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Marketplace Casework, Complaints and Appeals

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Different mechanisms and processes exist for resolving problems that consumers may face when applying for health insurance in the Marketplace. Consumers and assisters must understand the differences so that they use the appropriate mechanism to resolve issues. The options include asking the Marketplace Call Center to submit the case to casework, filing an appeal with the Marketplace or an insurer, or contacting the state Department of Insurance (DOI). Insurer appeals and Department of Insurance complaints are not specific to a marketplace but can apply to all consumers inside and outside the marketplaces. This fact sheet lays out the grounds for appeals and explains where consumers should go for assistance.

Depending on the situation, consumers may have four options for obtaining relief:

- **Request for Casework** – for help with a complex case, access to certain special enrollment periods or Form 1095-A that cannot be resolved through other resources;
- **Appeal to Marketplace** – for help with problems related to a final Marketplace eligibility determination;
- **Appeal to Insurer** – for help with problems related to a decision by an insurer or participating provider in a health plan; and
- **Complaint to Department of Insurance** – for help with problems related to an insurer's decision, discrimination by an insurer, or fraudulent selling of insurance.

Knowing the difference between the avenues consumers have to protect their rights is important to ensure consumers can get effective relief. Some of these avenues have time limitations. For example, a Marketplace appeal must generally be filed within 90 days of a final eligibility determination.

The casework and appeals processes described in this document applies to consumers that live in all 39 states that use healthcare.gov for eligibility determinations. Casework and appeals processes for State Based Marketplaces (SBMs) may vary, so visit the SBM's website for information about the appeal process. In general, consumers in states with SBMs may appeal to the FFM Appeals Group when they disagree with the SBM appeals entity's decision or the SBM appeals entity's denial of a request to vacate an appeal dismissal.

Definitions & Explanations

Casework: Issues that the Marketplace Call Center or CMS receives directly from the consumer that require CMS to research or review. When an issue is "escalated" at the Call Center, it may actually have been sent to casework. If a consumer receives a "HICS" (Health Insurance Casework System) number in relation to a complaint made to the Call Center, that means the case has been sent to casework.

CMS Casework handles:

- Approving or denying exceptional circumstance SEPs;
- Resolving 1095-A tax form and other complex issues;
- Referring cases to insurers, providing technical assistance to insurers, and monitoring insurer cases for staleness and trends; and
- Informing consumers of resolution, appeal rights, and next steps.

When is casework appropriate?

- Complex eligibility or coverage issue and neither the Call Center nor the insurer can help
- Might qualify for an exceptional circumstances special enrollment period if the Call Center cannot help
- Information on 1095-A tax form is incorrect and the Call Center cannot help

Ask the Marketplace Call Center to submit a case to CMS Casework

If a case is complex or there is a problem with a Form 1095-A and case cannot be resolved through the Call Center or other resources

- In casework, a person with policy knowledge takes a fresh look at a situation. Casework is available by request when the call center cannot answer an eligibility question or when it appears the call center has given an incorrect answer.
- For more information, see July 2015 CMS Assister Webinar: CMS Casework Overview

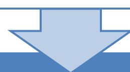
Marketplace Eligibility Appeals: An appeal is a legal action consumers can take when they receive a ***final*** eligibility decision from the FFM and they do not agree with the decision. Consumers generally have 90 days from the date an eligibility determination is made to appeal the decision. Consumers can mail or fax appeals to the FFM (consumers in states with their own State Based Marketplaces (SBMs) should check with their Marketplace about appeal procedures). Appeal forms are available here but consumers can also submit a description of their appeal issues in a letter. Consumers may request an "expedited" appeal if the time needed for the standard appeal process

might jeopardize the consumers' life, health or ability to attain, maintain or regain maximum function. Unfortunately, financial difficulties alone (such as difficulties paying a higher premium) will not trigger an expedited appeal.

Because their legal rights are at stake in an appeal, consumers may want to consult with a lawyer before filing an appeal or to assist in the appeals process. Low-income consumers may be eligible for free legal assistance through local legal services programs.

What types of decisions can be appealed to the FFM or SBM?

- Denial of APTCs or CSRs
- Amount of APTCs or CSRs
- Adjustment in APTCs or CSRs at end of 90-day inconsistency period
- Denial of eligibility to enroll in marketplace coverage
- Denial of a special enrollment period (SEP)
- Termination of marketplace coverage
- Denial of coverage exemption
- Denial of eligibility for Medicaid/CHIP



Appeal to the FFM or SBM

If consumer disagrees with a final marketplace eligibility determination

- Can file an appeal within 90 days of a final eligibility determination
- For more information, see Healthcare.gov: What You Can Appeal

<u>Insurer Appeals:</u> An insurer appeal is the process consumers use to have their plan's benefits or insurer's decisions reviewed. Appealable issues include problems accessing benefits or coverage cancellation. For a more detailed list of reasons and how to file an internal appeal with an insurer and the external review process please see this CMS presentation.

What are some types of issues that can be resolved through the insurer?

- Provider was listed as in-network, but when attempting to use coverage, the provider doesn't accept the consumer's insurance
- Went to the emergency room and the consumer's bill says the provider was out-of-network and payment is owed
- Insurer denied a claim for a covered service or procedure

- Insurer would not cover a prescription
- Insurer cancelled coverage

Appeal to the insurer

If consumer has a problem with coverage of a health care service or other benefits decision made by the insurer

- ***Internal Appeal:*** Within 180 days of receiving claim denial or adverse decision, ask insurer to conduct a full and fair review of its decision
- ***External Appeal:*** Appeal to an independent 3rd party after completion of an internal appeal

Department of Insurance (DOI) Complaints: Consumers can file a complaint with their DOI if they are not satisfied with their insurer's appeal decision, believe an insurer's actions are discriminatory or unfair, or believe they have been fraudulently sold health insurance. They can also complain to DOI about issues regarding billing (once enrollment is effectuated).

What are some types of issues that can be resolved by the DOI?

- Appealed the denial of a service with insurer which denied the appeal because:
  - → Not medically necessary (including appropriateness, healthcare setting, level of care or effectiveness);
  - → Experimental/investigational; or
  - → Due to a pre-existing condition
- Insurer incorrectly terminated coverage
- Provider was originally included in the provider directory for a health plan, but consumer is being told that was a mistake
- Insurer is denying a claim because it is for substance use or mental health care in violation of mental health parity laws
- Consumer was fraudulently sold health insurance

Contact State DOI

If the issue is due to discrimination by the insurer, fraudulent selling of health insurance or the consumer wants to appeal an external appeal decision received from an insurer

- Look at the Explanation of Benefits (EOB) or the insurer's final denial of the appeal for the DOI's contact information, or

- Visit the National Association of Insurance Commissioners

Conclusion

To ensure that consumers retain their legal rights to receive accurate eligibility determinations and access to the full range of health care services offered by their insurer, consumers may need to appeal decisions made by the marketplace or their insurer. Knowing the differences between casework and appeals as well as when to contact the Marketplace, insurer, or Department of Insurance will help consumers know how to obtain the most efficient and effective resolution of their complaints.