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No Surprises in the Final Rules Issued Under ACA

Final rules have been issued regarding grandfathered plans, pre-existing conditions, rescissions, dollar limits, claims and appeals procedures, and patient protections. These rules, effective on the first day of the plan year beginning on and after January 1, 2017, finalize the current interim final rules and amendments without substantial change, incorporating important clarifications issued in prior guidance. The final rules can be found here. Here is a sampling of the requirements addressed in the regulations:

- To maintain grandfather status, the plan must include a statement that it is believed to be a grandfathered plan, and contact information for questions or complaints, in any summary of benefits provided to participants (the prior model language is retained).
- Self-funded or other group health plans that are not required to cover essential health benefits (EHB) but which cannot impose annual or lifetime dollar limits on EHBs that are covered can choose between the 51 EHB base-benchmark plans selected by a State or the District of Columbia and the FEHBP base benchmark plan. Here is the current list.
- Lifetime and annual dollar limits on EHBs cannot be imposed on in-network or out-of-network benefits.
- Rescissions of coverage are eligible for external review; COBRA coverage can be terminated retroactively for failure to pay the required premiums without violating the prohibition on rescissions.
- If a plan restricts coverage to those living within a service area (as is typically the case with HMOs), such restrictions cannot be used to limit coverage for children under age 26.
- Terms of plan coverage cannot vary based on age (except for children over 26); coverage for grandchildren is not required.
- Plans must provide claimants, free of charge, any new or additional evidence relied on or generated in connection with the claim, and any new or additional rationale for a denial of an internal appeal, and an opportunity to respond to this new or additional information before making a decision. Providing a statement that new or additional evidence is available is insufficient.
- Adverse benefit determinations that involve medical judgments and are subject to external review include a determination of whether a participant is entitled to receive a reasonable alternative standard for a reward to a wellness program and a determination of whether a plan is complying with the non-quantitative treatment limitation provisions under the MHPAEA (relating to mental health parity).
- If a plan requires the designation of a primary care provider, each participant must be permitted to designate his or her own provider (and must be provided notice regarding the requirement and certain rights relating to the requirement).