

**PROVISIONS IN SUBTITLES A AND C OF TITLE I OF THE AFFORDABLE CARE ACT
THAT *DO NOT APPLY* TO GRANDFATHERED PLANS FOR SO LONG AS THEY
RETAIN GRANDFATHERED STATUS**

PHS Act Section	Description	Effective Date
§2701 (Added by ACA §1201, a Subtitle C” provision).	<i>Issuers in the individual and small group markets must determine premiums for using adjusted community rating rules. Premiums may vary based only on these risk factors: self-only or family enrollment; rating area, as specified by the state; age (by no more than a 3:1 ratio across age rating bands established by the Secretary of HHS, in consultation with the NAIC); and tobacco use (by no more than 1.5:1 ratio).</i>	Plan years beginning on or after January 1, 2014. This provision also does not apply to large group insurance market coverage in States that do not allow this coverage to be offered through the State exchanges.
§2702 (Added by ACA §1201, a “Subtitle C” provision).	<i>Individual and group health insurance issuers must offer coverage on a guaranteed issue basis. Health insurance issuers in both the individual and group markets must accept every employer and individual in the State that applies for coverage, but are permitted to limit enrollment to annual open and special enrollment periods for those with qualifying lifetime events</i>	Plan years beginning on or after January 1, 2014
§2703 (Added by ACA §1201, a “Subtitle C” provision).	<i>Individual and group health insurance issuers must offer coverage on a guaranteed renewal basis, regardless of health status, utilization of health services, or any other related factor. Coverage can only be cancelled under specific, enumerated circumstances.</i>	Plan years beginning on or after January 1, 2014
§2706 (Added by ACA §1201; a “Subtitle C” provision).	<i>Nondiscrimination requirements on group health plans and issuers in the individual and group markets with respect to the plans’ and issuers’ choice of health care providers that may serve as participating health care providers.</i>	Plan years beginning on or after January 1, 2014

<p>§2707 (Added by ACA §1201; a “Subtitle C” provision).</p>	<p><i>Issuers offering coverage in the individual or small group market must include the “essential health benefits package” (ACA §1302) necessary for a plan to constitute a “qualified health plan” and participate in the health exchanges. Group health plans must satisfy the limits on annual cost-sharing that accompany the “essential benefits package (ACA §1302(c)(1) and (2) -- HSA annual cost-sharing limit; \$2,000/\$4,000 single/other annual deductible limit).</i></p>	<p>Plan years beginning on or after January 1, 2014</p>
<p>§2709 (Added by ACA §1201; a “Subtitle C” provision”).</p>	<p><i>Plans and issuers may not deny participation in, and must cover routine patient costs of, individuals with respect to participation in approved clinical trials involving cancer or other life-threatening conditions.</i></p>	<p>Plan years beginning on or after January 1, 2014</p>
<p>§2713 (Added by ACA §1001; a “Subtitle A” provision).</p>	<p><i>Coverage of Preventive Health Services.</i> Group health plans and health insurance issuers offering group or individual health insurance coverage must cover certain preventive services, immunizations, and screenings, without any cost sharing.</p>	<p>Plan years beginning on or after September 23, 2010</p>
<p>§2715A (Added by ACA §1001; a “Subtitle A” provision).</p>	<p><i>Provision of additional information.</i> Group health plans and health insurance issuers offering group or individual health insurance coverage must (i) disclose to the Federal government and the State insurance commissioner certain enrollee information such as claims payment policies and practices and enrollee rights, and (ii) provide information to enrollees on the amount of cost-sharing for a specific item or service.</p>	<p>Plan years beginning on or after September 23, 2010</p>

<p>§2716 (Added by ACA §1001; a “Subtitle A” provision).</p>	<p><i>Prohibition on discrimination in favor of highly compensated individuals.</i> Plans must comply with the nondiscrimination rules in IRC §105(h)(2) -- which, prior to ACA, only applied to self-insured plans -- that prohibit discrimination in favor of highly compensated individuals as to eligibility to participate or as to benefits</p>	<p>Plan years beginning on or after September 23, 2010</p>
<p>§2717 (Added by ACA §1001; a “Subtitle A” provision).</p>	<p><i>Secretary of HHS must develop reporting requirements for use by group health plans and health insurance issuers in the group and individual markets to report annually on use of provider reimbursement structures and initiatives to improve health outcomes, reduce errors, and implement health and wellness activities.</i></p>	<p>Plan years beginning on or after September 23, 2010</p>
<p>§2719 (Added by ACA §1001; a “Subtitle A” provision).</p>	<p><i>Appeals process.</i> Group health plans and health insurance issuers offering group or individual health insurance coverage must provide an effective internal appeals process of coverage determinations and claims and comply with any applicable State external review process. If the State has not established an external review process that meets minimum standards or the plan is self-insured, the plan or issuer must implement an external review process that meets standards established by the Federal government.</p>	<p>Plan years beginning on or after September 23, 2010</p>

<p>§2719A (Added by ACA §1001; a “Subtitle A” provision).</p>	<p><i>Choice of health care professional; access to emergency services at in-network cost sharing levels.</i> ACA §1001; §2719A PHSA. Plans/insurers may not limit types of providers that may serve as primary care providers; plans/insurers that cover emergency services may not require prior authorization and must afford in- and out-of-network providers with the same coverage limits and cost-sharing; prohibits requiring referrals for OB/Gyn services.</p>	<p>Plan years beginning on or after September 23, 2010</p>
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