U.S. Department of Labor Employee Benefits Security Administration
Washington, D.C. 20210

TECHNICAL RELEASE 2011-01

DATE: MARCH 18, 2011

SUBJECT: EXTENSION OF NON-ENFORCEMENT PERIOD RELATING TO CERTAIN INTERIM PROCEDURES FOR INTERNAL CLAIMS AND APPEALS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

INTRODUCTION:

The Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments) have been issuing regulations in several phases to implement the revised Public Health Service Act (PHS Act) sections 2701 through 2719A and related provisions of the Patient Protection and Affordable Care Act (Affordable Care Act). Section 2719 of the PHS Act sets forth standards for plans and issuers that are not grandfathered health plans regarding internal claims and appeals and external review. The Departments published interim final regulations implementing PHS Act section 2719 on July 23, 2010, at 75 FR 43330 (the 2010 interim final regulations).

On September 20, 2010, the Department of Labor issued Technical Release 2010-02 (T.R. 2010-02), which set forth an enforcement grace period for compliance with certain new provisions with respect to internal claims and appeals until July 1, 2011.[1] Based on a review of the comments received on the 2010 interim final regulations and other feedback from interested stakeholders, this document, Technical Release 2011-01, modifies and extends the enforcement grace period set forth in T.R. 2010-02, as set forth below.

The Departments intend to issue an amendment to the 2010 interim final regulations in the near future that takes into account comments and other feedback received from stakeholders on the 2010 interim final regulations, and makes modifications to certain provisions of the 2010 interim final regulations. To avoid enforcing standards that the Departments intend to modify in the near future, the relief contained in this Technical Release 2011-01 is intended to act as a bridge until an amendment to the 2010 interim final regulations is issued.[2]

[1] T.R. 2010-02 is available at http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-02.pdf.

[2] Note: T.R. 2010-02 and this Technical Release 2011-01 describe circumstances in which the Departments will not treat a plan or issuer as being out of compliance for purposes of enforcement by the Departments. However, these documents do not address the rights of private parties in private litigation.

PURPOSE:

This guidance is intended to ensure that plan participants and beneficiaries are promptly accorded the important protections under the Affordable Care Act that provide for fuller and fairer processing of claims, the right to appeal claims that are denied, and the right to obtain effective external review of denials on appeal. The Departments are working with employer plan sponsors, health insurance issuers, States, and other stakeholders to assist them in coming into compliance with the law through an orderly and expeditious implementation process. Accordingly, this guidance seeks to minimize both cost and delay, and avoid confusion for participants and plans alike. As these implementation policies with respect to internal appeals and external review are phased in, refined, and finalized, the Departments will continue to work to strike a workable balance that gives effect to these protections for participants and beneficiaries without disruption, and ensures that they work as intended for families, individuals, issuers, and plan sponsors.

BACKGROUND:

Section 2719 of the PHS Act generally requires that group health plans and health insurance issuers that are not grandfathered health plans have an effective internal claims and appeals process. The statutory language provides further that plans, and issuers in the group market, shall provide an internal claims and appeals process that initially incorporates the procedures of 29 CFR 2560.503-1 (the 2000 DOL claims procedure regulation) and shall update such procedures in accordance with any standards established by the Secretary of Labor for such plans and issuers.

The 2010 interim final regulations, unlike the 2000 DOL claims procedure regulation, apply to health insurance issuers, in addition to group health plans. Moreover, the 2010 interim final regulations provide the following additional standards for internal claims and appeals processes:

1. The scope of adverse benefit determinations eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).[3]

2. Notwithstanding the rule in the 2000 DOL claims procedure regulation that provides for notification in the case of urgent care claims[4] not later than 72 hours after the receipt of the claim, a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as

[3] This definition is broader than the definition in the 2000 DOL claims procedure regulation, which already provides that a denial, reduction, or termination of, or a failure to provide payment (in whole or in part) for a benefit is an adverse benefit determination eligible for internal claims and appeals processes.

[4] A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer.[5]

3. Clarifications with respect to full and fair review, such that plans and issuers are clearly required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.

4. Clarifications regarding conflicts of interest, such that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, must not be based upon the likelihood that the individual will support the denial of benefits.

5. Notices must be provided in a culturally and linguistically appropriate manner, as required by the statute, and as set forth in paragraph (e) of the 2010 interim final regulations.

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.

7. If a plan or issuer fails to strictly adhere to all the requirements of the 2010 interim final regulations, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, regardless of whether the plan or issuer asserts

[5] Under the 2010 interim final regulations, there is a special exception if the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or under State law.

On September 20, 2010, in response to comments from stakeholders stating that more time was needed to come into compliance with PHS Act section 2719 and the additional internal claims and appeal standards in the 2010 interim final regulations, the Department of Labor issued T.R. 2010-02 setting forth an enforcement grace period with respect to some of the additional standards. Specifically, T.R. 2010-02 set forth an enforcement grace period until July 1, 2011 with respect to standard #2 above (regarding the timeframe for making urgent care claims decisions), standard #5 above (regarding providing notices in a culturally and linguistically appropriate manner), standard #6 above (requiring broader content and specificity in notices), and standard #7 above (regarding substantial compliance), and stated that, for that period, the Department of Labor and the Internal Revenue Service (IRS) would not take any enforcement action against a group health plan, and HHS would not take any enforcement action against a self-funded nonfederal governmental health plan, that is working in good faith to implement such additional standards but does not yet have them in place.[6]

CONCLUSION:

This technical release extends, with a few modifications, the enforcement grace period set forth in T.R. 2010-02 until plan years beginning on or after January 1, 2012 to give the Departments time to publish new regulations necessary or appropriate to implement the internal claims and appeals provisions of PHS Act section 2719(a). Specifically, this Technical Release 2011-01 extends the enforcement grace period until plan years beginning on or after January 1, 2012 with respect to standard #2 above (regarding the timeframe for making urgent care claims decisions), standard #5 above (regarding providing notices in a culturally and linguistically appropriate manner), and standard #7 above (regarding substantial compliance). During the grace period, the Department of Labor and the IRS will not take any enforcement action against a group health plan, and HHS will not take any enforcement action against a self-funded nonfederal governmental health plan, with respect to these provisions.[7] Similarly, HHS is encouraging States to provide similar grace periods with respect to issuers, and HHS will not cite a State for failing to substantially enforce PHS Act section 2719(a) in these situations. Moreover, whereas T.R. 2010-02 required plans to be working in good faith to implement such standards for the enforcement grace period to apply, under this Technical Release 2011-01, no such requirement will apply for either the extended or the original enforcement grace period.

With respect to standard #6 above (requiring broader content and specificity in notices), the Departments are extending the enforcement grace period in part only. Specifically, with respect to the requirement to disclose diagnosis codes and treatment codes (and their

[6]T.R. 2010-02 also stated that HHS was encouraging States to provide similar grace periods with respect to issuers and HHS would not cite a State for failing to substantially enforce the provisions of part A of title XXVII of the PHS Act in these situations.

[7] Moreover, no excise tax liability should be reported on IRS Form 8928 with respect to PHS Act section 2719(a) with respect to a failure to meet any of these particular standards.

corresponding meanings), this Technical Release 2011-01 extends the enforcement grace period until plan years beginning on or after January 1, 2012.[8] Accordingly, during this period, the Department of Labor and the IRS will apply the same enforcement policy applicable to standards #2, 5, and 7 (described in the paragraph immediately above) with respect to automatic disclosure of diagnosis and treatment information pursuant to standard #6.

The enforcement grace period will be extended with respect to the other disclosure requirements of standard #6 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). Therefore, 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[9]: (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,[10] 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.

To assist plans and issuers in making these disclosures, the Departments have taken several steps:

(1) The current list of relevant consumer assistance programs and ombudsmen is provided in the Appendix to this Technical Release 2011-01. Plans and issuers with July 1 plan years may rely upon the list in this Appendix when developing their notices of adverse benefit determination and final internal adverse benefit determination for plan years beginning on July 1, 2011. The Departments will continue to review and update this list, and will provide any updated information on their websites (www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html). For plan years beginning after July 1, 2011, plans and issuers should check these websites within a reasonable time before the beginning of the plan year to ensure that the notices contain information that is as up-to-date as practicable. In any case, plans and issuers are not required to update the information more than once per year.

[8] Note: Such information is, however, generally required to be provided to claimants upon request. See 29 CFR 2560.503-1(h)(2)(iii), which is also applicable to plans (whether or not they are ERISA plans) and issuers that are not grandfathered health plans pursuant to 29 CFR 2590.715-2719(b)(2)(i). Nevertheless, a request for such diagnosis and treatment codes (and/or their meanings), in itself, should not be considered to be a request for (and therefore trigger the start of) an internal appeal.

[9] Note: Any enforcement grace period with respect to disclosure requirements that has been provided under T.R. 2010-02 or this Technical Release 2011-01 does not affect disclosure requirements still in effect for ERISA plans under the 2000 DOL claims procedure regulation and/or Part 1 of ERISA.

[10] Note: A number of comments on the 2010 interim final regulations raised concerns about the scope of the Federal external review process. This Technical Release 2011-01, T.R. 2010-02, and the model notices authorized by the Departments do not address the scope of the Federal external review process, which is still being reviewed by the Departments and may be addressed in future guidance. Of course, for purposes of any applicable State external review process, the scope of claims eligible for external review is determined under State law.

(2) Regarding the description of external review processes for self-insured plans, the Department of Labor issued Technical Release 2010-01 on August 23, 2010, and has frequently-asked-question guidance available at www.dol.gov/ebsa/healthreform, to assist self-insured plans in understanding their responsibilities with respect to implementing external review processes.

(3) The Departments have issued model notices (also available at www.dol.gov/ebsa/healthreform) that provide a template for the disclosures that should be made regarding external review (*e.g.*, contact information and timeframes for initiating external review). As indicated in the preamble to the 2010 interim final regulations,[11] plans and issuers that complete and use the model notices authorized by the Departments are considered to meet the relevant content requirements.

With respect to insured coverage, the 2010 interim final regulations set forth standards for the required external review process, and indicated that HHS will make a determination as to whether the State external review process satisfies applicable requirements. HHS will provide guidance as to when external review will be performed in a Federally-operated external review process, instead of by a State process. Accordingly, insured plans and health insurance issuers should review the Departments' model notices and provide information (*e.g.*, contact information and timeframes for initiating an external review) consistent with the State external review process to the extent that process now applies, unless HHS determines that the Federally-operated external review process applies.[12] For the States in which the Federally-operated external review process applies, HHS has issued technical guidance[13] describing the interim process applicable to insured coverage, which is helpful in completing the model disclosures (including contact information and timeframes for initiating an external review). In the guidance HHS intends to issue on the applicability of the Federally-operated external review process to insured coverage in additional States and territories, HHS will provide insured plans and issuers with reasonable time to make any changes that are prompted by the new guidance.

Questions concerning the information contained in this technical release may be directed to the Office of Health Plan Standards and Compliance Assistance at 202-693-8335.

[11] See 75 FR 43334, published July 23, 2010.
[12] To date, the Federally-operated external review process is in effect for 3 States and 4 Territories: Alabama, Mississippi, Nebraska, US Virgin Islands, Northern Mariana Islands, Guam, and American Samoa.
[13] See http://www.cms.gov/CCIIO/Resources/Files/Downloads/technical_guidance_for_self_funded_non_fed_plans.pdf.

APPENDIX TO TECHNICAL RELEASE 2011-01
STATES WITH CONSUMER ASSISTANCE PROGRAMS UNDER PHS ACT SECTION 2793
** Current as of March 18, 2011 **
(Periodic updates will be posted at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html)

In addition to the State information provided in the chart below, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to participants and beneficiaries in need of assistance. Plans and issuers are encouraged to include EBSA's contact information in their notices as well. (EBSA contact information is also included in the Departments' model notices.)

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

State	Contact Information
Alabama	No program
Alaska	No program
American Samoa	Not yet operational
Arizona	No program
Arkansas	Arkansas Insurance Department, Consumer Services Division 1200 West Third St. Little Rock, AR 72201 (855) 332-2227 Insurance.consumers@arkansas.gov
California	California Department of Managed Health Care Help Center 980 9th Street, Suite 500 Sacramento, CA 95814 (888) 466-2219 http://www.healthhelp.ca.gov helpline@dmhc.ca.gov
Colorado	No program
Connecticut	Connecticut Office of the Healthcare Advocate P.O. Box 1543 Hartford, CT 06144 (866) 466-4446 www.ct.gov/oha healthcare.advocate@ct.gov
Delaware	Delaware Department of Insurance 841 Silver Lake Blvd Dover, DE 19904 (800) 282-8611 consumer@state.de.us
District of Columbia	DC Office of the Health Care Ombudsman and Bill of Rights 899 North Capitol Street, NE, 6th Floor, Room 6037 Washington, DC 20002 (877) 685-6391 healthcareombudsman@dc.gov
Florida	No program

Georgia	Georgia Office of Insurance and Safety Fire Commissioner Consumer Services Division 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, Georgia 30334 (800) 656-2298 http://www.oci.ga.gov/ConsumerService/Home.aspx
Guam	Guam Department of Revenue and Taxation 1240 Army Drive Barrigada, Guam 96921 (671) 635-1844
Hawaii	No program
Idaho	No program
Illinois	Illinois Department of Insurance 100 Randolph St, 9th Floor Chicago, IL 60601 (877) 527-9431, or Illinois Department of Insurance 320 W. Washington St, 4th Floor Springfield, IL 62727 http://www.insurance.illinois.gov DOI.Director@illinois.gov
Indiana	No program
Iowa	Iowa Consumer Advocate Bureau 330 Maple St Des Moines, IA 50319 (877) 955-1212
Louisiana	No program
Kansas	Kansas Insurance Department Consumer Assistance Division 420 SW 9th Street Topeka, KS 66612 (800) 432-2484 http://www.ksinsurance.org CAP@ksinsurance.org
Kentucky	Kentucky Department of Insurance, Consumer Protection Division P.O. Box 517 Frankfort, KY 40602 (877) 587-7222 http://insurance.ky.gov DOI.CAPOmbudsman@ky.gov
Maine	Consumer for Affordable Health Care 12 Church Street, PO Box 2490 Augusta, ME 04338-2490 (800) 965-7476 www.mainecahc.org consumerhealth@mainecahc.org

Maryland	Maryland Office of the Attorney General Health Education and Advocacy Unit 200 St. Paul Place, 16th Floor Baltimore, MD 21202 (877) 261-8807 http://www.oag.state.md.us/Consumer/HEAU.htm heau@oag.state.md.us
Massachusetts	Health Care for All 30 Winter Street, Suite 1004 Boston, MA 02108 (800) 272-4232 http://www.hcfama.org/helpline
Michigan	Michigan Office of Financial and Insurance Regulation MiCHAP P.O. Box 30220 Lansing, MI 48909 (877) 999-6442 http://michigan.gov/ofir ofir-ins-info@michigan.gov
Missouri	Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (800) 726-7390 www.insurance.mo.gov consumeraffairs@insurance.mo.gov
Mississippi	Health Help Mississippi 800 North President Street Jackson, MS 39202 (877) 314-3843 www.healthhelpms.org healthhelpms@mhap.org
Montana	Montana Consumer Assistance Program 840 Helena Ave Helena, MT 59601 (800) 332-6148 http://www.csi.mt.gov
Nebraska	No program
Nevada	Office of the Governor, Consumer Health Assistance 555 East Washington Ave #4800 Las Vegas, NV 89101 (702) 486-3587 (888) 333-1597 http://www.govcha.state.nv.us cha@govcha.state.nv.us
New Hampshire	New Hampshire Department of Insurance 21 South Fruit Street, Suite 14 Concord, NH 03301 (800) 852-3416 www.nh.gov/insurance consumerservices@ins.nh.gov

New Jersey	New Jersey Department of Banking and Insurance 20 West State Street, PO Box 329 Trenton, NJ 08625 (800) 446-7467 (888) 393-1062 (appeals) http://www.state.nj.us/dobi/consumer.htm ombudsman@dobi.state.nj.us
New Mexico	New Mexico Public Regulation Commission Division of Insurance 1120 Paseo De Peralta Santa Fe, NM 87504 (888) 427-5772 http://nmprc.state.nm.us/id.htm mchb.grievance@state.nm.us
New York	Community Service Society of New York, Community Health Advocates 105 East 22nd Street, 8th floor New York, NY 10010 (888) 614-5400 http://www.communityhealthadvocates.org/
North Carolina	North Carolina Department of Insurance Health Insurance Smart NC 430 N. Salisbury Street Raleigh, NC 27603 (877) 885-0231 www.ncdoi.com
North Dakota	No program
Ohio	No program
Oklahoma	Oklahoma Insurance Department Five Corporate Plaza 3625 Northwest 56th Street, Suite 100 Oklahoma City, OK 73112 (800) 522-0071 (in-state only) (405) 521-2828 http://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html
Oregon	Oregon Health Connect P.O. Box 14480 Salem, OR 97309-0405 (855) 999-3210 www.oregonhealthconnect.org health.connect@state.or.us
Pennsylvania	Pennsylvania Department of Insurance 1326 Strawberry Square Harrisburg, PA 17111 (877) 881-6388 www.insurance.pa.gov
Puerto Rico	Puerto Rico Oficina de la Procuradora del Paciente 1215 Ponce de Leon PDA 18 Santurce, PR 00907 (800) 981-0031 www.pacientes.gobierno.pr querellas@opp.gobierno.pr

Rhode Island	Rhode Island Department of Business Regulation 1511 Pontiac Avenue, Bldg 69-2 Cranston, RI 02920 (401) 462-9520 www.dbr.state.ri.us and www.ohic.ri.gov InsuranceInquiry@dbr.ri.gov and HealthInsInquiry@ohic.ri.gov
South Carolina	South Carolina Department of Insurance Consumer and Individual Licensing Services Division P.O. Box 100105 Columbia, SC 29202 (800) 768-3467 http://www.doi.sc.gov consumers@doi.sc.gov
South Dakota	No program
Tennessee	Tennessee Department of Commerce and Insurance 500 James Robertson Pkwy Davy Crockett Tower, 4th floor Nashville, TN 37243 (800) 342-4029 www.tn.gov/commerce/insurance CIS.Complaints@state.tn.us
Texas	Texas Consumer Health Assistance Program Texas Department of Insurance Mail Code 111-1A 333 Guadalupe P.O. Box 149091 Austin, TX 78714 (855) 839-2427 (855-TEX-CHAP) www.texashealthoptions.com chap@tdi.state.tx.us
Utah	No program
Vermont	Vermont Legal Aid 264 North Winooski Ave. Burlington, VT 05402 (800) 917-7787 www.vtlegalaid.org
Virginia	Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov
Virgin Islands	Not yet operational
Washington	Washington Consumer Assistance Program 5000 Capitol Blvd Tumwater, WA 98501 (800) 562-6900 http://www.insurance.wa.gov cap@oic.wa.gov

West Virginia	West Virginia Office of the Insurance Commissioner Consumer Service Division P.O. Box 50540 Charleston, WV 25305 (888) 879-9842 http://www.wvinsurance.gov
Wisconsin	No program
Wyoming	No program