

# Legislative Brief

## Health Care Reform: DOL Provides Grace Period for Internal Claims And Appeals Rules



### EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (PPACA) requires non-grandfathered group health plans to adopt an improved internal claims and appeals process and follow minimum requirements for external review. This requirement is generally effective for plan years beginning on or after **September 23, 2010**.

Interim final regulations implementing the appeals process rules were issued on July 23, 2010. On September 20, 2010, the Department of Labor supplemented the regulations with **Technical Release 2010-02**. This guidance establishes a grace period until **July 1, 2011** for some of the standards contained in the regulations.

During the grace period, the DOL, Internal Revenue Service and Department of Health and Human Services will not take enforcement action against plans that are working in good faith to implement the standards. HHS is also encouraging states to provide a similar grace period for issuers.

Specifically, the grace period applies to the following requirements:

- Expediting the review of urgent care claims (as soon as possible, but not later than 24 hours after receiving the claim);
- Providing notices in a culturally and linguistically appropriate manner;
- Including additional information in notices; and
- Strictly adhering to the appeals process rules.

This Chelko Consulting Group Legislative Brief summarizes the guidance contained in Technical Release 2010-02. Please read below for more detailed information. For a copy of the guidance, see [www.dol.gov/ebsa/newsroom/tr10-02.html](http://www.dol.gov/ebsa/newsroom/tr10-02.html).

### TECHNICAL RELEASE 2010-02

#### Discussion

PPACA generally requires that non-grandfathered group health plans and health insurance issuers have an effective internal claims and appeals process. This process must incorporate the DOL claims procedure regulations and must update those procedures according to standards established by the DOL.

The DOL established additional standards for internal claims and appeals in interim final regulations issued on July 23, 2010. The interim final regulations, unlike the DOL claims procedure regulations, apply to health insurance issuers, in addition to group health plans.

The interim final regulations provide the following additional standards for internal claims and appeals processes:

1. **Rescissions.** Rescissions of coverage must be included in the scope of adverse benefit determinations eligible for internal claims and appeals (whether or not the rescission has an adverse effect on any particular benefit at the time). This scope is broader than the definition of adverse benefit determination in the claims procedure regulations.

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2. **Urgent Care Claims.** The DOL claims procedure regulations require notification in the case of urgent care claims not later than 72 hours after the receipt of the claim. Under the health care reform requirements, a non-grandfathered plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer.
3. **Full and Fair Review.** The new standards clarify the requirements for a “full and fair review.” Under these rules, plans and issuers are clearly required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.
4. **Conflicts of Interest.** The new standards also clarify conflicts of interest related to claims and appeals. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual such as a claims adjudicator or medical expert must not be based upon the likelihood that the individual will support the denial of benefits.
5. **Notices.** Notices must be provided in a culturally and linguistically appropriate manner, as required by the health care reform statute and the interim final regulations.
6. **Content of Notices.** Notices to claimants must provide additional content. Specifically:
  - a. Any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
  - b. The plan or issuer must ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.
  - c. The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
  - d. The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
7. **Strict Compliance.** If a plan or issuer fails to strictly adhere to all the requirements of the interim final regulations, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, regardless of whether the plan or issuer asserts that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or under state law.

Since publication of the interim final regulations, some plans and issuers have stated that they did not anticipate some or all of the additional standards and more time is needed to change plan or policy procedures and to modify computer systems in order to come into compliance.

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### Conclusion

Technical Release 2010-02 sets an enforcement grace period until **July 1, 2011** with respect to some of the additional standards set forth in the interim regulations in order to give plans and issuers more time to implement procedures and make changes to computer systems in order to comply fully.

Specifically, with respect to standards #2 (regarding the timeframe for making urgent care claims decisions), #5 (regarding providing notices in a culturally and linguistically appropriate manner), #6 (requiring broader content and specificity in notices) and #7 (regarding substantial compliance), the Department of Labor and the Internal Revenue Service (IRS) will not take any enforcement action against a group health plan, and HHS will not take any enforcement action, during the grace period, against a self-funded nonfederal governmental health plan, that is working in good faith to implement such additional standards but does not yet have them in place.

Similarly, HHS is encouraging states to provide similar grace periods with respect to issuers and HHS will not cite a state for failing to substantially enforce the requirements in these situations.

Questions concerning the information contained in this technical release may be directed to the Office of Health Plan Standards and Compliance Assistance at 202-693-8335.

*Source: U.S. Department of Labor, Employee Benefits Security Administration*

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