



Health Reform: **Beyond the Basics**

healthreformbeyondthebasics.org

Marketplace Appeals Process

Presented in partnership with the National
Health Law Program

Center on Budget and Policy Priorities

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- NHeLP is a national, non-profit that protects and advances the health rights of low-income and underserved individuals and families
- NHeLP advocates, educates and litigates at the federal and state levels
- Find out more: www.healthlaw.org



DISCLAIMER: Today's presentation provides a general policy overview and does not provide direct legal advice

- When an eligibility decision can be appealed
- The role of assisters in appeals
- The process for filing an appeal
- How appeals decisions are carried out

- Consumers who disagree with certain eligibility determinations made by the marketplace have a right to appeal
- Consumers in the federal marketplace appeal to the **HHS Appeals Entity (Federal Appeals Entity, or FAE)**
 - Part of HHS separate from marketplace
 - Also handles Medicare appeals
- Consumers in state-based marketplaces first appeal to their state's appeals entity but can then appeal state determinations to the federal entity

What Determinations Can be Appealed

- A determination must be **final** and of **appropriate subject matter**
- Other types of issues that are not appealable to the FAE can be addressed in other ways:
 - Casework, after escalation by the Call Center
 - Appeal with the insurer
 - File a complaint with the State Department of Insurance

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](#)



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](#) and Call Center cannot help
- Information on 1095-A tax form is incorrect and the Call Center cannot help

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



What are some types of issues can be resolved through an appeal to 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

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: www.naic.org/state_web_map.htm



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

- Appealed the denial of a service with insurer and it was denied 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

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 www.healthcare.gov/marketplace-appeals/what-you-can-appeal



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
- Termination of marketplace coverage
- Denial of coverage exemption
- Denial of eligibility for Medicaid/CHIP

- Consumers in State-Based Marketplace (SBM) states can appeal the same issues to their SBMs
- Once they receive a decision from the SBM, consumers may appeal to the Federal Appeals Entity (FAE) if they disagree with:
 - ✓ The decision of the SBM eligibility appeals entity, or
 - ✓ The SBM appeals entity's refusal to reopen an appeal after it was dismissed
 - ✗ State Medicaid agency decisions by an SBM (or after an FFM assessment) are not appealable to the FAE

Reminder: States that use SBMs

CA, CO, CT, DC, ID, KY, MD, MA, MN, NY, RI, VT, WA

- The eligibility determination must be final before it can be appealed
- In the FFM, an eligibility determination that includes a request for additional information about the consumer's citizenship, immigration status and/or income is not considered final
 - These are cases that are usually referred to as having “inconsistencies” or “data-matching issues”
 - The determination cannot be appealed even if some parts of it are final

Example: What Can Be Appealed?

Jane applies for coverage:

- She is determined eligible for marketplace coverage with subsidies
- Her daughter, Ilana, is assessed eligible for Medicaid
- Ilana's application will be sent to Medicaid for a final determination



What can Jane appeal?

- ✓ Her (effective) denial of Medicaid coverage
- ✓ The amount of tax credits she's eligible for
- ✗ She cannot appeal the assessment that Ilana is eligible for Medicaid because that decision is not final
 - Jane can appeal to the state appeals entity if she disagrees with the final Medicaid determination

Family Member(s)	Results	Next Steps
Jane Taxpayer	<ul style="list-style-type: none"> • Eligible to purchase health coverage through the Marketplace • Can choose a health plan with lower copayments, coinsurance, and deductibles • Eligible for a tax credit (\$206 each month, which is \$2,472 for the year, for your tax household). This calculation is based on the yearly household income of \$30,135.00. This is the amount that you provided on your Marketplace application or the amount that came from the most recent income data sources available. 	<ul style="list-style-type: none"> • Choose a health plan and make first month's payment
Ilana Taxpayer	<ul style="list-style-type: none"> • May be eligible for Medicaid. This calculation is based on the monthly household income of \$2,511.25 that you provided on your Marketplace application. 	<ul style="list-style-type: none"> • You will receive a final decision from the [Medicaid agency name]. If you qualify for Medicaid, you won't qualify for a tax credit and lower copayments, coinsurance, and deductibles for Health Insurance Marketplace coverage.

Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

Health Insurance Marketplace

Your Eligibility Results

Review the table below for the results of your application

Example: “Temporary” Eligibility Determination

- John applied to the FFM and received an eligibility determination that says he is eligible for premium tax credits but not cost-sharing reductions
- The eligibility determination also says he must provide proof of his citizenship status



Can he appeal the decision that he isn't eligible for cost-sharing reductions?

NO. Not until the citizenship data-matching issue is resolved

- Until then, HHS considers his eligibility “temporary”
 - However, he can go back and check the income information he entered on his application and make any changes
 - If he makes changes in his application, a new eligibility determination notice will be generated and, based on the new information, his eligibility for cost-sharing reductions may change

We've successfully processed your application.

Step 1: View Your "Coverage Options at a Glance"

This section gives a quick snapshot of your eligibility. It's important to view your full "Eligibility Results" for more detailed information. Continue to Step 2.

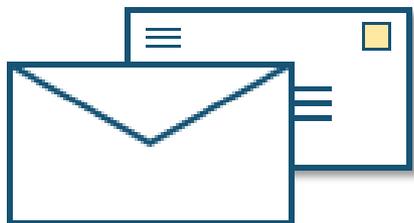
John Rogers	Eligible	For Marketplace health plans
		For up to \$534 in premium tax credits for your household

Temporary eligibility: You need to provide more information within the next 3 months to keep your coverage. View your "Eligibility Results" to learn how to submit this information.

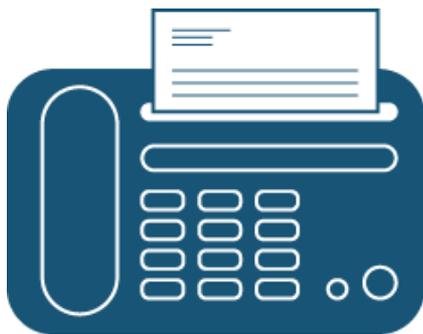
How to Request an Appeal

Ways to request a marketplace eligibility appeal:

- Complete an appeal request form (best option)
(available here: www.healthcare.gov/marketplace-appeals/appeal-forms); OR
- Write a letter explaining the reason for the appeal



→ Mail to: Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd
London KY 40750-0061



→ Fax to: 1-877-369-0129

In FFM states, appeals to the Federal Appeals Entity (FAE) must be submitted within:

- **90 days** of the contested eligibility determination; or
 - **30 days** of a notice declining to reopen the appeal after it was dismissed
- Appeal must be requested by consumer or by designated authorized representative

In SBM states, appeals to the FAE must be submitted within:

- **30 days** of the SBM appeals decision; or
- **30 days** of notice from the SBM declining to reopen the appeal after it was dismissed by the SBM

NOTE: *If 90 days has passed since the eligibility decision, consumers may be able to get an extension of time to file if they can provide a strong reason why they didn't file during the 90-day period.*

The Federal Appeals Entity (FAE) receives the appeal and determines the validity of the request

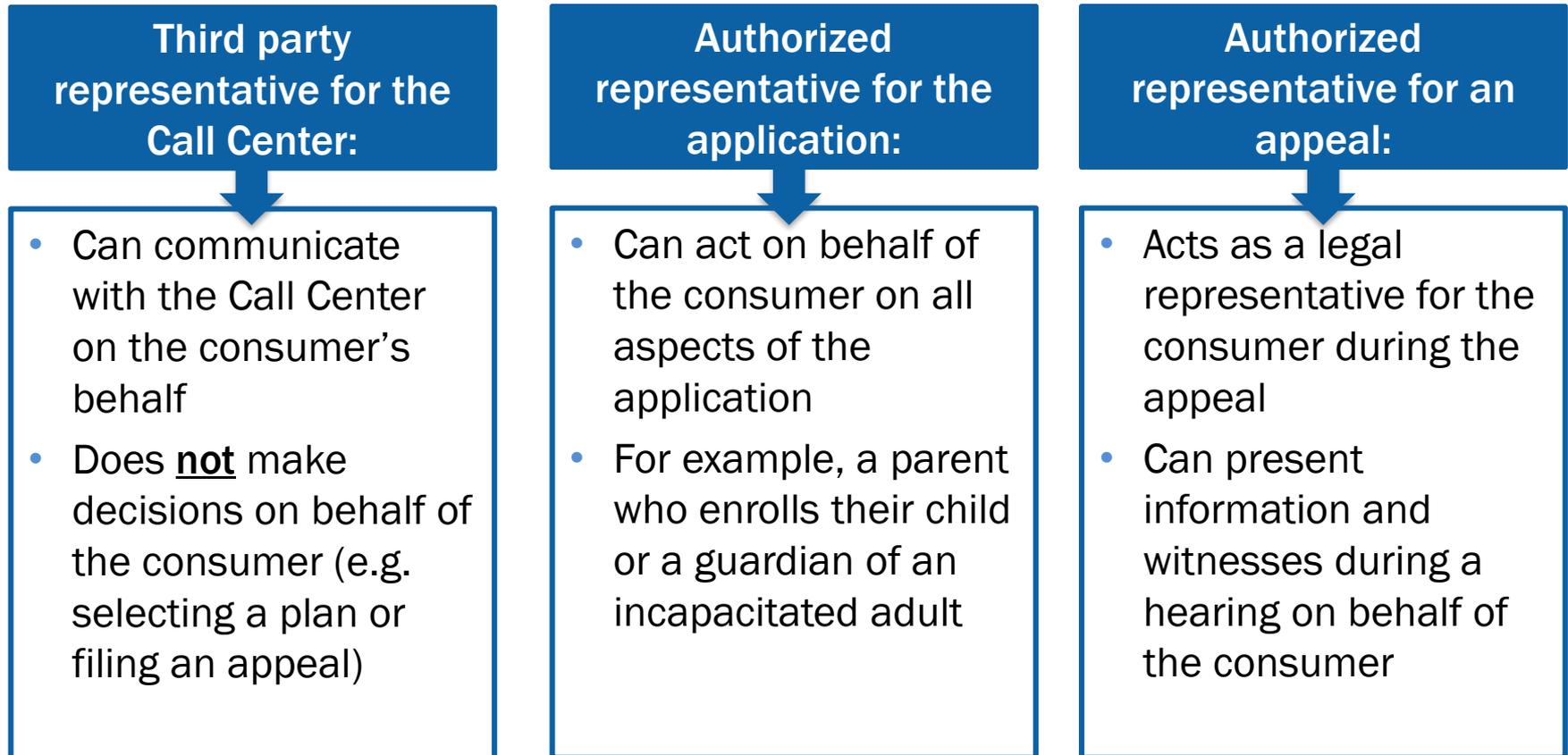
- ✓ If determined valid, the appeal is acknowledged in writing and the appeals process begins
- ✗ If determined invalid, a notice is mailed describing how to fix the problem and resubmit the appeal request

Why might an appeal be invalid?

- Filed more than 90 days after the eligibility determination notice
- Filed to contest a “temporary” eligibility determination rather than a final eligibility determination
- Filed to resolve an issue outside the authority of the FAE to resolve (e.g. whether an insurer covers a particular service)

An **authorized representative (AR)** can represent a consumer in an appeal

! **Caution:** The term “authorized representative” means different things at different stages of the eligibility process



- In the majority of appeals, the applicant represents herself, without legal assistance. A Navigator may be particularly helpful to appellants who don't have legal assistance.
- Navigators can help consumers:
 - Understand whether they have a right to an appeal
 - Understand the process of filing an appeal and what steps to take to complete an appeal
 - Access relevant marketplace resources, such as appeal request forms and mailing addresses and marketplace guidance on appeals
 - Identify and meet the deadline for appealing
 - Get information about free or low-cost legal help in their area

- Navigators should not:
 - Provide legal advice, such as by recommending consumers take specific action with respect to the right to appeal
 - Example: Navigators can help consumers understand the difference between an appeal and an expedited appeal but should not help them decide whether to request an expedited appeal
- Navigators do not have a duty to:
 - Represent a consumer in an appeal
 - Sign an appeal request
 - File an appeal on the consumer's behalf

NOTE: Navigators are not prohibited from being a consumer's AR but activities as an AR must be separate from Navigator duties and can't use Navigator grant funds to act as an AR

Example: Authorized Representative

- Ashley was unable to resolve her case through casework and now needs to appeal
- David helped Ashley file her appeal and followed up with the Federal Appeals Entity to make sure her appeal request was received
- The informal hearing is scheduled in a few weeks



Can David participate in the hearing on Ashley's behalf?

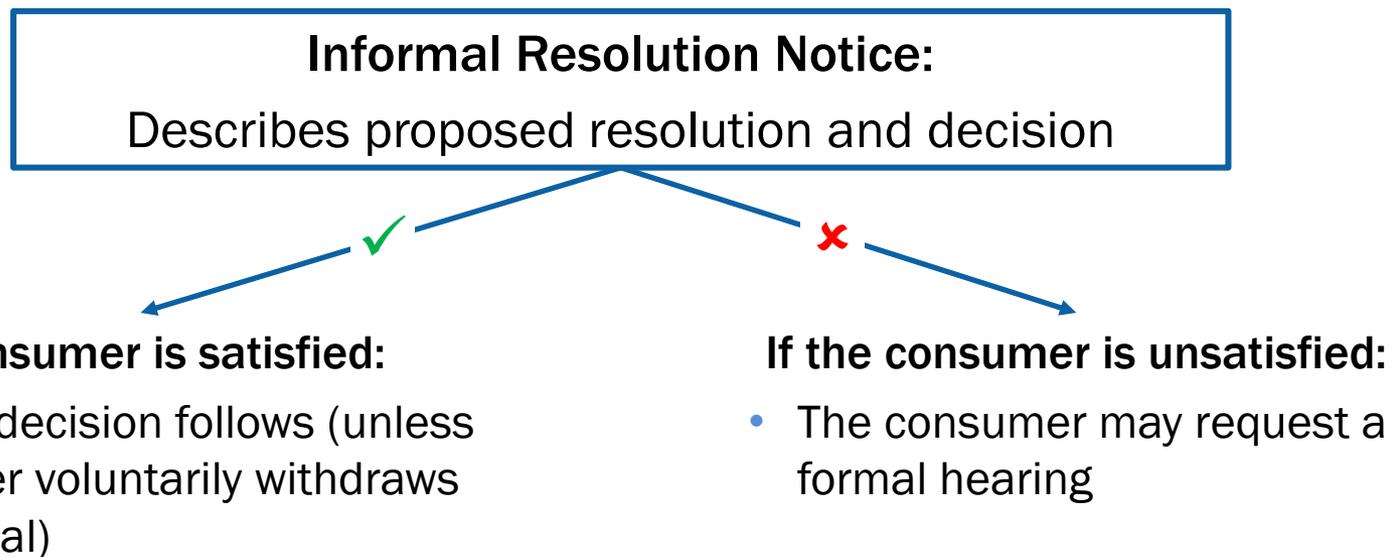
In a limited way.

- He can participate as a witness on Ashley's behalf during the hearing but if he is not a lawyer, he should not act as her authorized representative
- NOTE: Since Ashley's legal rights are at stake, she may want to have an attorney represent her
 - She can contact her local legal aid organization to see if she may qualify for free legal assistance: [lsc.gov/what-legal-aid/find-legal-aid](https://www.lsc.gov/what-legal-aid/find-legal-aid)

Appeals Process and Implementing Eligibility Decision

The FAE works with appellants to resolve eligibility appeals informally:

- Reviews facts and evidence
- Phone conversation with consumer (and authorized representative)



If the consumer is dissatisfied with the outcome of the informal resolution, case proceeds to a formal hearing:

- Written notice will be provided by the FAE at least 15 days prior to the hearing date (unless appeal is expedited)
- Conducted by telephone
- Federal hearing officer presides over the hearing

The Federal Appeals Entity conducts a “de novo review,” which means a fresh start for the consumer that doesn’t defer to the marketplace’s determinations

- Consumers can bring witnesses and present evidence
 - Have right to review the appeals record before and during the hearing (must request record in writing)
 - Consumer and witnesses provide testimony under oath

- Appeals can be expedited when the standard timeframe “could jeopardize the appellant’s life, health or ability to attain, maintain or regain maximum function”*
- **Request for an expedited appeal needs to be noted on appeal request**
 - If a consumer’s circumstances change, can request expedited appeal after submitting an appeal request
- If a request to expedite is denied, the FAE must:
 - Provide written notice of the reason for the denial
 - Consider the appeal under the standard timelines

Example: Expedited Appeal

- Diane had her APTCs terminated due to an income data-matching issue that wasn't resolved
 - She wants to file an appeal but while the appeal is pending, she will have to pay 100% of the premiums to maintain her coverage
- **Paying 100% of the premiums would be a financial hardship for Diane**

Can she request an expedited appeal?

NO.

- Financial hardship alone is insufficient to request an expedited appeal



Example: Expedited Appeal

- Diane had her APTCs terminated due to an income data-matching issue that wasn't resolved
 - She wants to file an appeal but while the appeal is pending, she will have to pay 100% of the premiums to maintain her coverage
- **But what if Diane has a chronic condition and needs monthly medication to maintain her current health status**

Can she request an expedited appeal?

YES.

- If Diane does not get her medication, her health may be at risk so she can request an expedited appeal



- Following the hearing, the Hearing Officer makes a decision based on the testimony, other evidence and the applicable legal rules
 - The decision is in writing and must be issued within 90 days of the date the appeals request is received (as “administratively feasible”)
- **The decision is final and binding but may be subject to judicial review**

If the appeal is successful, the consumer has two options:

- Have the decision implemented on a **prospective** basis
 - Change would be effective following regular effective date rules (e.g. if select a plan prior to the 15th of the month, coverage effective on the 1st of the following month)
- Request **retroactive** implementation
 - Change would be effective back to the coverage effective date the consumer did receive or could have received if the consumer had enrolled in coverage under the initial eligibility determination
 - **Note:** For retroactive coverage, the consumer has to pay his share of the premiums and cannot choose a different retroactive date.



Implementation may take additional follow-up with Call Center and/or issuer to ensure effectuation

Example: Retroactive Coverage

- Mei was denied APTCs for coverage that would have started on January 1, 2015
- She appealed the denial and was paying the full premium from January-June 2015 to keep her health coverage
- She won her appeal

Can she get retroactive APTCs back to January?

YES.

- Mei can choose to have the APTCs applied retroactive back to January 1, 2015 (or she can claim these on her 2015 tax return)
- If she receives retroactive APTCs, her insurer can either refund her excess payments from January-June or apply the retroactive APTCs to future months, reducing Mei's payments from June forward.

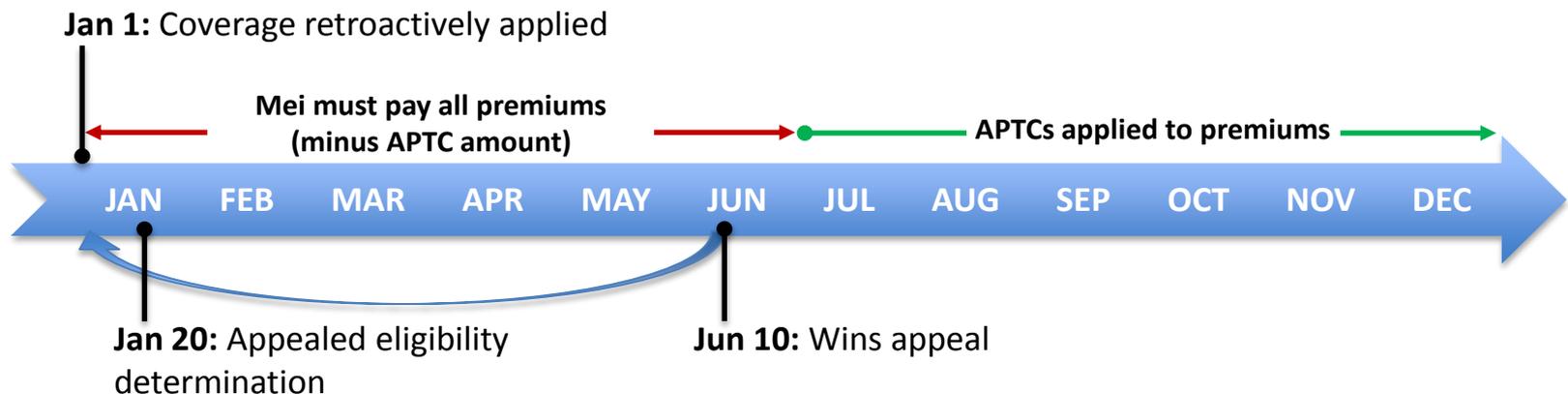
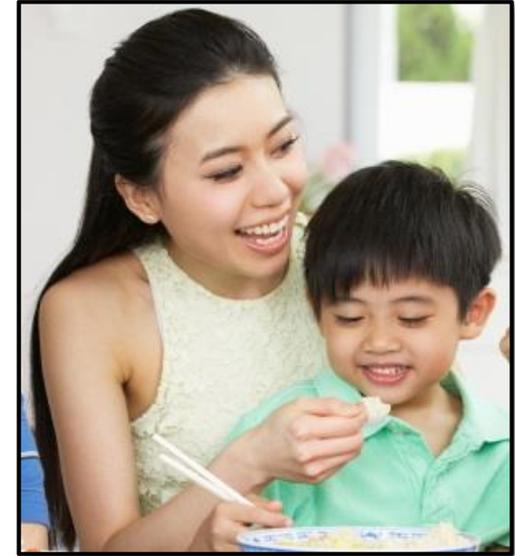


Example: Retroactive Coverage

→ But what if Mei didn't enroll in coverage during the appeal process?

Can she get retroactive coverage dating back to a date of her choosing (and only pay premiums for those months)?

- She cannot choose the month when retroactive coverage will start
- If she wants retroactive coverage, it will start January 1 and she will need to pay all the premiums owed from January – June



- Benita's husband has affordable insurance through his work but the cost to insure Benita is too expensive
- She falls in the "family glitch"
- When she applies to the Marketplace, she is denied APTCs



Can she appeal the denial of APTCs?

YES, but...

- This is an appealable issue because it is a disagreement with a final eligibility determination
- However, the appeal will be unsuccessful because the determination that Benita is ineligible for APTCs due to the family glitch is based on the law rather than an incorrect application of the eligibility rules (that is, she can't win her appeal because the ACA does not allow consumers in the family glitch to receive tax credits)

- **Marketplace Call Center** can explain how to request an appeal
 - Call 1-800-318-2596 (TTY: 1-855-889-4325)
- **Marketplace Appeals Center** can answer questions about a specific appeal
 - Call 1-855-231-1751 (TTY: 1-855-739-2231)
- **Finding an authorized representative:** Low-income consumers may be eligible for free legal assistance: [lsc.gov/what-legal-aid/find-legal-aid](https://www.lsc.gov/what-legal-aid/find-legal-aid)

Key Points to Remember

- ✓ Consumers can write a letter, complete an appeal request form and mail or fax the request to the Federal Appeals Entity
- ✓ The Marketplace Appeals Center will try to resolve eligibility appeals informally
- ✓ Appellants have a right to a hearing if they remain dissatisfied with the informal resolution
- ✓ Decisions are mailed within 90 days of receipt of the appeals request as administratively feasible

- Healthcare.gov VIDEO: *Marketplace Matters: Appeals*
www.youtube.com/watch?v=mrjpEkRohpE
- How to appeal marketplace eligibility:
www.healthcare.gov/marketplace-appeals/ways-to-appeal
- Marketplace decisions you can appeal:
www.healthcare.gov/marketplace-appeals/what-you-can-appeal
- Marketplace appeal forms:
www.healthcare.gov/marketplace-appeals/appeal-forms

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For more information and resources, please visit:

www.healthreformbeyondthebasics.org

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