SEYFARTH SHAW LLP ATTORNEYS

Health Care Reform Management Alert Series

Issue 17

Extension and Modification of Grace Period for Claims & Appeals Requirements

This is the seventeenth issue in our series of alerts for employers on selected topics in health care reform. (Click *here* to access our general summary of health care reform and other issues in this series) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

This supplements Issue *11* of our Health Care Reform Management Alert Series, which addressed the new claims and appeals regulations that apply to non-grandfathered plans under the Patient Protection and Affordable Care Act (PPACA). On March 18, 2011, the Department of Labor (DOL) issued guidance extending the grace period for most of the new internal claims and appeals requirements under PPACA. This *did not* delay the requirement that non-grandfathered plans permit participants to appeal to an independent external review organization following exhaustion of the internal claims and appeals process. This Alert addresses the new requirements and how the extended grace period affects plan sponsors.

[ ] Applies to grandfathered plans

[√] Applies to new health plans and plans that lose grandfathered status

Background – Initial Grace Period through July 1, 2011

PPACA modified the internal claims and appeals requirements as they relate to non-grandfathered group health plans. See Issue 11 for more information on the claims and appeals interim final regulations (IFRs). On September 20, 2010, however, the DOL announced that it would not take action against non-grandfathered plans that failed to comply with some of these requirements, as long as the plan sponsor was making a good-faith effort toward coming into compliance. This grace period was to expire July 1, 2011, regardless of plan year. Specifically, the non-enforcement grace period applied to the following provisions:

1. Plans must decide urgent care claims within 24 rather than 72 hours;

2. Plans must provide notices in a culturally and linguistically appropriate manner if the non-English speaking participant population exceeds certain thresholds;

3. For plans that fail to strictly adhere to all the requirements of the IFRs, claimants will be deemed to have exhausted the plan's internal claims and appeals processes, 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.(Claims under ERISA will be deemed denied without the exercise of discretion by a plan administrator and, thus, plans may lose the deferential standard of review); and

4. Plans must expand claim denial notices to include the following:

   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 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 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. Plans must ensure that the reason 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 standard that was used in denying the claim. In the case of a final internal adverse benefit determination, the description must also include a discussion of the decision.

   d. Plans must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

   e. Plans 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 (full list available *here*).

Extended Grace Period – Compliance Date Varies

Since providing the initial grace period, the DOL received many comments from plan sponsors expressing concerns about the claims and appeals IFRs. The DOL intends to modify the IFRs as a result of these comments and decided to provide an extended grace period so plan sponsors could wait for final regulations before coming into compliance with many of the requirements. The new grace period requires rolling compliance, however, based on plan year and provision, as detailed in the table below:

Provision(s) (listed above)	New Compliance Deadline
1, 2, 3, 4a	Plan years beginning on or after January 1, 2012
4b, 4c, 4d, 4e	Plan years beginning on or after July 1, 2011

New Grace Period Retroactively Removes Good-Faith Compliance Requirement

While the original grace period required plan sponsors to actively work in good-faith toward implementing the requirements of the IFRs, the new grace period removes this requirement. Instead, plan sponsors need not comply with the **listed** requirements at all until the end of the grace period. This change is retroactive to the start of the original grace period.

Employer Action Steps

- Determine whether your plan is grandfathered.
- If not, implement external appeals process and ensure plan complies with internal claims and appeals requirements not extended by the grace period (see *Issue 11* and Supplement to *Issue 11*).
- Determine when additional provisions will apply following the end of the grace period, based on plan year, and prepare to comply with those requirements.

- Determine whether to roll back provisions that were already implemented (or that are in the process of being implemented) but are now delayed pending expiration of the grace period.
- Determine how to communicate changes resulting from this extended grace period to participants.

For further details, or if you have any questions regarding the claims and appeals grace period extension, contact your Seyfarth Shaw LLP attorney or any Employee Benefit attorney listed on the website at www.seyfarth.com/employeebenefits, or send your questions to HealthReform@seyfarth.com.