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Actuaries and Consultants

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SPECIAL BULLETIN

Extension of Non-Enforcement Period Relating to Certain Procedures for Internal Claims and Appeals Under PPACA Until Plan Years Beginning on or After January 1, 2012

The Department of Labor (DOL) issued *Technical Release 2011-01* which generally extends the non-enforcement of certain internal claims and appeals rules under the *Patient Protection and Affordable Care Act (PPACA)* from July 1, 2011 until plan years beginning on or after January 1, 2012, with some limited exceptions which are noted below. *T.R. 2011-01* is available online at the DOL website at: *http://www.dol.gov/ebsa/pdf/tr11-01.pdf* or by *"clicking here."*

Previously, in *Technical Release 2010-02*, the DOL had set forth an enforcement grace period until July 1, 2011 for compliance with certain new provisions with respect to internal claims and appeals. 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 grace period applies to enforcement action against a group health plan that is working in good faith to implement such additional Standards but does not yet have them in place. See *Benefit News Briefs 2010-68* for more information on *T.R. 2010-02*. The seven Standards are listed in both *Technical Releases* or by *"clicking here."*

Technical Release 2011-01 **extends the non-enforcement periods** for **Standards #2** (regarding the timeframe for making urgent care claims decisions), **#5** (regarding providing notices in a culturally and linguistically appropriate manner), and **#7** (regarding substantial compliance) until **plan years beginning on or after January 1, 2012** and does away with the requirement that health plans be working in good faith to implement such Standards for the enforcement grace period to apply. The extension of the non-enforcement period for Standard #6 is a little more complicated. A chart showing the Compliance Dates is available by "*clicking here*."

Standard #6 states:

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6. 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.

Specifically, with respect to the requirement under Standard #6(a) to disclose *diagnosis codes* and *treatment codes* (*and their corresponding meanings*), this *Technical Release 2011-01* extends the enforcement grace period until plan years beginning on or after January 1, 2012.

Accordingly, during this period, the Department of Labor and the IRS will apply the same non-enforcement policy applicable to Standards #2, 5, and 7 (described in the paragraphs above) with respect to automatic disclosure of *diagnosis* and *treatment* information pursuant to Standard #6.

The enforcement grace period for the other disclosure requirements of Standard #6(a)-(d) will be extended 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 and sooner for plans with Plan Years beginning August through December).

Therefore, enforcement with respect to the following provisions of Standard #6 will take effect 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 *Technical Release* also contains information on state health consumer assistance program or ombudsman.

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