DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

OVERSIGHT GROUP

Date: April 25, 2018

To: Health Insurance Issuers in Missouri, Oklahoma, Texas, and Wyoming

RE: Checklist for Non-Grandfathered Plan Form Reviews

The Centers for Medicare & Medicaid Services (CMS) is responsible for enforcing provisions of title XXVII of the Public Health Service Act (PHS Act) with respect to health insurance issuers in the group and individual markets when a state informs CMS that it does not have authority to enforce or is not otherwise substantially enforcing one or more of the provisions. Within CMS, the Oversight Group in the Center for Consumer Information & Insurance Oversight (CCIIO) is the primary entity responsible for this work. This checklist is a summary of provisions of federal law that may be used by the Oversight Group during the form review of non-grandfathered plans.

This checklist is intended for use as a reference tool by health insurance issuers submitting non-grandfathered health insurance products in the individual, small group, and large group markets that will be offered in Missouri, Oklahoma, Texas, or Wyoming. The use of this checklist is optional. It does not provide an exhaustive or all-inclusive list of provisions that may be used during the review, and does not replace or revise any law, regulation, or guidance.

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Guaranteed Availability: PHS Act § 2702 (42 U.S.C. § 300gg-1)			
Guaranteed availability of coverage 45 C.F.R. § 147.104	Issuers that offer coverage in a state must accept every individual or employer in that state that applies for such coverage, subject to certain exceptions.	• **Group market** • **Individual market**[1]	☐ YES ☐ NO

[1] A health insurance issuer that offers student health insurance coverage is not required to accept individuals who are not students or dependents of students in such coverage, and, notwithstanding the requirements of 45 C.F.R. § 147.104(b), is not required to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or to offer policies on a calendar year basis. (45 C.F.R. § 147.145(b)(1)(ii)).

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Guaranteed Renewability: PHS Act § 2703 (42 U.S.C. § 300gg-2)			
Guaranteed renewability of coverage 45 C.F.R. § 147.106	Issuers must renew or continue in force coverage at the option of the plan sponsor or individual with six exceptions: 1. nonpayment of premiums 2. fraud 3. violation of participation or contribution rules 4. termination of product 5. enrollees' movement outside service area 6. association membership ceases. An issuer also is not required to renew or continue in force coverage for which continued eligibility would otherwise be prohibited under applicable Federal law.[2]	• **Group market** • **Individual market**[3]	☐ YES ☐ NO
Preexisting Condition Exclusions: PHS Act § 2704 (42 U.S.C. § 300gg-3)			
Prohibition of preexisting condition exclusions 45 C.F.R. § 147.108	Issuers may not use preexisting condition exclusions.	• **Group market** • **Individual market**	☐ YES ☐ NO
Non-Discrimination in Health Care: PHS Act § 2706 (42 U.S.C. § 300gg-5)			
Non-discrimination of health care providers	Issuers may not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law.	• **Group market** • **Individual market**	☐ YES ☐ NO

[2] Issuers that have knowledge that an enrollee in individual market coverage is entitled to Medicare Part A or enrolled in Medicare Part B are prohibited from renewing the individual market coverage if it would duplicate benefits to which the enrollee is entitled, unless the renewal is effectuated under the same policy or contract of insurance. 81 Fed. Reg. 94058 at 94068 (2018 Payment Notice Final Rule (Dec. 22, 2016)).

[3] A health insurance issuer that offers student health insurance coverage is not required to renew or continue in force coverage for individuals who are no longer students or dependents of students. (45 C.F.R. § 147.145(b)(1)(iii)).

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Essential Health Benefits (EHB): PHS Act § 2707 (42 U.S.C. § 300gg-6)			
Coverage of EHB 45 C.F.R. §§ 147.150, 156.115	Issuers must provide benefits that are substantially equal to the EHB-benchmark plan, including covered benefits and limitations on coverage, for the following categories: 1. ambulatory patient services 2. emergency services 3. hospitalization 4. maternity and newborn care 5. mental health and substance use disorder services, including behavioral health treatment 6. prescription drugs 7. rehabilitative and habilitative services and devices 8. laboratory services 9. preventive and wellness services and chronic disease management 10. pediatric services, including oral and vision care	• **Small group market** • **Individual market**	☐ YES ☐ NO ☐ N/A
Prescription drug benefits 45 C.F.R. § 156.122	To provide EHB, a plan must: 1. provide benefits that cover at least the greater of one drug in every United States Pharmacopeia category and class or the same number of prescription drugs in each category and class as the EHB-benchmark plan, and 2. have procedures in place to allow an enrollee to request an exception and gain access to clinically appropriate drugs not covered by the health plan.	• **Small group market** • **Individual market**	☐ YES ☐ NO ☐ N/A
EHB discrimination 45 C.F.R. § 156.125, 80 Fed. Reg. 10749 at 10823 (2016 Payment Notice Final Rule (Feb. 27, 2015))	An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Whenever a plan subject to the EHB requirement reduces the generosity of a benefit for subsets of individuals, issuers are expected to base such reductions on clinical guidelines and medical evidence, and are expected to use reasonable medical management.	• **Small group market** • **Individual market**	☐ YES ☐ NO ☐ N/A
Actuarial Value (AV) calculation 45 C.F.R. § 156.135	Individual and small group market plans must be offered at one of the four metal levels of actuarial value. Individual market plans also may be offered as catastrophic plans. Issuers of individual and small group market plans generally must use the AV Calculator to determine the AV for those plans that	• **Small group market**	☐ YES ☐ NO ☐ N/A

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
	have designs that are compatible with the AV calculator. For plan design features that deviate substantially from the parameters of the AV Calculator, issuers must have an actuary who is a member of the American Academy of Actuaries calculate and certify, in accordance with generally accepted actuarial principles and methodologies, an estimate of the fit of its plan design into the parameters of the AV Calculator, or appropriate adjustments to the AV identified by the calculator.	• **Individual market**[4]	
Maximum out-of-pocket 45 C.F.R. § 156.130(a)	The proposed maximum out-of-pocket cost for plan year 2019 may not exceed $7,900 for self-only coverage plan and $15,800 for other than self-only coverage (https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Actuarial-Value-Methodology.pdf). This limit must include deductibles, coinsurance, copayments, or similar charges and any other expenditure required of an individual which is a qualified medical expense for EHB. This limit is not required to include premiums, balance billing amounts for non-network providers and other out-of-network cost-sharing, or spending for non-EHBs.	• **Group market** • **Individual market**	☐ YES ☐ NO

[4] The requirement to provide a specific level of coverage described in section 1302(d) of the Affordable Care Act does not apply to student health insurance coverage. However, the benefits provided by such coverage must provide at least 60 percent actuarial value. The issuer must specify in any plan materials summarizing the terms of the coverage the actuarial value and level of coverage (or next lowest level of coverage) the coverage would otherwise satisfy. (45 C.F.R. § 147.145(b)(2)).

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): PHS Act § 2726 (42 U.S.C. § 300gg–26)			
Mental health parity 45 C.F.R. §§ 146.136 and 147.160	An issuer that provides mental health/substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits, must comply with parity requirements for: lifetime and annual dollar limits; financial requirements; quantitative treatment limitations; cumulative financial requirements and quantitative treatment limitations; and non-quantitative treatment limitations (NQTLs). The processes, strategies, evidentiary standards or other factors used in applying a NQTL to MH/SUD benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the NQTL to M/S benefits in the same classification.	• **Group market**[5] • **Individual market**	☐ YES ☐ NO
Prohibition on Excessive Waiting Periods: PHS Act § 2708 (42 U.S.C. § 300gg-7)			
Prohibition on waiting periods that exceed 90 days 45 C.F.R. § 147.116	An issuer may not apply any waiting period that exceeds 90 days. A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective. Being otherwise eligible to enroll means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period).	• **Group market**	☐ YES ☐ NO ☐ N/A

[5] While MHPAEA does not apply directly to small group plans, its requirements are applied to the small group market indirectly in connection with the EHB requirements in 45 C.F.R. §§ 147.150, 156.115.

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Clinical Trials: PHS Act § 2709 (42 U.S.C. § 300gg-8)			
Coverage of clinical trials	Issuers that cover a "qualified individual" may not: • deny the individual from participating in an approved clinical trial; • deny (or limit or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection to the individual's participation in the trial; or • discriminate against the individual on the basis of the individual's participation in the trial.	• **Group market** • **Individual market**	☐ YES ☐ NO
Dollar Limits: PHS Act § 2711 (42 U.S.C. § 300gg-11)			
Lifetime and annual dollar limits 45 C.F.R. § 147.126	Issuers may not establish any lifetime or annual limits on the dollar value of EHBs. Any dollar limits imposed by the EHB-benchmark plan may be converted to actuarially equivalent non-dollar limits.[6]	• **Group market** • **Individual market**	☐ YES ☐ NO
Rescissions: PHS Act § 2712 (42 U.S.C. § 300gg-12)			
Rescissions 45 C.F.R. § 147.128	Issuers may not rescind coverage unless the covered individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. Prior to rescinding coverage, an issuer must provide at least thirty days advance written notice to each participant who would be affected.	• **Group market** • **Individual market**	☐ YES ☐ NO
Preventive Health Services: PHS Act § 2713 (42 U.S.C. § 300gg-13)			
Coverage of preventive health services 45 C.F.R. § 147.130	Issuers must provide coverage of preventive health services without imposing cost-sharing requirements for the services identified in 45 C.F.R. § 147.130(a)(1)	• **Group market** • **Individual market**	☐ YES ☐ NO

[6] Frequently Asked Questions on the Essential Health Benefits Bulletin, February 17, 2012, Q.9, available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf.

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Religious Exemption/ Accommodation 45 C.F.R. § 147.131(a) and (b)	Issuers must provide coverage of preventive health services identified in 45 C.F.R. § 147.130(a)(1) without imposing cost-sharing requirements, including coverage of all FDA approved contraceptive services for women with child-bearing capacity, as prescribed by a provider. However, group health plans established or maintained by a religious employer may be exempt from having to provide coverage for contraceptives, and other employers that are eligible organizations may be eligible for an accommodation.	• **Group market**	☐ YES ☐ NO ☐ N/A
Dependent Coverage until 26 Years of Age: PHS Act § 2714 (42 U.S.C. § 300gg-14)			
Eligibility of children until at least age 26 45 C.F.R. § 147.120	An issuer that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.	• **Group market** • **Individual market**	☐ YES ☐ NO
Summary of Benefits and Coverage (SBC): PHS Act § 2715 (42 U.S.C. § 300gg-15)			
Summary of benefits and coverage and uniform glossary 45 C.F.R. § 147.200	Issuers must provide a SBC for each benefit package without charge, and provide a uniform glossary containing standardized definitions of specified health coverage and medical terms.	• **Group market** • **Individual market**	☐ YES ☐ NO
Notice of material modification 45 C.F.R. § 147.200(b)	If an issuer makes any material modification in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the issuer must provide notice of the modification not later than 60 days prior to the date on which the modification will become effective.	• **Group market** • **Individual market**	☐ YES ☐ NO

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Appeals: PHS Act § 2719 (42 U.S.C. § 300gg-19)			
Internal claims and appeals and external review processes 45 C.F.R. § 147.136	Issuers must implement an effective internal claims and appeals process, which includes, but is not limited to: 1. providing notice of available internal and external appeals processes, 2. providing notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established to assist such enrollees with the appeals processes, and 3. allowing an enrollee to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.	• **Group market** • **Individual market**	☐ YES ☐ NO
Patient Protections: PHS Act § 2719A (42 U.S.C. § 300gg-19a)			
Choice of health care professional 45 C.F.R. §147.138(a)(1)	If an issuer requires or provides for a participating primary care provider (PCP), then the issuer must permit each participant to designate any participating PCP who is available to accept the participant.	• **Group market** • **Individual market**	☐ YES ☐ NO
Choice of pediatrician as primary care provider 45 C.F.R. § 147.138(a)(2)	If an issuer requires or allows the designation of a PCP for a child, the participant shall be permitted to designate a physician who specializes in pediatrics as the child's PCP, if such provider participates in the network of the plan or issuer and is available to accept the child.	• **Group market** • **Individual market**	☐ YES ☐ NO
Patient access to obstetrical and gynecological care 45 C.F.R. § 147.138(a)(3)	If an issuer covers obstetrical or gynecological (OB/GYN) care and requires the designation of a participating PCP, the issuer may not require prior authorization or referral for a female patient to see a participating health care professional specializing in OB/GYN care.	• **Group market** • **Individual market**	☐ YES ☐ NO
Notice of right to designate a primary care provider 45 C.F.R. § 147.138(a)(4)	If an issuer requires the designation of a PCP, the issuer must provide a notice of the terms of the plan or health insurance coverage regarding designation of a PCP and of the rights enumerated in 45 C.F.R. § 147.138(a)(1)-(3).	• **Group market** • **Individual market**	☐ YES ☐ NO

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Coverage of emergency services 45 C.F.R. § 147.138(b)	If an issuer provides benefits for services in the emergency department of a hospital, then such emergency services must be provided without: 1. requiring prior authorization, 2. regard to whether the health care provider is in or out-of-network, 3. imposing any administrative requirement or limitation on coverage provided out of network that is more restrictive than the requirements or limitations that apply to emergency service received from in-network providers, and 4. higher cost-sharing requirements for out-of-network services.	• **Group market** • **Individual market**	☐ YES ☐ NO
Women's Health and Cancer Rights Act (WHCRA) 42 U.S.C. § 300gg-27			
WHCRA	An issuer providing coverage that provides medical and surgical benefits with respect to a mastectomy must provide, in a case of a participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: 1. All stages of reconstruction of the breast on which the mastectomy has been performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.	**Reviewed by CCIIO for Wyoming issuers only** • **Group market** • **Individual market**	☐ YES ☐ NO ☐ N/A
Newborns' & Mothers' Health Protection Act of 1996 (NMHPA) 42 U.S.C. § 300gg-25			
Standards relating to benefits for mothers and newborn 45 C.F.R. §§ 146.130 and 148.170	An issuer that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.	**Reviewed by CCIIO for Wyoming issuers only** • **Group market** • **Individual market**	☐ YES ☐ NO ☐ N/A

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Discrimination Based on Health Status: PHS Act § 2705 (42 U.S.C. § 300gg-4)			
Prohibiting discrimination against participants and beneficiaries based on a health factor 45 C.F.R. §§ 146.121 and 147.110	Issuers may not establish any rule for eligibility of any enrollee to enroll for benefits under the terms of the plan or charge more for coverage because of any of the following health factors: • health status • medical condition, including physical and mental illnesses • claims experience • receipt of health care • medical history • genetic information • evidence of insurability • disability • any other health status-related factor determined appropriate by the Secretary.	• **Group market** • **Individual market**	☐ YES ☐ NO
Source of injury exclusions 45 C.F.R. §§ 146.121(b)(2)(iii) and 147.110	An issuer offering coverage of benefits for a specific type of injury may not deny benefits otherwise provided for the treatment of such injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).	• **Group market** • **Individual market**	☐ YES ☐ NO
Genetic Nondiscrimination 42 U.S.C. § 300gg-53, 45 C.F.R. §§ 146.121(c)(2)(i), 146.122, 147.110 and 148.180	Issuers may not: • increase the group premium or contribution amounts based on genetic information; • request or require an individual or family member to undergo a genetic test • Request, require, or purchase genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.	• **Group market** • **Individual market**	☐ YES ☐ NO

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Health contingent wellness programs 45 C.F.R. § 146.121(f)(3) and (4)	A health-contingent wellness program is non-discriminatory if: 1. The program gives individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year; 2. The reward does not exceed the applicable percentage[7] of the cost of health coverage; 3.The wellness program is reasonably designed to promote health or prevent disease; 4. The full reward is made available to all similarly situated individuals and reasonable alternative means of qualifying for the reward is offered to individuals whose medical conditions make it unreasonably difficult, or for whom it is medically inadvisable, to meet the specified health-related standard; and 5. The terms of the program (including the reasonable alternative standard(s)) are disclosed in all plan materials.	• **Group market**	☐ YES ☐ NO ☐ N/A
Rating Factors: PHS Act § 2701 (42 U.S.C. § 300gg)			
Fair health insurance premiums 45 C.F.R. § 147.102	The only factors allowed in determining rates for health insurance coverage are: 1. family (generally per-member build-up; 3-person cap for child dependents under age 21) 2. geographic rating area 3. age (3:1 for adults) 4. lawful tobacco use (1.5:1), subject to the provisions in PHS Act § 2705	• **Small group market** • **Individual market**	☐ YES ☐ NO

[7] The applicable percentage is 30%, except that the applicable percentage may be increased by an additional 20 percentage points (to 50%) to the extent the additional percentage is in connection with a program designed to prevent or reduce tobacco use. See 45 C.F.R. § 146.121(f)(5).

Federal Law Citations	Summary of Provision	Market Applicability	Is Contract Compliant?
Single Risk Pool: (42 U.S.C. 18032(c))			
Single risk pool 45 C.F.R. § 156.80(d)(4)(i) and (ii)	Issuers may not establish an index rate or make the market-wide or plan-level adjustments, more or less frequently than annually except for a health insurance issuer in the small group market. A health insurance issuer in the small group market (not including a merged market) may establish index rates and make market-wide adjustments no more frequently than quarterly, provided that any changes to rates must have effective dates of January 1, April 1, July 1, or October 1.	• **Small group market** • **Individual market**[8]	☐ YES ☐ NO ☐ N/A

[8] Student health insurance coverage is not subject to the single risk pool requirements applicable to other non-grandfathered individual market insurance coverage. A health insurance issuer that offers student health insurance coverage may establish one or more separate risk pools for an institution of higher education, if the distinction between or among groups of students (or dependents of students) who form the risk pool is based on a bona fide school-related classification and not based on a health factor (as described in 45 C.F.R. § 146.121. However, student health insurance rates must reflect the claims experience of individuals who comprise the risk pool, and any adjustments to rates within a risk pool must be actuarially justified. (45 C.F.R. § 147.145(b)(3)).