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Extended Grace Period for Claims and Appeals Standards

The government agencies have issued a technical release modifying and extending the previous enforcement grace period for certain new requirements related to internal appeals processes under the health reform law. These new appeals process requirements apply to non-grandfathered plans. See our Conner Strong Update for background on the claims and appeal requirements and other earlier guidance.

The original enforcement grace period issued last fall was due to end on July 1, 2011. The newly released technical release extends, with a few modifications, the original enforcement grace period until plan years beginning on or after January 1, 2012. The new technical release document states that the agencies intend to issue an amendment to the 2010 interim final appeals regulations in the near future, and the relief contained in the new technical release is intended to act as a bridge until the amendment is issued.

Background: The health reform law generally requires that group health plans that are not grandfathered health plans have an effective internal claims and appeals process. Interim final regulations issued in 2010 provided the following new (additional) standards for internal claims and appeals processes:

1. The scope of adverse benefit determinations eligible for internal claims and appeals includes a rescission of coverage.
2. A plan must notify a claimant of a benefit determination with respect to a claim involving urgent care as soon as possible, taking into account the medical emergencies, but not later than 24 hours after the receipt of the claim by the plan or issuer.
3. Plans must provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan 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. 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 must be provided in a culturally and linguistically appropriate manner.
6. Notices to claimants must provide additional content. Specifically:
   - 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.
   - The reason or reasons for an adverse benefit determination or final internal adverse benefit determination must include the denial code and its corresponding meaning, as well as a description of the plan'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.
   - A description of available internal appeals and external review processes, including information regarding how to initiate an appeal must be provided.
   - The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman must be provided.
7. If a plan fails to strictly adhere to all the requirements of the 2010 interim final regulations, the claimant is deemed to have exhausted the plan's internal claims and appeals process, regardless of whether the plan 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.

The original grace period: The original technical release set forth an enforcement grace period until July 1, 2011 with respect to standard #2 above (regarding the timeframe for making urgent care claims decisions), #5 above (regarding providing notices in a culturally and linguistically appropriate manner), #6 above (requiring broader content and specificity in notices), and #7 above (regarding substantial compliance), and stated that, for that period, the DOL and IRS would not take any enforcement action against a group health plan, and HHS would not take any enforcement action 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.

The new extended grace period: The newly released technical release extends, with a few modifications, the enforcement grace period described above until plan years beginning on or after January 1, 2012. Specifically, the enforcement grace period is further extended for non-grandfathered, self-funded plans with respect to #2 above (deciding urgent care appeals within 24 hours), #5 above (providing notices in a culturally and linguistically appropriate manner), and #7 above (regarding substantial compliance). During the grace period, the DOL and IRS will not take any enforcement action against a group health plan, and HHS will not take any enforcement action against a self-funded nonfederal governmental health plan, with respect to these provisions. The original 2010 technical release required plans to be working in good faith to implement such standards for the enforcement grace period to apply, but under the new 2011 technical release, no such requirement will apply for either the extended or the original enforcement grace period.

The enforcement grace period is extended in part only for standard #6 above (requiring broader content and specificity in notices). Specifically, the extended enforcement grace period applies with respect to the requirement to automatically disclose diagnosis codes and treatment codes (and their corresponding meanings). 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 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. The government will not enforce these provisions as long as plans are working in good faith to comply. HHS encourages states to do the same for insured plans.

Additional resources: Plans must update their list of relevant consumer assistance programs and ombudsmen (if applicable) at the beginning of the year. The new technical release includes the current list and the agencies will periodically update this information. The agencies have issued other technical releases and frequently-asked-question (FAQ) guidance to assist self-insured plans in understanding their responsibilities with respect to implementing external review processes. This guidance and model notices that provide a template for the disclosures that should be made regarding external review are available at www.dol.gov/ebsa/healthreform. Questions concerning the information contained in the technical releases may be directed to the DOL Office of Health Plan Standards and Compliance Assistance at 202-693-8335.

Should you have questions about this or any aspect of healthcare reform, contact your Conner Strong account representative toll free at 1-877-861-3220. For a complete list of Legislative Updates issued by Conner Strong, visit our online Resource Center.