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## **PPACA'S NEW BENEFIT CLAIMS REQUIREMENTS**

Health Care Reform legislation (the Patient Protection and Affordable Care Act, or "PPACA") imposes additional claims processing requirements on subject group health plans and insurers. There are new claims notices, revised procedures and, for self-funded ERISA plans, a Federal external claims review requirement.

Additional guidance in the form of amended regulations and technical releases has recently been issued with respect to the PPACA internal claims and appeals process as well as the Federal external review requirement. The amended regulations are generally effective July 1, 2011 but are subject to existing enforcement grace periods. The government will not take enforcement action against group health plans (including self-funded government health plans) for failure to comply with the new rules during the grace periods, but for calendar year plans, enforcement grace periods will end on December 31, 2011.

Highlights of the new claims, appeals and review rules include:

- Notwithstanding any enforcement grace periods, action by non-grandfathered group health plans and insurers may be required by December 31, 2011. For example, self-insured group plans relying on the "safe harbor" provided in the new external review rules will need to hire at least two "independent review organizations" by January 1, 2012 and then a third IRO by July 1, 2012.
- Certain plan communications are required to be given in languages other than English, but only in counties where at least ten percent of residents are literate in the same foreign language (prior regulations had applied this requirement on the basis of the composition of each employer's workforce). Adverse benefit determinations and final claims review decisions for residents of such counties must contain a one-sentence notice about the availability of language assistance. Residents of Kane County, Illinois who are literate in Spanish currently qualify for communications in that language. This is the only Illinois county to which the alternative language rules apply at this time. The text of the sentence to be included in adverse benefit determinations and final claims review decisions for Spanish speakers subject to the alternate language requirement reads as follows:

Para obtener asistencia en Español, llame al [insert telephone number].

Note that the listing of counties throughout the country as to which residents qualify for alternative language information is updated annually on the basis of Census Bureau data.

- Model notices for adverse benefit determinations have been revised and are available on-line in the appendix to Technical Release 2011-2.
- Affected plans will have 72 hours under the amended regulations (not 24 hours as required by prior regulations) in which to respond to “urgent care claims.”
- Diagnosis and treatment codes no longer have to be included in adverse benefit determinations but such codes must be available on request and claimants must be given a notice of their right to request them.
- The scope of the Federal external review procedure has been narrowed to cover only appeals involving medical judgment or coverage rescission (issues involving eligibility and related legal issues are not subject to the new external review procedure at this time). This restriction is effective as to external review requests filed on or after September 20, 2011.

*Recommendations:* Benefits staff and administrators of self-funded group health plans that are not grandfathered under PPACA need to establish compliant internal claims and appeals procedures because existing ERISA claims requirements have been superseded. Further, self-funded group health plans not subject to state laws regulating group health insurance (ERISA plans) will need to implement the new Federal external claims review requirement and give serious consideration to the compliance “safe harbor.” All subject calendar year plans need to bear in mind that enforcement grace periods for the PPACA claims, appeals and review rules expire as to such plans on December 31, 2011, so *full* compliance (subject to the safe harbor option) will be required by that date. Anyone administering a self-funded plan subject to the new rules needs to work diligently with professional advisors, third party administrators and other plan service providers to assure timely compliance.

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