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Health Care Reform Act
Extension of Enforcement Grace Period Relating to Certain Internal Claims and Appeals Procedures

The Departments of Labor, Health and Human Services, and Treasury (Departments) will not be enforcing certain internal claims and appeals requirements under the Health Care Reform Act until January 1, 2012.

Background. The Health Care Reform Act requires non-grandfathered group health plans to implement internal claims and appeals processes that incorporate the existing ERISA claims and appeals procedures as well as any additional standards issued by the Departments.

On July 23, 2010, the Departments issued interim final regulations, adding the following standards to the existing ERISA claims and appeal procedures:

(1) A rescission of coverage is treated as an adverse benefit determination that is eligible for internal claims and appeals.

(2) A plan must notify a claimant of a benefit determination for urgent care claims within 24 hours.

(3) A claimant must receive, free of charge, any new or additional evidence or rationale considered or relied upon in connection with the appeal of a denied claim and must be provided a reasonable opportunity to respond to the new evidence or rationale.

(4) Claims and appeals procedures must be designed to ensure independence and impartiality of the decisions makers.

(5) Notifications must be provided in a culturally and linguistically appropriate manner.

(6) Notices of adverse benefit determinations must include additional information. Specifically, the notice must include information sufficient to identify the claim involved, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, a description of the standard used in denying the claim, a description of the internal and external appeals process, and the availability of, and contact information for, any health consumer assistance ombudsman.

(7) If the plan administrator fails to strictly adhere to the internal appeal procedures with respect to a claim, the claimant will be deemed to have exhausted the internal appeal process, even if the failure by the plan administrator was minor.

These requirements generally became effective for plan years beginning on or after September 23, 2010. However, an enforcement grace period was applied to standards 2, 5, 6, and 7 until July 1, 2011. During the enforcement grace period, the Departments will not take any enforcement action against a group health plan for failing to comply with these standards.

Extension of Grace Period. The enforcement grace period has now been extended for standards 2, 5, 7 and part of 6 (specifically, the requirement to disclose diagnose and treatment codes and their required meanings) until plan years beginning on or after January 1, 2012. However, for the remaining standard 6 requirements (specifically, including information sufficient to identify the claim, a description of the standard used in denying the claim, a description of the internal and external appeals process, and the availability of any health consumer assistance ombudsman), the enforcement grace period has only been extended until the first day of the first plan year beginning on or after July 1, 2011. Calendar year plans will effectively have a single effective date (*i.e.,* January 1, 2012), but different effective dates may apply for non-calendar year plans.

Next Steps. The Departments are expected to amend the interim final regulations, which added the standards described above, in the near future. The enforcement grace period is intended to act as a bridge in order to avoid enforcement action for standards that may be modified. Plan sponsors of non-grandfathered self-funded group health plans will need to continue to work with third party administrators in order to take advantage of the enforcement grace periods and implement effective claims and appeals procedures.

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