Federal Mandates

Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co insurance. ***(****PHSA §2713; 75 Fed Reg 41726; 45 CFR §147.130; CCIIO ACA Implementation FAQs - Set 18)*

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC);
- Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and
- Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.

Coverage for emergency services required. *(PHSA §2719A; 75 Fed Reg 37188; 45 CFR §147.138*)

- Cannot require prior authorization;
- Cannot be limited to only services and care at participating providers;
- Must be covered at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider); and
- Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate.
- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity that a person would reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn child.
- "Emergency medical services" means a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department to evaluate the condition; and within the capabilities of the staff/facilities available at the hospital, examination/ treatment required to stabilize the patient.
- "Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Parity in mental health and substance use disorder benefits as required under the Mental Health Parity and Addiction Equity Act (MHPAEA). ***(****PHSA §2726; 45 CFR §146.136)*

Coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act). *(PHSA §2727)*

If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient.

- Coverage must include:
  - Reconstruction of the breast on which the mastectomy was performed (all stages);
  - Surgery and reconstruction of the other breast to produce symmetrical appearance;
  - Prostheses; and
  - Treatment of physical complications at all stages of mastectomy.
- This benefit can be subject to annual deductibles and coinsurance provisions if consistent with those established for
- other medical/surgical benefits under the coverage.
- The issuer is prohibited from denying a patient eligibility to enroll or renew coverage solely to avoid these requirements; penalizing or offering incentives to an attending provider to induce the provider to furnish care inconsistent with these requirements.

- Notice about the availability of mastectomy-related benefits must be given at issue and annually.

Coverage for individuals participating in approved clinical trials. *(PHSA §2709)*

- Issuer must cover "routine patient costs" – items and services consistent with benefits for typically covered services.
- If an in-network provider is participating in a clinical trial, the issuer may require participation in the trial through the participating provider if the provider will accept the individual as a participant.
- An individual may participate in an approved clinical trial conducted outside the state in which the individual resides.
- "Qualified individual" – eligible to participate according to trial protocol and referring health care professional/ medical information establishing appropriateness.
- "Approved clinical trial" means a phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.