plan coverage versus going “outside” of their health plan benefit to purchase a prescription drug.<sup>107</sup> Stated another way, this requirement aims to end what some refer to as *gag clauses* in contracts between pharmacies and plans or pharmacy

<sup>104</sup> 42 U.S.C. §300gg-115(a).

<sup>105</sup> More specifically, the requirements on plans at 42 U.S.C. §300gg-111 and the requirements on providers prohibiting balance billing in certain circumstances at 42 U.S.C. §§300gg-131, 132. The term *balance billing*, which is one type of surprise bill, refers to amounts that an out-of-network provider can charge a consumer for care that is in addition to the amount the consumer pays in out-of-network cost sharing and the amounts that the provider receives from a plan for such services. For more information on the relationship between surprise bills and balance bills, see the “Private Health Insurance Billing Overview” in CRS Report R46856, *Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services*. For a discussion of the surprise billing requirements at 42 U.S.C. §300gg-111 regarding out-of-network emergency services and covered, nonemergency services provided by an out-of-network provider at an in-network facility (when notice and consent requirements have not been satisfied), see “Preventing Surprise Medical and Air Ambulance Bills.”

<sup>106</sup> 42 U.S.C. §300gg-115(c).

<sup>107</sup> 42 U.S.C. §300gg-19b. *Pharmacy benefit managers* (PBMs) are intermediaries between health plans and pharmacies, drug wholesalers, and manufacturers. PBMs perform functions such as designing drug formularies, negotiating prices, and administering prescription drug payment systems. For more information, see CRS Report R44832, *Frequently Asked Questions About Prescription Drug Pricing and Policy*.

benefit managers and to allow pharmacies to inform health plan enrollees if it would be less expensive for them to obtain their prescription without using their health plan benefit.<sup>108</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Disclosure to Enrollees of Individual Market Coverage**

Plans are required to disclose to enrollees any direct or indirect compensation provided to agents or brokers associated with enrolling individuals in such coverage.<sup>109</sup> Plans must make this disclosure prior to an individual finalizing a plan selection and must include the disclosure on any documentation confirming the individual's enrollment. The plan also must annually report similar information to HHS.

Non-group plans are subject to this requirement.

### **Appeals Process and External Review**

Plans must implement an effective appeals process for coverage determinations and claims.<sup>110</sup> 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.

Plans also must implement either a state or a federal external review process for coverage determinations and claims.<sup>111</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Federal and Public Reporting Requirements**

The following requirements relate to the reporting of specified information to the federal government and/or the public disclosure of certain information.

In addition to the requirements discussed in this section, certain provisions discussed elsewhere in this report also have federal and public reporting requirement components (see, e.g., “Mental Health Parity”).

### **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.<sup>112</sup> The Secretary also was

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<sup>108</sup> For more information on prescription drug coupons and patient assistance programs, see CRS Report R44264, *Prescription Drug Discount Coupons and Patient Assistance Programs (PAPs)*.

<sup>109</sup> 42 U.S.C. §300gg-46. Separately, disclosure provisions require those providing “brokerage services” or “consulting” to group health plans to disclose specified information, including information regarding direct and indirect compensation, to plan fiduciaries. See 29 U.S.C. §1108(b)(2).

<sup>110</sup> 42 U.S.C. §300gg-19(a).

<sup>111</sup> 42 U.S.C. §300gg-19(b).

<sup>112</sup> 42 U.S.C. §300gg-17.

required to publish regulations governing acceptable provider reimbursement structures not later than two years after ACA enactment. No later than 180 days after these regulations were promulgated, the U.S. Government Accountability Office was required to conduct a study regarding the impact of these activities on the quality and cost of health care. To date, the HHS Secretary has not published the required final regulations.

However, the Department of Labor's (DOL's) Employee Benefits Security Administration published a proposed rule on July 21, 2016, that would modify current annual reporting requirements for pension and other employee benefit plans under ERISA Titles I and IV.<sup>113</sup> Under these modified 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 subject to ERISA that complies with these reporting requirements would satisfy the quality reporting requirements in PHSA Section 2717, as incorporated in ERISA. To date, this proposal has not been finalized through rulemaking.

Once the reporting requirements are implemented, plans would 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
- Implement wellness and health-promotion activities<sup>114</sup>

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

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

## Reporting Requirements Regarding Air Ambulances

HHS, in consultation with the Department of Transportation, was required to issue rulemaking no later than one year after enactment of the No Surprises Act indicating how plans should submit specified air ambulance information to the federal government.<sup>115</sup> A proposed rule regarding this requirement was published on September 16, 2021, but a final rule had not been published as of the date of this report.<sup>116</sup>

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<sup>113</sup> DOL, Employee Benefits Security Administration, "Annual Reporting and Disclosure," Proposed Rule, 81 *Federal Register* 47495, July 21, 2016.

<sup>114</sup> 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.

<sup>115</sup> § 106(d) of the No Surprises Act, part of the Consolidated Appropriations Act, 2021 (P.L. 116-260).

<sup>116</sup> Office of Personnel Management; Treasury, Internal Revenue Service; DOL, Employee Benefits Security Administration; HHS, CMS, "Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement," Proposed Rule, 86 *Federal Register* 51730, September 16, 2021.



Once the final rule is promulgated, plans would be required to report air ambulance claims data and other specified information regarding air ambulance providers to the federal government for two consecutive plan years.<sup>117</sup>

HHS, in consultation with the Department of Transportation, is required to summarize the information submitted by plans to develop a report that is made available to the public.<sup>118</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Reporting Requirements Regarding Pharmacy Benefits and Drug Costs**

Plans are required to annually submit specified information on prescription drug and total health care spending to HHS, DOL, and Treasury.<sup>119</sup> This information includes, but is not limited to, the plan's 50 brand prescription drugs most frequently dispensed by pharmacies; the plan's 50 most costly prescription drugs by total annual spending; the plan's 50 prescription drugs with the greatest increase in plan spending; total health care spending broken down by specified categories; and impacts on premiums by rebates, fees, and other remuneration paid by drug manufactures to the plan for enrollees.<sup>120</sup>

HHS, DOL, and Treasury are required to biannually issue a public, online report on prescription drug reimbursements, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases.

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

### **Transparency in Coverage**

Plans are required to satisfy certain disclosure and reporting requirements relating to price transparency.<sup>121</sup> Plans are required to publicly post on a website, and monthly update, three machine-readable files that separately include

- in-network rates with providers for all covered services,
- out-of-network allowed amounts and billed charges for covered services during a specific time period, and
- negotiated rates and historical net prices for covered prescription drugs.

HHS, DOL and Treasury have deferred enforcement of the prescription drug machine-readable file component of this requirement.<sup>122</sup>

Large-group, small-group, self-insured, and non-group plans are subject to this requirement.

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<sup>117</sup> 42 U.S.C. §300gg-118.

<sup>118</sup> §106(c) of the No Surprises Act, part of the Consolidated Appropriations Act, 2021 (P.L. 116-260).

<sup>119</sup> 42 U.S.C. §300gg-120.

<sup>120</sup> Regulations provide further specification for how plans are to meet this requirement. See Office of Personnel Management; Treasury, Internal Revenue Service; DOL, Employee Benefits Security Administration; HHS, CMS, "Prescription Drug and Health Care Spending," Interim Final Rule, 86 *Federal Register* 66662, November 23, 2021.

<sup>121</sup> 42 U.S.C. §300gg-15a and 45 C.F.R. §147.212.

<sup>122</sup> DOL, HHS, and Treasury, "FAQs Part 49."

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