



## **Extension of Enforcement Grace Period for Select Internal Claims and Appeals Rules Until Plan Years Beginning On or After Jan. 1, 2012**

The Affordable Care Act generally requires group health plans (except for grandfathered plans) and health insurance issuers in the group market to implement an effective internal appeals process for coverage determinations and claims, beginning with plan years starting on or after September 23, 2010. Interim final regulations released in July 2010 by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury describe the new procedures, including seven new standards required for internal claims and appeals.



The Departments previously delayed the enforcement of certain standards set forth in the interim final regulations until July 1, 2011, regarding:

- The timeframe for making urgent care claims decisions;
- Providing notices in a culturally and linguistically appropriate manner;
- Requiring broader content and specificity in notices; and
- Substantial compliance.

### **Extension of Enforcement Grace Period**

Technical Release 2011-01 further extends, with a few modifications, the enforcement grace period previously set forth. Specifically, the enforcement grace period is extended **until plan years beginning on or after January 1, 2012** with respect to the timeframe for making urgent care claims decisions, providing notices in a culturally and linguistically appropriate manner, and substantial compliance.

During the grace period, the Department of Labor and the IRS will not take any enforcement action against a group health plan with respect to these provisions. There is no requirement that plans be working in good faith to implement such standards for either the extended or the original enforcement grace period to apply.

### **Original Enforcement Grace Period Applies to Certain Provisions**

With respect to the requirement of broader content and specificity in notices, the Departments are extending the enforcement grace period *in part only*. 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**:

- The disclosure of information sufficient to identify a claim (other than the diagnosis and treatment information);
- The reasons for an adverse benefit determination;
- The description of available internal appeals and external review processes; and
- 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.

For more information and compliance assistance, please see [Technical Release 2011-01](#). To read more about the requirements related to the new internal claims and appeals procedures, please visit the HR360 [Health Care Reform](#) section and click on Claims and Review Processes in the left-hand navigation.

Sincerely,

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