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HEALTH LAW ALERT
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Grace Period for ACA Claims & Appeals Provisions Extended
24-Hour Urgent Care Decisions, Other Provisions Affected

Today, the Department of Labor ("DOL") issued guidance extending a compliance grace period that applies to several provisions of claims and appeals procedure requirements arising from the Affordable Care Act. DOL Technical Release 2011-01 describes an extended grace period that applies to certain requirements of the interim final rules adopted last year to implement the Affordable Care Act's provisions related to claims and appeals procedures. Under the grace period extension, the DOL, the Department of Health and Human Services, and the Department of the Treasury (together, "the Agencies") will not enforce the affected provisions until plan years beginning on or after January 1, 2012. The extended grace period applies to some (but not all) of the provisions that were subject to an earlier enforcement grace period that was to end on July 1, 2011. (Click here for my Health Law Alert on the original grace period.) Provisions subject to the extended grace period are:

- The requirement that a health plan notify a claimant of an urgent-care benefit determination (whether adverse or not) within 24 hours;[1]

- The requirement that benefit determination notices be provided in a culturally and linguistically appropriate manner;

- The requirement to include diagnosis codes, treatment codes, and the meaning of the respective codes in benefit determination notices[2] (see below, however, concerning other benefit determination content requirements); and

- Deemed exhaustion of the health plan's internal claims and appeals process (which permits the claimant to initiate remedies available under ERISA or State law) if the health plan "fails to strictly adhere to all the requirements" of the interim final rule.

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[1] The Department of Labor's 72 hour standard will remain in effect during the grace period. *See* 29 C.F.R. § 2560.503-1(f)(2)(i).

[2] Technical Release 2011-01 reminds health plans that diagnosis codes, treatment codes, and the meaning of the respective codes "generally [must] be provided to claimants on request," whether or not the information is in benefit determination notices.

The Agencies do **not** require health insurance issuers and self-funded group health plans to work in good faith to implement these standards by January 1, 2012 to qualify for the grace period. The Agencies explain that they "intend to issue an amendment to the 2010 interim final regulations in the near future" and that the purpose of the extended grace period is to "avoid enforcing standards that the [Agencies] intend to modify in the near future." This suggests that the Agencies expect to make significant changes to these provisions when they amend the interim final rule.

Other Benefit Determination Notice Content Requirements

Although Technical Release 2011-01 also extends the grace period with respect to interim final rule notice content requirements other than diagnosis and treatment codes and their meanings, it does not appear that the Agencies intend to make significant changes to those requirements. This other required content includes a description of available appeals processes (internal and external), and contact information for a health insurance consumer assistance office or ombudsman. (See box below for information on this requirement.) These requirements for the content of benefit determination notices goes into effect on the first day of the first plan year beginning on or after July 1, 2011 (the original grace period simply required compliance beginning on July 1, 2011).

Notice of Consumer Assistance Program or Ombudsman

The interim final rule requires health plans to "disclose" in benefit determination notices "the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under [the Affordable Care Act] to assist individuals with the internal claims and appeals and external review processes." An appendix to Technical release 2011-01 lists States that have programs, along with contact information.

The DOL indicates that plans should include consumer assistance program contact information in benefit determination notices starting with plan years beginning on or after July 1, 2011. Plans should check the DOL (or HHS) website at least annually to update consumer assistance program contact information (or, for plans with enrollees in States without consumer assistance programs, to determine whether programs have been established). States that **do not** have consumer assistance programs operating at this time are:

- Alabama
- Alaska
- American Samoa
- Arizona
- Colorado
- Florida
- Hawaii
- Idaho
- Indiana
- Louisiana
- Nebraska
- North Dakota
- Ohio
- South Dakota
- Utah
- Virgin Islands
- Wisconsin
- Wyoming

Plans with enrollees in States not listed above may find contact information for applicable State consumer assistance programs in the Appendix of Technical Release 2011-1 (click here).

Guidance on External Review Processes

Technical Release 2011-01 reiterates that the Department of Health and Human Services will determine when insurers must use the Federal external review process, rather than a State process. The guidance explains that, as of March 18, 2011, the Federal external review process applies to insurers in three States—Alabama, Mississippi, and Nebraska—and four territories—the U.S. Virgin Islands, Northern Mariana Islands, Guam, and American Samoa. Insurers in other States should continue to comply with the interim final rules by utilizing the respective State external review processes for insured claimants.

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