Disclosures, Claims, and Appeals

Authorized Representative (needed for filing claims, appeals, and requesting plan instruments/analyses)

- Automatic for urgent claims and appeals

  29 C.F.R. 2560.503-1, states that "a claim involving urgent care has the meaning given in 29 C.F.R. 2560.503–1(m)(1), ***as determined by the attending provider***, and the ***plan or issuer shall defer to such determination of the attending provider***."

- May be required by health plans for non-urgent appeals

  State-compliant form or
  Insurer-specific form (if required by insurer)

Plan Documents (usually 75-150 pages)

- Self-funded plans

  Summary Plan Description (SPD)* must be provided by employers within 30 days of request pursuant to 29 U.S.C. § 1024(b)(4). NOT to be confused with 5-7 page Summary of Benefits and Coverage (SBC)

- Fully-insured plans

  Certificate of Coverage or Evidence of Coverage obtained from either insurers or employers
  80 Fed.Reg. 34292 (Aug. 17, 2015)

Designated Record Sets

To receive insurer claims data for patients, complete both insurer-specific forms (preferably upon intake):

- HIPAA Release
- HIPAA Access

Requested information must be provided within 30 days and in the format requested, pursuant to 45 C.F.R. § 164.524(c)(2).

Parity Disclosures

Must request specific health plan analysis of compliance with federal parity law (see April 20, 2016 United States Department of Labor FAQ #9)

Enforcement

- DOL regulates non-governmental self-funded plans* with respect to:
  - Plan documents
  - Parity disclosures

  Complaints can be transmitted through: https://www.askebsa.dol.gov/WebIntake/Home.aspx

- HHS regulates:
  - Self-funded non-federal governmental plans with respect to plan documents
  - HIPAA for all plans

    https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

- State insurance departments regulate all fully-insured plans regarding:
  - Plan documents
  - HIPAA*
  - Parity*

*) Some exceptions apply