



EXTENDED RELIEF FOR CERTAIN INTERNAL CLAIMS AND APPEALS NON-GRANDFATHERED FULLY INSURED AND SELF-FUNDED PLANS

May 2011

*THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES AND TREASURY (THE DEPARTMENTS) ISSUED **TECHNICAL RELEASE 2011-01** THAT MODIFIES AND EXTENDS THE ENFORCEMENT GRACE PERIOD FOR INTERNAL CLAIMS AND APPEALS UNDER THE AFFORDABLE CARE ACT (ACA). CARRIERS AND PLAN SPONSORS WILL BASICALLY HAVE UNTIL **PLAN YEARS BEGINNING ON AND AFTER JANUARY 1, 2012** TO COMPLY WITH MANY OF THE REQUIREMENTS THAT HAD INITIALLY BEEN DELAYED UNTIL **JULY 1, 2011**.*

*THIS EDITION OF **INSIGHTS & IMPLICATIONS** WILL **BRIEFLY** DISCUSS KEY ELEMENTS OF **TECHNICAL RELEASE 2011-01** AND WHAT THE IMPACT WILL BE FOR EMPLOYERS AND PLAN SPONSORS*

INTERNAL CLAIMS AND APPEALS UNDER ACA

The ACA requires non-grandfathered fully insured and self-funded plans to establish more uniform internal (plan level) appeals processes in the event of an adverse benefit determination, such as a denial of claim payment. Enforcement for many new requirements, initially delayed until July 1, 2011, has now generally been extended to take effect with the first plan year on or after January 1, 2012. The delay allows carriers, administrators, plan sponsors and others additional time to implement the ACA requirements.

IMPLICATIONS AND ACTION STEPS

- Remember - the ACA internal claims appeal and external review processes do not apply to grandfathered plans. However, many carriers and third party administrators intend to apply the ACA standards to grandfathered plans, as well. If you maintain a grandfathered plan, check with your carrier or administrator to confirm the appeal and review standards that will apply to your plan.
- Plan sponsors of fully insured plans may generally

rely on the carrier to establish and adhere to the claims and appeals requirements. Review with your carrier when the rules will apply to your plan.

- Plan sponsors of self-funded plans should discuss what steps the plan administrator is undertaking to implement the ACA internal appeals and external review requirements and determine what, if any, actions you may need to take to comply with the standards.
- Plan documents and SPDs will need to be updated. We suggest this be delayed until further guidance is issued. However, plan members are still entitled to information about what appeals procedures are currently in place in the event of an adverse benefit determination. Your carrier or plan administrator should be able to provide guidance on this.
- The ACA external review requirements for non-grandfathered fully insured and self-funded plans have not been impacted by this Technical Release. An external review, performed by an Independent Review Organization, provides an additional level of review in the event that an unsatisfactory ruling results from the internal, plan-level appeal. More information about the external review requirements can be found at <http://www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf>.

The internal claims appeal and external review processes are complex and are being implemented in phases under differing time tables. In addition, the Departments expect to issue amendments to earlier guidance and have stated that this delay is considered a “bridge” until the regulations are issued. Your Chernoff Diamond consultant and the compliance team can help you understand the requirements to ensure your plan will comply with the law and regulations.

INTERNAL CLAIMS AND APPEALS – WHAT IS DELAYED?
The following internal claims and appeals requirements

Insights & Implications

for non-grandfathered fully insured and self-funded plans are delayed until the first plan year beginning on and after January 1, 2012:

- ◆ A claimant must be notified of an urgent care benefit determination within 24 hours.
- ◆ Notices must be provided in a culturally and linguistically appropriate manner.
- ◆ Notices must disclose the diagnosis and treatment codes as well as their meaning.
- ◆ If the plan or issuer fails to strictly adhere to all the requirements of the interim final regulations, the claimant will be deemed to have exhausted the internal claims and appeals process and will be able to initiate an external review or other remedies available under ERISA or state law.

The following is delayed until the first plan beginning on and after July 1, 2011

- ◆ Adverse benefit determination notices must provide additional content such as:
 - Information to identify the claim,
 - The reason for the adverse determination,
 - A description of the internal appeals and external review processes, and
 - Applicable contact information including assistance that may be available from the State (State-specific contact information is provided in Technical Release 2011-01).

A copy of Technical Release 2011-01 (with numerous links to earlier guidance) can be found at <http://www.dol.gov/ebsa/newsroom/tr11-01.html>

ADDITIONAL INFORMATION

For specific questions concerning information contained in this **INSIGHTS & IMPLICATIONS**, please contact your Chernoff Diamond consultant.

Information contained in this **INSIGHTS & IMPLICATIONS** is not intended to render tax or legal advice. Employers should consult with qualified legal and/or tax counsel for guidance in respect of matters of law, tax and related regulation.

Chernoff Diamond provides comprehensive consulting and administrative services with respect to all forms of employee benefits, risk management and qualified and non-qualified retirement plans.

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