Standards for Health Insurance Plans, by Plan Type

	Individual Marketplace plans and new non-Marketplace plans	Small-group Marketplace plans	Grand-fathered plans	Non-grandfathered employer-sponsored plans	Self-insured employer-sponsored plans
No lifetime or annual limits: Plans are now prohibited from limiting the lifetime dollar value of benefits. Annual limits are currently restricted to between $1.25 million and $2 million and are banned completely beginning Jan. 1, 2014. Some plans have been granted waivers to the annual limit requirements through 2013.	✓	✓	✓ (ban doesn't apply to grand-fathered individual plans)	✓	✓
Dependents under age 26: Plans must allow adult children under age 26 to enroll in a parent's plan effective now. Through 2013, a grandfathered employer sponsored plan is permitted to limit coverage of adult children to those that are ineligible for another employer-sponsored plan.	✓	✓	✓	✓	✓
Plan administrative costs: Plans must now provide rebates to consumers if the percentage of premiums spent on medical services and quality improvement activities falls below 85 percent for large group plans or 80 percent for small group and individual plans (or higher standard set by state, if applicable).	✓	✓	✓	✓	
Preventive care: Plans must now offer first dollar coverage (no cost sharing or deductible) for certain preventive services.	✓	✓		✓	✓
Internal appeals and external review: Plans are required to provide a fair internal appeal and independent external review process for adverse coverage determinations.	✓	✓		✓	✓
Patient protections: Plans are now prohibited from requiring a referral to see an OB-GYN and from requiring prior authorization or higher cost sharing for out-of-network emergency services.	✓	✓		✓	✓
Out-of-pocket maximums: Plans must limit out-of-pocket costs to $6,400 for single coverage and $12,800 for family coverage effective in 2014.	✓	✓		✓ (postponed to 2015)	✓ (postponed to 2015)
Pricing: Medical underwriting is prohibited and rating variation is only allowed based on age (3:1 ratio), tobacco (1.5:1.0), family composition and geography effective in 2014.	✓	✓		Small group only	n/a
Deductibles: Plans must limit deductibles to $2,000 for single coverage and $4,000 for family coverage in 2014. Plans may exceed limit if they cannot reasonably reach the specified actuarial value.		✓		Small group only	n/a
Essential health benefits: Plans must cover preventive and primary care, emergency, hospital, physician, outpatient, maternity and newborn care, pediatric (including dental and vision), medical/surgical care, prescription drugs, lab, and mental health and substance abuse, effective in 2014. States set benchmarks within each category. Except for catastrophic plans, cost sharing must be limited to provide a minimum actuarial value of 60% and designed to offer one of four "metal" levels of coverage tied to specific actuarial values.	✓	✓		Small group only	

Adapted from: UC Berkeley Center for Labor Research and Education, "Affordable Care Act: Summary of Provisions Affecting Employer-Sponsored Insurance" (April 2013) (see http://laborcenter.berkeley.edu/healthpolicy/ppaca12.pdf) and other sources including ACA text, guidance and implementing regulations. Table last updated on Sept. 3, 2013.