



Department of Labor Extends Enforcement Grace Period for Certain Claims Appeals Process Changes

The following information, provided by The Department of Insurance, is being sent as a courtesy to keep you informed on the status of the Health Care initiatives taking place in our government.

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (the Departments) have been issuing regulations in several phases to implement the revised Public Health Service Act (PHS Act) sections 2701 through 2719A and related provisions of the Patient Protection and Affordable Care Act (PPACA). Section 2719 of the PHS Act sets forth standards for plans that are not grandfathered health plans regarding internal claims and appeals and external review. Interim final regulations implementing PHS Act Section 2719 was published on **July 23, 2010**.

The DOL Technical Release 2010-02 (T.R. 2010-02) released in **September 2010** provided an enforcement grace period for compliance with certain provisions regarding internal claims and appeals until **July 1, 2011**. Based on comments and feedbacks to this release, the DOL has published Technical Release 2011-01, which modifies and extends the enforcement grace period as noted below.

The Departments intend to issue an amendment, which will make modifications to certain provisions of the **2010** interim final regulations. To avoid enforcing standards that the Departments intend to modify in the near future, DOL Technical Release 2011-01 extends certain provisions of the grace period until an amendment to the 2010 interim final regulations is issued.

This relief is intended to provide employers and administrators with more time to change their group health plan procedures and to modify their computer systems to comply with the claims appeals process changes required under PPACA.

This technical release **specifically** extends the enforcement grace period set forth in T.R. 2010-02 until plan years beginning on or after **January 1, 2012** with regard only to the following claims appeals process changes to the standards listed under PPACA:

- Standard #2: The 24-hour timeframe for making urgent care claims decisions;
- Standard #5: The requirement to provide notices in a culturally and linguistically appropriate manner;
- Standard #6: The expanded content requirement for notices, but **only** with respect to the requirement to disclose diagnosis and treatment codes (and their corresponding meaning) in a notice of adverse benefit determination; and
- Standard #7: The deemed exhaustion of the plan's internal claims and appeals process if a plan fails to adhere to the claims appeals process changes.

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 of the following provisions 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) disclosure of information sufficient to identify a claim (other than diagnosis and treatment information), (b) reasons for an adverse benefit determination, (c) 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. **[Note: Florida does not have a program in place at this time.]**

The Departments have taken several steps to assist plans and issuers in making these required disclosures including the following:

1. A current list of relevant consumer assistance programs and ombudsmen is provided in the Appendix to T.R. 2011-01. Plans and issuers with **July 1** plan years may use this list when developing their notices of adverse benefit determination and final internal adverse benefit determination for plan years beginning on **July 1, 2011**. Periodic updates to this list will be posted to the following websites: www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>. Plans and issuers should check these websites within a reasonable time before the beginning of their plan year to ensure that the notices contain information that is as up-to-date as possible. Plans and issuers are not required to update the information more than once per year.
2. To assist self-insured plans in understanding their responsibilities with respect to implementing external review processes, the Department of Labor issued Technical Release 2010-01 on **August 23, 2010**, and has information on frequently asked questions available at www.dol.gov/ebsa/healthreform.
3. The Departments have issued model notices that provide a template for the disclosure that should be made regarding external review (e.g., contact information and timeframes for initiating external review). Plans and issuers that complete and use these model notices are considered to meet the relevant content requirements.

The **2010** interim final regulations set forth standards for the required external review process, and indicated that HHS will make a determination as to whether the State external review process satisfies applicable requirements. HHS will provide guidance as to when external review will be performed in a Federally operated external review process, instead of by a State process. Insured plans and health insurance issuers should review the Departments' model notices and provide information (e.g., contact information and timeframes for initiating an external review) consistent with the State external review process to the extent that process now applies, unless HHS determines that the Federally operated external review process applies. For States in which the Federally operated external review process applies, HHS has issued technical guidance describing the interim process applicable to insured

model disclosures (including contact information and timeframes for initiating an external review.) In the guidance HHS plans to issue on the applicability of the Federally-operated external review process to insured coverage in additional States and territories, HHS will provide insured plans and issuers with reasonable time to make any changes that are prompted by the new guidance.

As always, we will keep you posted of significant developments as they occur.

If you have any questions, please contact your HARDEN Employee Benefits Account Manager.

Sources:

U.S. Department of Labor; Technical Release 2011-01. <http://www.dol.gov/ebsa/pdf/tr11-01.pdf>