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# Extension of Enforcement Grace Period for Internal Claims and Appeals under ACA

**March 30, 2011**

On March 18, 2011, the Department of Labor ("DOL") issued Technical Release 2011-01 (the "Release"), which provides a non-enforcement period with respect to various notice, content and timing requirements applicable to group health plans under the Affordable Care Act (the "Act"). Under the Act, group health plans (other than grandfathered plans) must begin complying with new internal claims and appeals and external review procedures starting with plan years beginning on or after September 23, 2010.

In the Release, the DOL announces its intent to modify certain provisions of the new internal claims and appeals requirements that were previously introduced in the form of interim final regulations (see our June 30, 2010 client alert). The DOL issued the Release to extend the enforcement grace period established under Technical Release 2010-02 that was set to expire on July 1, 2011 in order to avoid enforcing standards it intends to modify in the near future.

## NEW INTERNAL CLAIMS AND APPEALS STANDARDS

Under the interim final regulations, seven new standards were imposed on group health plans and insurance carriers in addition to the existing DOL claims procedures. The new standards include:

## EXTENDED ENFORCEMENT GRACE PERIOD

| Standard No. | Description | Effective Plan Years Beginning On or After |
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| 1. | Broader definition of "adverse benefit determination," which now includes a rescission of coverage | 9/23/10 |

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| 2. | Requirement that urgent care claims be decided as soon as possible, but no later than 24 hours after sufficient information is provided (the time period for appeals of urgent care claims is unchanged) | 1/1/12 |
| 3. | Additional criteria to ensure claimants receive a full and fair review | 9/23/10 |
| 4. | New criteria to avoid conflicts of interest by decision makers | 9/23/10 |
| 5. | Requirement that notices be provided in a culturally and linguistically appropriate manner | 1/1/12 |
| 6. | Certain additional content must be included in notices to claimants, which includes: | |
| 6.(a) | Information identifying the claim involved, including the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code, and the corresponding meaning of those codes | 7/1/11, except for diagnosis and treatment codes, which are effective 1/1/12 |
| 6.(b) | The reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the plan’s standard, if any, that was used to deny the claim (for notices of final internal adverse benefit determinations, the description must include a discussion of the decision) | 7/1/11 |

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| 6.(c) | A description of available internal appeals and external review processes, including how to initiate an appeal | 7/1/11 |
| 6.(d) | Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Act to assist individuals with the internal claims and appeals and external review processes | 7/1/11 |
| 7. | Requirements that plans strictly adhere to their claims procedures, or claimants will be deemed to have exhausted their internal remedies and may initiate any available external review process or remedies available under ERISA or state law | 1/1/12 |

As illustrated in the table above, the Release extends the original enforcement grace period (under Technical Release 2010-02) with respect to standards 2, 5 and 7 above, until plan years beginning on or after January 1, 2012. In addition, while Technical Release 2010-02 requires plans to be working in good faith to implement the new standards for the grace period to apply, under the Release, no such requirement will apply during either the extended or the original enforcement grace period.

With respect to standard 6 above (requiring broader content and specificity in notices), the Release extends the enforcement grace period only with respect to 6(a). In other words, the same non-enforcement policy applicable to standards 2, 5, and 7 above will apply with respect to automatic disclosure of diagnosis and treatment information pursuant to standard 6(a), until the first day of the first plan year beginning on or after January 1, 2012.

The enforcement grace period will be extended with respect to the other disclosure requirements of standard 6 from July 1, 2011 until the first day of the first plan year beginning on or after July 1, 2011 (which is January 1, 2012 for calendar year plans).

Therefore, enforcement with respect to the following provisions of standard 6 will take effect on a rolling plan year basis, starting on the first day of the first plan year beginning on or after July 1, 2011: (a) the disclosure of information sufficient to identify a claim (other than the diagnosis and treatment information); (b) the reasons for an adverse benefit determination; (c) the description of available internal appeals and external review processes; and (d) for plans and issuers in states in which an office of health consumer assistance program or ombudsman is operational, the disclosure of the availability of, and contact information for, such program.

**ASSISTANCE WITH DISCLOSURES STANDARD**

To assist plans and issuers in complying with the requirements of standard 6(d), the Release includes a list of relevant consumer assistance programs and ombudsmen. For plan years beginning prior to July 1, 2011, plans can rely on the list in the Release when developing their notices of adverse benefit determination and final internal adverse benefit determination. For plan years beginning after July 1, 2011, plans should check

- www.dol.gov/ebsa/healthreform, and http://cciio.cms.gov/programs/consumer/capgrants/index.html

prior to the beginning of the plan year to ensure that the notices contain information that is as up-to-date as practicable. Generally, plans are not required to update the information more than once per year.

Model notices are available (see www.dol.gov/ebsa/healthreform), which provide a template for the disclosures that should be made regarding external review (e.g., contact information and timeframes for initiating external review). Plans that use the model notices are considered to meet the relevant content requirements.

The enforcement grace period under the Release applies only to the internal claims and appeals procedures; see our July 30, 2010 and September 24, 2010 client alerts for guidance on the Act's external review requirements. Although the Release did not directly affect the rules governing implementation of the Act's external review requirements, the DOL noted at Footnote 10 of the Release that the Agency is continuing its review of the scope of the Federal external review process (*i.e.*, what types of claims are eligible for external review) and may provide future guidance on that issue.

Please contact your Proskauer attorney or any member of our Health Care Reform Task Force should you have questions regarding any aspect of health care reform.