

ACA Compliant Form Filing Guidance

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OPRAS - Ohio Department of Insurance

ACA Compliant Form Filing Guidance

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I Forward

Beginning in 2014, most major provisions of the Affordable Care Act (ACA) will take effect. This will necessarily require a significant amount of form and rate filings by health plan issuers. In order to continue a level playing field, provide an efficient and effective review of plans and products, and to meet deadlines imposed by federal law, the Ohio Department of Insurance (Department) has created this training document. This document provides filing guidance for health plan issuers as they work to comply with both state and federal law.

Ohio Bulletin 2009-11 mandates the use of SERFF for all health plan issuers filing forms and rates. In accordance with that bulletin, this filing guidance involves the use of SERFF for form and rate filings. Specifically, this guidance provides health plan issuers with “how to use” information, significant guidance and checklists that vary depending on market type. These resources will be available on SERFF, making it easily accessible during a health plan issuer’s submission process. Additionally, Department staff from the Office of Product Regulation and Actuarial Services will be available to answer questions pertaining to this guidance.

ODI strongly urges all health plan issuers to consult this training packet throughout the submission process. Failure to follow this guidance could result in delay or disapproval during the intake process. Regardless of changes mandated by federal law, Department staff are required to comply with state law timelines regarding form and rate reviews. The Ohio Revised Code provides for limited deemer periods in which issuer form and rate submissions must be reviewed. Health issuers operating under Title 39 of the Revised Code have a 30 day deemer period. Health issuers operating under Title 17 of the Revised Code have a 60 day deemer period. Filings with excessive objections will either need to be withdrawn by health plan issuers or will be disapproved.

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II Authority

This guidance has been developed in conjunction with the regulatory authority provided to the Ohio Department of Insurance by the Ohio Revised Code. Excerpts of the specific provisions that provide this authority are shown below.

- Accident and Sickness coverage, Title 39 of the Ohio Revised Code

Ohio Revised Code Section 3923.02 Policy forms

...No such policy, certificate, i(e)ndorsement, rider or application shall be delivered, issued for delivery, or used until the expiration of **thirty days** after the form of such policy, certificate, i(e)ndorsement, rider or application has been filed with the superintendent, unless he has previously given the insurer his written approval thereto. If the superintendent finds that any such form of policy, certificate, indorsement, rider, or application which has been filed with him by an insurer contains any provision which is contrary to the law of this state, or contains inconsistent provisions, or contains any question, provision, title, heading, backing, or other indication of its contents, which is ambiguous, misleading, or deceptive, or likely to mislead or deceive the policyholder, certificate holder or applicant, he shall give written notice of his finding to the insurer which has filed such form, and thereafter no insurer which has filed such form shall deliver, issue for delivery, or use such form in this state.

- Health Insuring Corporation coverage, Title 17 of the Ohio Revised Code

Ohio Revised Code Section 1751.11 (C), (D) (1) Evidence of coverage

(C) No evidence of coverage, or amendment to the evidence of coverage, shall be delivered, issued for delivery, renewed, or used, until the form of the evidence of coverage or amendment has been filed by the health insuring corporation with the superintendent of insurance. If the superintendent does not disapprove the evidence of coverage or amendment within **sixty days** after it is filed it shall be deemed approved...

(D)(1) No evidence of coverage or amendment shall be delivered, issued for delivery, renewed, or used ...If it contains provisions or statements that are inequitable, untrue, misleading, or deceptive...

Ohio Revised Code Section 1751.31 (A) Solicitation

(A) Any changes in a health insuring corporation's solicitation document shall be filed with the superintendent of insurance. The superintendent, within **sixty days** of filing, may disapprove any solicitation document or amendment to it on any of the grounds stated in this section. Such disapproval shall be effected by written notice to the health insuring corporation. The notice shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

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III Definitions

The following terms and definitions are applicable specifically to the context of this guidance.

Standard Benchmark Plan	A complete policy/certificate that provides, at a minimum, all benefits and services necessary for compliance with the Ohio Essential Health Benefits (EHB) Benchmark Plan requirements and otherwise complies with all applicable requirements of Ohio and federal law. This form can be used as the basis for Standard Plan Variations that include distinct actuarially equivalent EHB substitutions and/or additional coverage.
Standard Plan Variation	A complete policy/certificate that is a unique variation of a Standard Benchmark Plan by the inclusion of distinct actuarially equivalent EHB substitutions and/or higher benefit levels (i.e., higher quantitative limits or less restrictive exclusions than the Standard Benchmark Plan), and/or coverage for additional treatments or services. Each unique Standard Plan Variation must have its own form number.
Standard Plan Rider	A separate form that can only be used as follows: 1) in combination with a Standard Benchmark Plan , to construct a unique plan variation with increased benefit levels (i.e., higher quantitative limits or less restrictive exclusions than the Standard Benchmark Plan), and/or coverage for additional treatments or services; or, 2) in combination with a Standard Plan Variation , to provide additional “stand alone” types of coverage (e.g., dental coverage). A Standard Plan Rider cannot be used to reduce coverage provided in a Standard Benchmark Plan . Each Standard Plan Rider must have its own form number.
Amendment or Endorsement	A separate form that can be used to make Permitted Revisions to a Standard Benchmark Plan or a Standard Plan Variation . An Amendment or Endorsement cannot be used to reduce coverage provided in a Standard Benchmark Plan . Each Amendment or Endorsement must have its own form number.

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<i>Permitted Revisions</i>	As applicable for future revisions to 2014 ACA compliant forms: 1) Administrative revisions necessary to contract language or content that do not change benefit levels or treatments and services covered under a plan (e.g., a change to contact information or name due to an assumption); or 2) For plans that will be offered <u>only</u> outside of the federal health insurance exchange, changes to benefit levels or treatments and services that will be effective only for newly issued plans or at renewal; or 3) For plans approved to be offered on the federal health insurance exchange, changes to benefit levels or covered treatments and services that will be effective for plans issued on or after January 1 of the next calendar year benefit period.
<i>Permitted Variable Content</i>	Variable content is limited to cost sharing options and alternative language or content that does not determine the treatments or services covered, or the benefit levels (quantitative limits and/or exclusions) applicable to treatments or services covered by a plan. To support identification of covered benefits and services at a plan level, optional variations in treatments or services covered and/or applicable benefit levels must be offered as a <i>Standard Plan Variation</i> or a <i>Standard Plan Rider</i> . All variable content must be clearly identified and indexed to a Statement of Variability as described later in this guidance.

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IV General Filing Guidelines

These guidelines apply to only ACA compliant **Individual, Non-Employer Group, and Small Employer Group**, non-grandfathered health products filed with the Ohio Department of Insurance and should be used in conjunction with related sections of the Ohio Revised Code and the Ohio Administrative Code.

1. **SERFF Coding Instructions** - in accordance with Ohio Bulletin 2009-11, all product filings must be submitted through SERFF (the System for Electronic Rate and Form Filing). Please contact the SERFF Marketing Team at serffmktg@naic.org for more information about the system. Specific instructions regarding the SERFF filing format are shown below:
 - a. **Type of Insurance (TOI)** – All products that must comply with ACA must use the appropriate TOIs and sub-TOIs as defined in the “TOI and Sub-TOI Coding Instructions” table. The table is attached to this guidance as Appendix A. Please note small and large group filings can no longer be combined in one filing. The “Any Size Group” sub-TOI is restricted to non-employer group plans only.
 - b. **Filing Type** – To enable a quick turnaround of filings, it is strongly recommended that the “Advertising/Solicitation” filing type be used for HIC advertising only filings and the “Form” filing type be used for all other required form filings. The “Form/Rate” filing type is NOT recommended because both the form and rate portions of the filing will need to be completed prior to approval of the filing.
 - c. **PPACA Indicator** – All products that must comply with ACA will include the PPACA option. Please indicate whether the product will be available to Grandfathered plans or Non-Grandfathered plans. To ensure appropriate compliance requirements, Grandfathered and Non-Grandfathered plans can no longer be combined in one filing. The “Not PPACA Related” option may ONLY be utilized when the filing contains only applications, application amendments, a name change or an assumption. ACA reforms applicable to grandfathered and non-grandfathered plans are detailed in the attached appendices. The “Individual Market Reforms” table is attached as Appendix B; the “Group Market Reforms” table is attached as Appendix C.
 - d. **Include Exchange Intentions Indicator** – Please select “YES” if any portion of the filing is intended for sale through the federal health insurance exchange. A text box will be provided to allow for specific details on the particular forms.

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- e. **Market Type** – Select the type of market where the product will be sold. Additional selection criteria will appear to detail the market size and individual or group market type. Please reference the “SERFF Market Type Options” table attached as Appendix D. Please note non-employer group plans must select the “Individual” market type.
- 2. Filing Description** - Include pertinent filing information in the Filing Description portion of the General Information tab. This information should at a minimum:
- a. Indicate if this is a new form or a revision to an existing form.
 - b. Indicate if this filing represents a new use of an existing form.
 - c. Indicate if the form will be offered to existing insureds, new applicants or both, and explain with how the form will interact with existing forms.
 - d. When submitting an amendatory form (***Amendment or Endorsement, or a Standard Plan Rider***) detail how the form will be used with the base form. For example, will the base form remain unchanged and the amendatory form be issued with the base form, or will the amendatory form only be used for existing forms and the changes to language be included in a new amended base form, or will the new language be added to the existing base form in all cases.
 - e. When submitting an advertisement/solicitation detail the form being advertised and include the ODI/SERFF tracking number(s) and approval date(s). Advertising and solicitation material can only be submitted with the advertised form or after the advertised form has been approved for use in Ohio.
 - f. Describe how the form will be marketed, e.g. direct sales or agent sales, etc.
 - g. List all forms to be used with the submission, including ODI/SERFF tracking number(s) and approval date(s) or refer to a separate list under the Supporting Documentation tab.
 - h. When submitting future ***Permitted Revisions*** to an approved 2014 ACA compliant form, include the previous version’s ODI/SERFF tracking number(s) and approval date(s).
 - i. Indicate whether the form is a resubmission of a previously disapproved or withdrawn 2014 ACA compliant form and include the ODI/SERFF tracking number(s) and disposition date(s) of the previous submission under the Submission Type section of the General Information tab. Be sure to include responses to all questions and inquiries of the previous submission under the Supporting Documentation tab.

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- j. Indicate the ODI/SERFF tracking number for the approved or pending rate filing(s) applicable to the form submission. **For EHB initial filing submissions, if rates have not already been submitted, an indication of when rates will be filed must be provided.**
- 3. Attachment Format** - All attachments to the Form Schedule and Supporting Document tabs must be provided in a searchable PDF format. For documents that reasonably must be submitted in MS Excel format (e.g., actuarial calculations/data), a PDF format copy must also be provided.
- 4. Form Design**
 - a. Matrix filing types will NOT be accepted for ACA compliant plan filings.
 - b. Every form filed must display a unique form number on the bottom left hand corner of the first page of the form. The form number must be identical to the form number shown on the Form Schedule tab in SERFF.
 - c. The form must comply with all form-related specifications found in the appropriate checklist(s), the Ohio Revised Code and the Ohio Administrative Code.
 - d. The form must meet the qualifications stated in ORC 3902.04 (A) including, but not limited to, printing in no less than ten-point type, one point leaded (unless stated otherwise in the Ohio Revised Code or Ohio Administrative Code).
- 5. Form Organization** - Coverages, limitations, exclusions and other terms and conditions are to be organized in logical, reasonable, understandable, and rational order and set forth in such a way that is clear and unambiguous to the average consumer.
 - a. Format and organization must be consistent throughout the form.
 - b. A table of contents must be included in all policies and certificates.
 - c. Coverages are clearly explained and there is a clear distinction between what is and is not covered.
 - d. All important terms that affect the coverage must be defined. The term must be distinguished, wherever used, as a defined term (e.g. in quotes, bolded, underlined, capitalized, etc.)

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- e. The definition of a term cannot include an exclusion or limitation that alters coverage unless the exclusion or limitation is also clearly described in the applicable coverage or restriction provision(s).
- f. Titles, labels or headings for restrictions (exclusions or limitations, etc.) should reflect the type of restriction contained in the provision or section, i.e. limitations are identified as limitations, NOT exclusions.
- g. Restrictions need to be indicated as such. The format must alert the reader that both coverage and restrictions are present if combined in the same sentence, paragraph or section.
- h. Restrictions need to be in close proximity to the coverage, i.e., immediately following the description of coverage. General Restrictions that apply to the entire form should be located in a separate, clearly identified section.

6. Permitted Variable Content – must be documented as follows:

- a. All variable form content must be bracketed AND indexed for reference to the Statement of Variability (SOV).
- b. The SOV must include a clear description of the conditions for use (i.e., factors that determine when and how the value of a variable may change) AND the specific alternative language, values, range of values, or other content that can be inserted.
- c. The SOV must be submitted as a separate form for approval under the Form Schedule tab in SERFF. Please use the Form Type “OTH”.
- d. The SOV must have its own unique form number in the bottom left hand of the document. This could be as simple as using the form number of the affected form and adding the suffix -SOV.
- e. Only variable content that is approved by ODI can be used in a form. Department approval of variable content is limited to the conditions and alternatives specified in the filed SOV. Future changes in the conditions for use or the alternative values for variable content must be filed and approved by ODI prior to use.

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- 7. Permitted Filing Revisions** (*see definition*) – future revisions to approved 2014 ACA compliant forms must be documented as follows:
- a. The filing must include, under the Supporting Document tab:
 - i. A reference copy of the 2014 ACA compliant base form as it has been approved to date; and
 - ii. A “red-lined” version showing all additions and/or deletions to the previously approved 2014 ACA compliant base form.
 - b. When revising, adding or deleting language in a form, the form must be refiled with a new unique form number.
 - c. The analyst may require a company to file an entirely new version of the base form if there are numerous or significant changes made by an **Amendment or Endorsement**, or a **Standard Plan Rider**.
- 8. Requirements for Filing Standard Plan Riders** - when filing a new optional benefit provision(s) that will be offered in addition to a base form, the following instructions apply:
- a. All such additions are to be filed as a **Standard Plan Rider** form describing the particular additional coverage.
 - b. More than one new optional provision may be filed at a time, but each must be on separate forms with separate identifiers unless the intent is to always sell them together.
 - c. Each separate **Standard Plan Rider** must contain a unique form number at the bottom left-hand corner of the first page.
 - d. A **Standard Plan Rider** to be offered with an in-force base form cannot reduce benefits, delete benefits or provide less favorable terms except when effective at renewal.

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V Initial 2014 Ohio Essential Health Benefits (EHB) Benchmark Plan Submission Requirements

The following requirements apply to all 2014 EHB Benchmark Plans, whether the plan will be offered on the federal health insurance exchange or in the outside market:

1. To expedite the review process, a **Standard Benchmark Plan** and one or more **Standard Plan Variations** and/or **Standard Plan Riders** (see Definitions) for the same market type (Individual, Non-Employer Group, or Small Group) may be included in the same filing.
2. Provide a “red-lined” comparison between each **Standard Plan Variation** and the **Standard Benchmark Plan**, along with a certification that the “red-lined” comparison is accurate and shows all changes made to the **Standard Benchmark Plan**.
3. All EHB Benchmark plans must be filed as complete policies, certificates and riders, as applicable (no matrix filings).
4. Initial 2014 EHB Benchmark plan submissions cannot be filed as revisions, amendments, or endorsements to previously approved forms (*i.e., those forms filed for use prior to January 1, 2014*).
5. Each **Standard Benchmark Plan** and **Standard Plan Variation** must have its own unique form number.
6. To assist in form/plan identification, the form number should appear on the bottom left hand corner of each page.
7. EHB Benchmark plan submissions that include actuarial equivalent substitutions for EHB benefit levels or covered treatments and services within one or more EHB categories, must include, on the Supporting Document tab, an Actuarial Certification and Memorandum demonstrating the substitutions are actuarially equivalent and non-discriminatory. (See Ohio Essential Health Benefits (EHB) Benchmark Plan Checklist.)

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VI Form Filing Guidance and Checklists

These filing assistance documents are attached to the Supporting Documentation tab and serve as SERFF submission requirements. The specific document(s) attached to a particular filing are determined by the Filing Type, the TOI and the sub-TOI selected. A filing submitted under an incorrect Filing Type, TOI or sub-TOI will be REJECTED. Some additional filing assistance documents are attached to all filings regardless of Filing Type or TOI. There are two main categories of filing assistance documents, Form Review Requirements and Compliance Confirmation. Each category includes a guidance worksheet and a filing checklist. A description of each document and its use are shown below.

1. Form Review Requirements

- a. Guidance - This guidance was created to provide the complete list and text of Ohio Revised Code and Ohio Administrative Code sections that specify requirements that must be included in a particular form. Additionally, the Ohio Essential Health Benefits (EHB) Benchmark Plan guidance details the EHB benefits package selected by the State of Ohio and the Federal Requirements guidance provides a complete list of federal law that impacts the form for all market types. These guidance materials are reference documents and include working links to the specific code references.
- b. Checklist - A checklist, which is an abbreviated version of the guidance, must be completed for each form. The code references include working links and the level of detail is significantly reduced as code text is not included here. To complete, begin by selecting the appropriate TOI and sub-TOI, and indicate the form name and form number to be reviewed. Indicate whether the Review Requirement applies by responding in the "Included" column. Provide the location of the Review Requirement by noting the page number and if applicable, the document where it can be found. A comment section has been provided to include any additional detail on a particular requirement or the reason a requirement was bypassed.

2. Compliance Confirmation

- a. Guidance - This guidance provides a complete list and text of the additional Ohio Revised Code and Ohio Administrative Code sections that should be considered when creating the form. In most cases the references are items that should NOT be included in the form. Some additional references have been included for informational purposes. This guidance is a reference document that includes working links to the specific code references.
- b. Checklist - The checklist must be completed for each form and is an abbreviated version of the guidance. The code references include working links and the level of detail is significantly reduced as code text is not included here. To complete,

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begin by selecting the appropriate TOI and sub-TOI, and indicate the form name and form number to be reviewed. Confirm compliance with the Review Requirement by responding in the “Confirm Compliance” column. A comment section has been provided to include any additional detail on a particular requirement or the reason a requirement was bypassed.

3. Sample Guidance and Checklists

a. Form Review Requirements

- i. Essential Health Benefits [GUIDANCE](#) and [CHECKLIST](#)
- ii. Federal Requirements [CHECKLIST](#)*
- iii. Fraternal Requirements [GUIDANCE](#) and [CHECKLIST](#)
- iv. HIC Application [GUIDANCE](#) and [CHECKLIST](#)
- v. HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)
- vi. Individual HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- vii. Individual Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- viii. Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- ix. Large Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- x. Large Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- xi. Major Medical Application [GUIDANCE](#) and [CHECKLIST](#)
- xii. Non Employer Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- xiii. Non Employer Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- xiv. Small Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- xv. Small Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)

** No guidance document provided.*

b. Compliance Confirmation

- i. Fraternal Requirements [GUIDANCE](#) and [CHECKLIST](#)
- ii. HIC Application [GUIDANCE](#) and [CHECKLIST](#)
- iii. HIC Solicitation [GUIDANCE](#) and [CHECKLIST](#)
- iv. Individual HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- v. Individual Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- vi. Internal Appeals and External Review [GUIDANCE](#) and [CHECKLIST](#)
- vii. Large Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)

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- viii. Large Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- ix. Major Medical Application [GUIDANCE](#) and [CHECKLIST](#)
- x. Non Employer Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- xi. Non Employer Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)
- xii. Small Group HIC Medical [GUIDANCE](#) and [CHECKLIST](#)
- xiii. Small Group Major Medical [GUIDANCE](#) and [CHECKLIST](#)

TOI and Sub-TOI Coding Instructions: For ACA Compliant Filings

The table below lists TOIs and Sub-TOIs that must be utilized when filing ACA compliant filings. This coding structure will be used to display applicable Filing Requirements in SERFF, and will also help us to collect data necessary for a variety of tracking and reporting activities, including requirements relative to recent federal health care reform regulations.

Effective immediately, please implement this coding structure for all ACA compliant form or rate filing submissions.

TOI	SUB-TOI	DESCRIPTION AND USE
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Ohio Title 39 Indemnity Issuers

Ohio Title 39 Indemnity Issuers		
H16G <u>Group</u> Health - Major Medical ANY SIZE GROUP	H16G.001A	Any Size Group – PPO: <u>ONLY</u> for Non-Employer Group* plans
	H16G.001B	Any Size Group – POS: <u>ONLY</u> for Non-Employer Group* plans
	H16G.001C	Any Size Group – Other: <u>ONLY</u> for Non-Employer Group* plans
H16G <u>Group</u> Health – Major Medical LARGE GROUP ONLY	H16G.002A	Large Group Only – PPO
	H16G.002B	Large Group Only – POS
	H16G.002C	Large Group Only – Other
H16G <u>Group</u> Health – Major Medical SMALL GROUP ONLY	H16G.003A	Small Group Only – PPO
	H16G.003D	Small Group Only – POS
	H16G.003G	Small Group Only – Other
H16I <u>Individual</u> Health – Major Medical INDIVIDUAL ONLY**	H16I.005A	Individual – PPO
	H16I.005B	Individual – POS
	H16I.005C	Individual – Other

Ohio Health Insuring Corporations (HMOs)

Ohio Health Insuring Corporations (HMOs)		
HOrg02G <u>Group</u>	HOrg02G.002C	HMO Any Size Group – Restricted Network plan <u>ONLY</u> for Non-Employer Group plans
	HOrg02G.003C	HMO Large Group – Restricted Network plan
	HOrg02G.004F	HMO Small Group – Restricted Network plan
HOrg02I <u>Individual</u>	HOrg02I.005C	HMO Individual – Other <u>ONLY</u> for Conversion or Ohio Basic and Standard Restricted Network plans
	HOrg02I.005D	HMO Individual – Restricted Network plan

*Non-Employer Group plans are those sold to Individuals through associations, trusts or other entities

**Only for use with true Individual plans not sold through associations, trusts or other entities

ACA Immediate Through 2014 Market Reforms

Individual Market Reforms

Individual Market = Individual plans and plans marketed to Individuals through associations, trusts or other entities (Non-Employer).

Grandfathered Plans

PHS Section	Provision	Effective 2010	Effective 2014
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2714	Dependent to Age 26	✓	

Non-Grandfathered Plans

PHS Section	Provision	Effective 2010	Effective 2014
2704	No Pre-Existing Under Age 19	✓	
2711	Annual Dollar Limit	✓	
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2713	Preventive Services	✓	
2714	Dependent to Age 26	✓	
2719	Appeals Process	✓	
2719 A	Emergency Services	✓	
2719 A	Access to Pediatricians and OB/GYNs	✓	
2704	No Pre-Existing For All		✓
2705	Prohibit Discrimination Based on Health Status		✓
2706	No Discrimination Against Providers In Scope		✓
2707	Provide Essential Health Benefits Package		✓
2709	Coverage For Approved Clinical Trials		✓

ACA Immediate Through 2014 Market Reforms

Group Market Reforms

Group Market = Small and Large Group Employer plans

Grandfathered Plans

PHS §	Provision	Effective 2010	Effective 2014
2704	No Pre-Existing Under Age 19	✓	
2711	Annual Dollar Limit	✓	
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2714	Dependent to Age 26	✓	
2704	No Pre-Existing For All		✓
2708	Prohibit Excessive Waiting Periods		✓

Non-Grandfathered Plans

PHS §	Provision	Effective 2010	Effective 2014
2704	No Pre-Existing Under Age 19	✓	
2711	Annual Dollar Limit	✓	
2711	Lifetime Dollar Limit	✓	
2712	Prohibit Rescissions	✓	
2713	Preventive Services	✓	
2714	Dependent to Age 26	✓	
2719	Appeals Process	✓	
2719 A	Emergency Services	✓	
2719 A	Access to Pediatricians and OB/GYNs	✓	
2704	No Pre-Existing For All		✓
2705	Prohibit Discrimination Based on Health Status		✓
2706	No Discrimination Against Providers In Scope		✓
2707	Provide Essential Health Benefits Package		✓
2708	Prohibit Excessive Waiting Periods		✓
2709	Coverage for Approved Clinical Trials		✓

SERFF Market Type Options

Market Type:		
Individual		Individual Market Type Options:
		Individual
		Non Employer Group – Individual
Franchise		
Group	Group Market Size Options:	
	Small	
	Large	
	Small and Large	
		Group Market Type Options:
		Employer
		Association
		Blanket
		Discretionary
		Trust
		Other