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Agencies Clarify Requirements for Health Plan Claims Procedures

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The Patient Protection and Affordable Care Act (PPACA) mandates certain requirements for claims and appeals procedures that must be followed by all health insurers and group health plans, including employer-provided plans that are subject to the Employee Retirement Income Security Act (ERISA). PPACA was originally enacted in 2010, and initially required compliance only with ERISA's claims and appeals rules. However, through prior guidance issued jointly by the Departments of Treasury, Labor and Health and Human Services (the Departments), the claims and appeals rules have been expanded. In guidance issued on June 22 (the Guidance), the Departments have clarified the new claims and appeals requirements.

Before PPACA, ERISA generally set forth claims and appeals procedures that included deadlines for responses to claims and appeals and mandated the inclusion of certain provisions in such responses. Pursuant to the previously issued guidance, the PPACA claims and appeals requirements (which will supersede ERISA's requirements) expand upon the pre-PPACA requirements. The new requirements include:

- expanding the scope of the procedures to address claims related to coverage rescission;
- mandating response to urgent care claims no later than 24 hours after receipt;
- requiring that additional plan-produced material related to the claim must be provided to a claimant upon request;
- clarifying conflict of interest rules that apply when hiring claims adjudicators;
- demanding that response letters must be drafted using language that is culturally and linguistically appropriate;
- increasing the information that must be included in claim denials;
- allowing claimants access to court if the plan/employer does not strictly adhere to the claims rules; and
- establishing an external review procedure for certain claims.

The Guidance clarifies and finalizes the items described above. The Guidance provides that, for the most part, the new requirements do not become fully effective until the beginning of the 2012 plan year (January 1, 2012, for calendar year plans). Prior to that effective date, plan sponsors are encouraged to review their health plan claims and appeals procedures to ensure that they are updated to comply with new PPACA requirements. This review may require updates to the plan

document and summary plan description for each health plan, and may also require contracting with third-party vendors to ensure compliance with mandated external review procedures.

The guidance can be found here.

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