MARKET REFORMS

NON-GRANDFATHERED STUDENT HEALTH INSURANCE COVERAGE PROVISIONS

Compliance Checklist

Created June 2018

45 C.F.R. § 147.145 defines "student health insurance coverage" as a type of individual market health insurance coverage that is offered to students and their dependents under a written agreement between an institution of higher education (as that term is defined for purposes of the Higher Education Act of 1965) and a health insurance issuer. Accordingly, student health insurance coverage is generally subject to the Public Health Service Act (PHS Act) individual market requirements.[1] This checklist is intended for use as a reference tool by health insurance issuers offering non-grandfathered student health insurance products. The use of the checklist is optional. It does not provide an exhaustive list of provisions that apply to non-grandfathered student health insurance products and does not replace or revise any law, regulation or guidance. This checklist only includes provisions of Federal law. States may have additional requirements with respect to student health insurance coverage.

Federal Law Citation	Summary of the Provision	Links to Regulations/Guidance/FAQs/Resources
PHS Act § 2701 (42 U.S.C. § 300gg)	**Fair health insurance premiums** With respect to the premium rate charged for a particular plan or coverage, the only rating factors allowed: 1. Family (generally per-member build-up; 3-covered child cap under age 21) 2. Geographic rating area 3. Age (3:1) 4. Tobacco use (1.5:1)	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Market-Rating-Reforms.html **Regulations and Guidance:** 45 C.F.R. § 147.102 https://www.ecfr.gov/cgi-bin/text-idx?SID=ef0b61058fc6a3c8696c2d16568d2f01&mc=true&node=se45.1.147_1102&rgn=div8 https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Guidance-Regarding-Age-Curves-and-State-Reporting-12-16-16.pdf
PHS Act § 2702 (42 U.S.C. § 300gg-1)	**Guaranteed availability of coverage** Issuers that offer coverage in a state must accept every individual in that state that applies for coverage, subject to certain exceptions.	**Regulations and Guidance:** 45 C.F.R. § 147.145(b)(1)(ii)

[1] CMS has exercised its authority under section 1560(c) of the Patient Protection and Affordable Care Act to modify some of its rules as applied to student health insurance coverage, including those related to the guaranteed availability, guaranteed renewability, actuarial value, and single risk pool requirements.

Federal Law Citation	Summary of the Provision	Links to Regulations/Guidance/FAQs/Resources
	For purposes of section 2702 of the PHS Act, 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.	https://www.ecfr.gov/cgi-bin/text-idx?SID=c18bdf647a62cca3d64328dd699dbaa8&mc=true&node=se45.1.147_1145&rgn=div8
PHS Act § 2703 (42 U.S.C. § 300gg-2)	**Guaranteed renewability of coverage** Issuers must renew or continue in force coverage at the option of the 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 services area, or 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] *For purposes of section 2703(a) of the PHS Act, 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.*	**Regulations and Guidance:** 45 C.F.R. § 147.145(b)(1)(iii) https://www.ecfr.gov/cgi-bin/text-idx?SID=c18bdf647a62cca3d64328dd699dbaa8&mc=true&node=se45.1.147_1145&rgn=div8
PHS Act § 2704 (42 U.S.C. § 300gg-3)	**Preexisting condition exclusions**	**Regulations and Guidance:** 45 C.F.R. § 147.108

[2] Issuers that have knowledge that an enrollee in individual market coverage is entitled 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 if effectuated under the same policy or contract of insurance. See 81 FR 94058 at 94068 (2018 Payment Notice Final Rule (December 22, 2016)).

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	Issuers may not use preexisting condition exclusions.	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=835de4f9fe93139e0e0158778be79f24&mc=true&n=pt45.1.147&r=PART&ty=HTML#se45.1.147_1108 **Fact Sheets and FAQs:** https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html
PHS Act § 2705 (42 U.S.C. § 300gg-4)	**Prohibiting discrimination against participants and beneficiaries based on a health factor** Issuers may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. Issuers may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual. If a group health plan and a health insurance issuer offering group or individual health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health	**Regulations and Guidance:** 45 C.F.R. § 147.110 (applying 146.121) https://www.ecfr.gov/cgi-bin/text-idx?SID=7f71549677e40a1254ceacb1d2915850&mc=true&node=se45.1.147_1110&rgn=div8 45 C.F.R. § 146.121 https://www.ecfr.gov/cgi-bin/text-idx?SID=7f71549677e40a1254ceacb1d2915850&mc=true&node=se45.1.146_1121&rgn=div8

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	conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.	
PHS Act § 2706 (42 U.S.C. § 300gg-5)	**Nondiscrimination in health care** Health insurance issuers may not discriminate with respect to participation under the plan or coverage against any provider operating within their scope of practice under applicable state law. Does not require that a plan contract with any willing provider or prevent tiered networks.	**Fact Sheets and FAQs**: "The statutory language of PHS Act section 2706(a) is self-implementing, and the Departments do not expect to issue regulations in the near future." https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html
PHS § 2707 (42 U.S.C. § 300gg-6)	**Essential Health Benefits (EHB)** EHBs, which include items and services within at least the following 10 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 **Actuarial Value** AV levels specified in Part 156 do not apply. *Student health coverage must provide at least 60 percent actuarial value, as calculated in accordance with §156.135. The issuer must specify in any plan materials summarizing the terms of the coverage the actuarial value and level of coverage (or next lowest*	**CCIIO webpage**: https://www.cms.gov/cciio/resources/data-resources/ehb.html **Regulations and Guidance:** 45 C.F.R. 156, Subpart B https://www.ecfr.gov/cgi-bin/text-idx?SID=6806aec6df232ceb8a5690bc0e495c8e&mc=true&node=sp45.1.156.b&rgn=div6 2017 Benchmark plans https://downloads.cms.gov/cciio/Final%20List%20of%20BMPs_15_10_21.pdf Please note: States may select new EHB-Benchmark for plans beginning on or after January 1, 2020. See: https://www.gpo.gov/fdsys/pkg/FR-2018-04-17/pdf/2018-07355.pdf (page 17068) 45 C.F.R. § 147.145(b)(2) https://www.ecfr.gov/cgi-bin/text-idx?SID=594c2b33d0e46aeca7bf22663aa3a797&mc=true&node=se45.1.147_1145&rgn=div8

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	level of coverage) the coverage would otherwise satisfy under §156.140.	
PHS Act § 2709 (42 U.S.C. § 300gg-8)	**Clinical Trials** Issuers may not: (1) deny a qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) discriminate against the individual on the basis of the individual's participation in the trial.	**Fact Sheets and FAQs:** "The statutory language of PHS Act section 2709 is self-implementing, and the Departments do not expect to issue regulations in the near future." https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html
PHS Act § 2711 (42 U.S.C. § 300gg-11)	**Lifetime and annual limits** No lifetime or annual limits on the dollar value of EHBs. If the limit is not a dollar limit (i.e., a visit limit), the lifetime or annual limit prohibition may not be triggered. As with lifetime limits, issuers are not prohibited from using annual limits for specific covered benefits that are not EHBs, nor from excluding all benefits for non-EHBs for all enrollees. If the limit is not a dollar limit (i.e., a visit limit), the annual limit prohibition would not be triggered, unless the visit limit has a specified dollar amount for each visit.	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Annual-Limits.html **Regulations and Guidance:** 45 C.F.R. § 147.126 https://www.ecfr.gov/cgi-bin/text-idx?SID=6c9de92307741726d976017a50200ee0&node=se45.1.147_1126&rgn=div8 **Fact Sheets and FAQs:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/alw-faq.html
PHS Act § 2712 (42 U.S.C. § 300gg-12)	**Rescissions** Prohibition on rescissions: cancelling or discontinuing coverage with retroactive effect.	**Regulations and Guidance:** 45 C.F.R. § 147.128 https://www.ecfr.gov/cgi-bin/text-idx?SID=ffbbb6abec85ef1a9809929db0767858&mc=true&node=se45.1.147_1128&rgn=div8

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	Exception to prohibition on rescission: the 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. Discontinuation/cancellation with retroactive effect due to non-payment of premiums is not a rescission. A health insurance issuer is required to provide thirty (30) days advance written notice prior to rescinding coverage. The enrollee may appeal this decision under 45 C.F.R. § 147.136.	**Fact Sheets and FAQs:** https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html
PHS Act § 2713 (42 U.S.C. § 300gg-13	**Preventive services** Health insurance issuers must provide coverage for all of the following items and services, and may not impose any cost sharing requirements with respect to those services: • Current U.S. Preventive Services Task Force (USPSTF) A or B rated items or services with respect to the individual involved; • For infants, children, and adolescents, evidence-informed preventive care screenings supported by Health Resource and Services Administration (HRSA) guidelines; • For women, preventive care screenings recommended by HRSA and not already included in recommendations by the USPSTF; and • Immunizations for routine use in children, adolescents, and adults with recommendation from Advisory Committee on Immunization Practices (ACIP) of the CDC.	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Prevention.html **Regulations and Guidance:** 45 C.F.R. § 147.130 https://www.ecfr.gov/cgi-bin/text-idx?SID=6806aec6df232ceb8a5690bc0e495c8e&mc=true&node=se45.1.147_1130&rgn=div8 **Fact Sheets and FAQs on the CCIIO website:** http://cciio.cms.gov/resources/factsheets/index.html#prevention **FAQs about Preventive Care on the Department of Labor website:** http://www.dol.gov/ebsa/faqs/faq-aca12.html

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	The issuer is not required to cover recommended preventive services delivered by out-of-network providers, and may impose cost-sharing requirements for such providers (if the relevant service is also available from an in-network provider – See 45 C.F.R. § 147.130(a)(3)(ii)).	**USPSTF A and B recommendations:** https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ **Advisory Committee on Immunization Practices Recommendations:** http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html **Health Resources and Services Administration Recommendations (HRSA):** https://www.healthcare.gov/coverage/preventive-care-benefits/ Also see 45 C.F.R. § 147.145(c)(2) Notwithstanding the requirements under section 2713 of the Public Health Service Act and its implementing regulations, student administrative health fees as defined in paragraph (c)(1) of this section are not considered cost-sharing requirements with respect to specified recommended preventive services.
PHS Act § 2714 (42 U.S.C. § 300gg-14)	**Extension of dependent coverage** Health insurance issuers that issue policies providing for dependent coverage for children must continue to make such coverage available to married and unmarried dependents up to age 26. The issuer does not have to provide coverage to such dependents' spouses or children. Dependent eligibility can only be defined in terms of the relationship between the child and the subscriber. Requirements for eligibility cannot include factors including:	**CCIIO webpage:** https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html#Coverage for Young Adults https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Coverage-for-Young-Adults.html **Regulations and Guidance:** 45 C.F.R. § 147.120 https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=6806aec6df232ceb8a5690bc

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	• Financial dependency; • Residency • Student status; • Employment; and Terms of dependent coverage cannot vary based on age. For example: plans cannot impose a premium surcharge for dependents over 18. Note that this does not prohibit plans from imposing age rating, pursuant to PHS Act § 2701 and 45 C.F.R. § 147.102.	0e495c8e&mc=true&n=pt45.1.147&r=PART&ty=HTML#se45.1.147_1120 **Fact Sheets and FAQs:** https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html#Coverage for Young Adults https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html
PHS Act § 2715 (42 U.S.C. § 300gg-15)	**Uniform summary of benefits and coverage and standardized definitions** Health insurance issuers must provide an SBC for each benefit package without charge and provide a uniform glossary containing standardized definitions of specified health coverage and medical terms. 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.	**CCIIO webpage:** http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html **Regulations and Guidance:** 45 C.F.R. § 147.200 https://www.ecfr.gov/cgi-bin/text-idx?SID=0697f248e9f8d2c5d3f728147c0f29c1&mc=true&node=se45.1.147_1200&rgn=div8 **Fact Sheets and FAQs:** https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html#Summary of Benefits and Coverage and Uniform Glossary https://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#Summary of Benefits and Coverage and Uniform Glossary
PHS Act § 2718 (42 U.S.C. § 300gg-18)	**Medical loss ratio (MLR)** Health insurance issuers are required to submit data on the proportion of premium revenues spent on clinical services and quality improvement.	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html

Federal Law Citation	Summary of the Provision	Links to Regulations/Guidance/FAQs/Resources
	Individual market issuers are required to spend at least 80% of premium dollars on medical care. Issuers are required to issue rebates to enrollees if their MLR does not meet minimum standards.	**Regulations and Guidance:** 45 C.F.R. Part 158 https://www.ecfr.gov/cgi-bin/text-idx?SID=0697f248e9f8d2c5d3f728147c0f29c1&mc=true&node=pt45.1.158&rgn=div5 **Forms and Resources:** https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Medical%20Loss%20Ratio
PHS § 2719 (42 U.S.C. § 300gg-19)	**Claims and appeals** The issuer must provide a written or electronic notification of a plan's benefit determination. Content of notification must include: • Enough information to identify the claim involved; • Reason(s); • Reference to specific plan provision(s); and • A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the corresponding code and its meaning. Issuer must provide a description of available claims procedures, internal appeals and external review processes, including information regarding how to initiate an appeal as part of the Summary Plan Description (or policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to enrollees). The issuer must also describe the exceptions available to exhausting the internal review and appeals process ("deemed exhaustion") such as: • Issuer waives internal appeal;	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html **Regulations and Guidance:** 45 C.F.R. § 147.136 https://www.ecfr.gov/cgi-bin/text-idx?SID=6806aec6df232ceb8a5690bc0e495c8e&mc=true&node=se45.1.147_1136&rgn=div8 **Fact Sheets and FAQs:** https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html#External Appeals

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	• Urgent care situations where simultaneous expedited internal and external review may occur; or • Failure to comply with all requirements of internal appeals process except in cases where the violation was: o De minimis; o Non-prejudicial; o Attributable to good cause/matters beyond issuer's control; In context of ongoing good-faith exchange of information; and o Not reflective of a pattern or practice of non-compliance.	
PHS § 2719A (42 U.S.C. § 300gg-19a)	**Patient Protections** Issuers may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. See regulation. If a plan requires or provides for the designation of a participating primary care provider for a child, the enrollee shall be permitted to designate a physician who specializes in pediatrics (allopathic or osteopathic) as a child's primary care provider, if such provider participates in the network of the plan or issuer and is available to accept the child. If emergency services benefits in the emergency department of a hospital are covered or provided for by the issuer, then emergency services shall be covered:	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Patients-Bill-of-Rights.html **Regulations and Guidance:** 45 C.F.R. § 147.138 https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=d07c94c1c8de75bba4d1fdde9814fbc9&mc=true&n=pt45.1.147&r=PART&ty=HTML#se45.1.147_1138 **Fact Sheets and FAQs:** https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Patient's Bill of Rights

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	• Without the need for a prior authorization determination; • Without regard to whether the health care provider furnishing such services is a participating provider with respect to such services; and • If such services are provided by an out of network (OON) provider, without imposing administrative requirements or coverage limitations that are more restrictive than or cost sharing requirements that exceed those that would apply if such services were provided in-network.	
PHS Act § 2726 (42 U.S.C. § 300gg-26)	**Mental Health / Substance Use Parity** In general, for plans that provide both medical and surgical benefits and mental health or substance use disorder benefits (MH/SUD), requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on MH/SUD benefits not be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.	**CCIIO website:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html **Regulations and Guidance:** 45 C.F.R. § 147.160 https://www.ecfr.gov/cgi-bin/text-idx?SID=f5f9dce3c0ddd45ac24f657d7575130b&mc=true&node=se45.1.147_1160&rgn=div8 **Fact Sheets and FAQs:** https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/MHAPEAChecklistWarningSigns.pdf https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html#Regulation https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance_Assistance_Materials_Index_10-25-16_4-40pm.pdf

Federal Law Citation	Summary of the Provision	Links to Regulations/Guidance/FAQs/Resources
PHS Act § 2725 (42 U.S.C. § 300gg-25)	**Newborns' and Mothers' Health Protection Act (NMPHA)** 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.	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html **Regulations and Guidance:** 45 C.F.R. § 146.130 https://www.ecfr.gov/cgi-bin/text-idx?SID=500c16425e656caa7ff14f747f84520f&mc=true&node=se45.1.146_1130&rgn=div8 45 C.F.R. § 148.170 https://www.ecfr.gov/cgi-bin/text-idx?SID=500c16425e656caa7ff14f747f84520f&mc=true&node=se45.1.148_1170&rgn=div8

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PHS Act § 2727 (42 U.S.C. § 300gg-27)	**Women's Health and Cancer Rights Act (WHCRA)** An issuer 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.	**CCIIO webpage:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/WHCRA.html
PHS Act § 2753 (42 U.S.C. § 300gg-53)	**Genetic Non-discrimination** Issuers may not: • establish rules for eligibility of an individual based on genetic information; • adjust premium or contribution amounts based on genetic information; • request or require an individual or family member to undergo a genetic test; or • request, require or purchase genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.	**HHS webpage:** https://www.hhs.gov/hipaa/for-professionals/special-topics/genetic-information/index.html **Regulations and Guidance:** 45 C.F.R. § 148.180 https://www.ecfr.gov/cgi-bin/text-idx?SID=7f71549677e40a1254ceacb1d2915850&mc=true&node=se45.1.148_1180&rgn=div8