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Welcome

Good afternoon everyone. My name is Melissa MacLean and I will be your host today. I am with the CMS Consumer Support Group. Before we start the presentation I want to cover some technical details. First of all, all of our lines have been muted so that everyone can have a good learning experience. If you are listening through your computer speakers and happen to have any audio issues or the slides do not advance, please try to refresh the webinar. The refresh webinar icon looks like two arrows and it is the third icon in the road near the volume bar. If you continue having issues and refresh didn't help, you can log out of the webinar and log back in. Sometimes that helps to reset things. You are always welcome to join us via the telephone. Instructions for that are included in the alternate audio tab. If you have questions during the presentation and would like to ask them, please type them into the ask a question tab and we will see if we can take any of those questions. I will now turn our conference over to Michelle Koltov. Michelle please go ahead.

Great. Thank you so much Melissa and good afternoon everyone. Thank you for joining us today and welcome to our biweekly assister call. My name is Michelle Koltov and I am the technical assistance

team lead in the Division of Consumer Advocacy and Support for the Marketplace. As reminder, this call is intended as technical assistance for assisters. Is not intended for press purposes and is not on the record. If you are a member of the press, please email our press office at press@cms.hhs.gov. Please note that the information in this webinar is informal technical assistance for assisters and is not intended as official CMS guidance.

Today we have some special guests from the CMS Marketplace Appeals Group in the Office of Hearings and Inquiries for a deep dive on understanding Marketplace eligibility appeals. Before we get into our first presentation we have a few Marketplace updates to go over. Just as reminder, if you have any questions throughout today's presentation, please feel free to submit them through the webinar chat feature.

Marketplace Updates

Failure to Reconcile SEP

First, we wanted to let folks know that as of February 5th, CMS is providing a Special Enrollment Period, or SEP, to consumers who don't have Marketplace coverage due to failure to file and reconcile. Specifically this SEP is for consumers who are not currently enrolled in 2016 coverage through the FFM, are not receiving advance payments of the premium tax credit (APTC) in 2016 because they failed to file a tax return for 2014 and reconcile their APTC, but subsequently did file their 2014 tax return and reconciled their 2014 APTC. The SEP will be available to consumers only after they restore their eligibility for APTC by filing a 2014 tax return, reconciling APTC paid on their behalf in 2014, and returning to the Marketplace to attest to having filed and reconciled 2014 APTC. This time-limited special enrollment period is available through March 31, 2016. More information about this was included in last week's newsletter and you can view the full announcement in the link provided on the slide.

Tax Season Spotlight

As we approach the April 15 tax deadline, we know a lot of assisters have tax-related questions. As you are probably already aware, the Marketplace mailed all of the 1095-A forms as of February 1st and the deadline for insurers and other coverage providers and certain employers to provide forms 1095-B and 1095-C has been extended to March 31st. But if you're working with consumers who have not yet received their 1095-A form, please advise them to wait to file their 2015 income tax return until they receive their 1095-A. However, there is no need to wait for forms 1095-B or 1095-C in order to file. We also remind you to advise consumers to carefully select their own tax preparers that they use to help to file their taxes. You can view a complete guide to the 2015 health coverage and your tax status by clicking on the link provided on the slide.

Assister Help Resource Center (AHRC) Open through April 15th

As a reminder, we still have our Assister Health Resource Center open and it will be open through April 15th from 9 AM to 6 PM Eastern Time, Monday through Friday. Assistors can reach the AHRC via telephone. The phone number is on the slide and it's 1-855-811-7299 as they conduct their post-enrollment activities such as helping consumers with their 1095-A forms and enrolling in special enrollment periods.

Reminder: Payment Required to Complete Plan Enrollment

Our last Marketplace update - we just want to encourage assisters to remind consumers that they must select a plan and submit their first premium payment in order to confirm their enrollment. Specifically consumers should check with their insurance company to find out when their first premium is due, pay

their contribution to the first month's premium to the plan directly - it should not be paid to the Marketplace. Carefully review their member card and other materials the plan sends them, confirm that the correct household members are covered by the plan and contact their plan if any questions come up or they don't receive their membership card.

Understanding Marketplace Eligibility Appeals

That's it for our Marketplace updates for today. For our presentation we are joined by our colleagues Jill Goss and Hillary Dalin from the Marketplace Appeals Group in the CMS Office of Hearings and Inquiries for a deep dive on understanding Marketplace appeals. As a reminder, you can submit your questions through the webinar chat feature and we'll try to answer them at the end of today's webinar. Jill?

Great. Thank you so much Michelle. And thank you all of you for joining this call today about Marketplace eligibility appeals. As Michelle mentioned, I am joined by my colleague Hillary Dalin whose voice you will hear intermittently through the presentation.

Let's begin, on slide 2, what can consumers appeal? We know consumers do appeal lots of different things including things that we really don't have any jurisdiction over. We are going to focus mostly on all the things that the regulation permits consumers to appeal. That is our scope of jurisdiction. There are a lot of other remedies that might be available to consumers if they are grieved about something other than what is appealable under the regulations. It's important for you as assisters to understand that because we want to make sure consumers problems get resolved and make sure that their complaints are directed to the right place.

Obviously if they have an issue over which we do have subject matter jurisdiction, we absolutely want to have those issues brought to us as appeals.

Let's begin on slide three. What are all the things that the regulations provide in terms of what is appealable? Essentially, what we're talking about are eligibility determinations that are made by the Marketplace. Today we will focus mostly on the Federally-facilitated Marketplace – although I think a few slides will just touch on SBM's, or State-based Marketplace appeals but by and large today's presentation focuses on the Federally-facilitated Marketplace.

Consumers can appeal to us if they received an eligibility determination about their eligibility for qualified health plan including a catastrophic plan. They can also appeal to us about advanced payments of the premium tax credits or APTC as well as cost sharing reductions. I would say by and large this is our highest volume of appeals where consumers are coming to us because they are aggrieved by the amount of premium tax credit and cost sharing reductions that the Marketplace has found them eligible for.

So Jill, what if I'm a consumer and I live in a Federally-facilitated Marketplace state and I applied and I got an eligibility determination that gave me some advance premium tax credits, but I think that a mistake was made and I should've gotten more? Is that something would be subject to an eligibility appeal or is there something else I should do?

Absolutely. In the case that you just described, here is a person who went to the Marketplace and got an eligibility determination that provided them maybe some assistance, but they want more of that assistance. That absolutely is an appeal over which we would have jurisdiction.

Thank you.

Moving on to slide number four. What else is appealable? Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) and there is a provision here. What we're talking about is that would only apply for residents of certain states that have delegated to the HHS appeals entity appeals of certain types of Medicaid determination made by the Federally facilitated Marketplace. Let's unpack that because there is a fair amount in that statement. We know that the Federally-facilitated Marketplace either makes determinations or assessments of eligibility for Medicaid and CHIP. In the handful of states for which the Federally-facilitated Marketplace is making determinations of eligibility and almost all of those cases we as the HHS appeals entity have jurisdiction and the authority to adjudicate those determinations of eligibility. So those eight states are Alabama, Alaska, Arkansas, Montana, New Jersey, Tennessee, West Virginia, and in the case of Medicaid -- Wyoming.

So for all of those states, if the consumers in that state, let's say for the sake of argument, got a determination of eligibility for QHP, qualified health plan, and premium tax credit, but did not get Medicaid and believes that they should be eligible for Medicaid, they can appeal to us directly. When they do appeal to us, they have a choice. They have a choice about whether they want their appeal heard by their state fair hearing entity or if they want their appeal to be adjudicated by us at the HHS appeals entity.

Let's further unpack this with a few questions. For people who live in the states I'm about to mention, these were sort of selected deliberately, meaning no offense to anyone who lives in these states. We love these states, OK. First, I live in Tennessee and that's one of the states you just mentioned. I applied through the Federally-facilitated Marketplace and I got an eligibility determination notice that says I'm eligible to enroll in a qualified health plan but it didn't give me any subsidies. I really think that I should have Medicaid. I am reading this thing to be a denial of Medicaid. Is that something I would appeal through the HHS appeals entity?

Yes you can.

And if I decided that actually I did not want the HHS appeals entity to hear my case but I wanted a Tennessee fair hearing, how would I indicate that to you? And what would you do about that?

You can certainly indicate that to us in your appeal request. If you go to HealthCare.gov and you locate our appeal request form for these states, you will see on the form that there is a place for the consumer to indicate that they want their Medicaid appeal to be heard by their state fair hearing entity.

Okay. So now, I've suddenly switched my residency and I don't live in Tennessee anymore. I live in Illinois. I got an eligibility determination that looks to me like it's either telling me I have Medicaid or I will get Medicaid and I don't understand it. Have I been granted Medicaid in which case I'm fine or has the Federally-facilitated Marketplace denied Medicaid? In which case I want to appeal. What's the situation here? Can I appeal this thing that says Federally-facilitated Marketplace thinks that I'm eligible for Medicaid?

In that situation a final determination of Medicaid eligibility has not been made by the Federally-facilitated Marketplace. That final Medicaid eligibility determination would be made by that state Medicaid agency in Illinois and would be responsible for issuing eligibility determination for Medicaid.

And there would be appeal rights afforded to that consumer and they would have to appeal through that Medicaid state fair hearing entity.

So again - just remembering the facts that I just presented: I live in Illinois, I got an eligibility determination from the Federally-facilitated Marketplace and it says, we the Federally-facilitated Marketplace think that you are eligible for Medicaid. I should not appeal to the HHS appeals entity?

That is correct.

I should in fact go to the Illinois Medicaid agency because they are going to do the final determination of Medicaid eligibility for me.

Correct. And they will be responsible of informing you of your appeal rights through the state.

Ok. Great.

All right. So now that we've talked about Medicaid and CHIP appeals, what else is appealable? You can appeal your eligibility to enroll in a Marketplace qualified health plan outside of the regular open enrollment period. Here we're talking about appeals we see from denials of special enrollment periods. You can also appeal your eligibility for an exemption from the individual shared responsibility payment requirement. In the 13 states that operate their own State-based Marketplace, they do have limited jurisdiction here - where consumers in those states are afforded special appeal rights through us as the HHS appeals entity. Those consumers can appeal their SBM eligibility appeal decision, or they can appeal the SBM's decision to deny the consumer's request to vacate a dismissal of their eligibility appeal.

Moving on to the next slide.

How does someone appeal to us as the HHS appeals entity? As I mentioned earlier we have appeal request forms that are available on HealthCare.gov. You can go to the website that is listed on the slide, or you can simply go to HealthCare.gov and type in appeal in the search bar. That's what I typically do to locate our appeals page where the appeal request forms are located. We do have forms that are specific to the state in which the consumer lives. You can locate your state and complete the appropriate form.

Alternatively you can write a letter to us that explains the reason why you are appealing so you are not necessarily confined to using the form. And then once you do put together your appeal request, you need to get it to us and there are two ways to do that. You can either mail it to the London Kentucky address or you can fax your completed appeal request to the telephone number provided.

Something to keep in mind that is unique to this mailing address - if you look at the ZIP Code plus 4 extension you will see that the numbers are 0061. That uniquely identifies for us an appeal request. You might recognize this London, Kentucky address because that is where consumers submit documentation for resolving inconsistencies or data matching issues. They also can submit their appeal request to that address. If they do, we would encourage you all to make sure you are using that 0061 plus 4 ZIP Code extension.

I will ask this later. Sorry everybody.

What happens when we get an appeal request? The HHS appeals entity which we refer to as a Marketplace appeals center, we will be reviewing that appeal request to make sure that the appeal request is valid. What do we mean when we say the appeal request is valid? What we mean here is that it is timely and we are receiving it within the timeframe prescribed by our regulations which is 90 days from the date the eligibility determination that the consumer is appealing and in the case of the state-based Marketplace appeals, they have 30 days to get their appeal requests into us. We are also making sure that it's a matter over which we have subject matter jurisdiction which we covered in slides 3 and 4. We are also making sure that the right person is asking for the appeal. So what we are looking for is really making sure that it is the consumer asking for the appeal or the consumer's designated authorized representative. We will talk a little bit about this later but essentially, consumers have the ability to appoint someone to stand in their shoes during the appeal. They do that by submitting a document in writing with their signature that essentially gives consent to the individual to represent them in the appeal.

This is where I want to ask a question, Jill. I want to file an appeal and it's about one of the problems that you already described. There is jurisdiction. I file my appeal request and then I realized that I really don't want to do this alone. I want someone to help me. What do I do?

So what you can do is, you can call the Marketplace appeals center and ask them to send you a form. It's called, the title of the form is appoint an authorized representative for my appeal. You can complete that form and send it in either through the mail or by fax. You can also locate that appointment form on [HealthCare.gov](https://www.healthcare.gov). I believe it's the section called getting help with your appeal. You would complete the form and send it in directly to the Marketplace appeals center. There is an address provided on that form. If you are already known to us as an appellant, as a consumer and you want to have someone stand in your shoes during the appeal, then you would just send in that form to us. That address is in Pittston, Pennsylvania.

But if I know right when I file my appeal request, Jill you have been helping me all along and I want you, not just to help me with enrollment, but I also want you to help with the appeal. Would I do the same thing and still mail it to the Pittston address?

Let's just say in this scenario, right at the outset, you know you want to have someone stand in your shoes during the appeal. What you would do, along with your appeal request, you would include this appointment form. Again, that appointment form is available on [HealthCare.gov](https://www.healthcare.gov). Or if you don't want to complete that form, you can just write a letter that includes basically your written consent which you would sign, naming the person that is going to be serving as your authorized representative. Both of those documents could be sent in to London, Kentucky or they can be faxed at the number provided earlier.

Okay.

So what happens when an appeal request is invalid? It can be invalid – any - for any one of the aforementioned reasons. It wasn't timely, it wasn't a matter over which we had jurisdiction or it – the appeal request wasn't submitted by the right person. If it's the case where about a matter over which we don't have jurisdiction, what we're going to do is we're going to send you a notice letting the consumer know that essentially they have submitted something to us that we just don't have the ability to review as an appeal. They have the ability -- what we call secure [indistinguishable] -- and resubmit the appeal request to us. Assuming they do that, and let's just say maybe they initially said, they really

don't like their plan and that was the appeal reason. And we say well that's all well and good that you really don't like your plan, and we let them know that is not an appealable reason. But then they tell us in a subsequent appeal request, that it's not really about that. It's because they weren't permitted to switch their plan and the Marketplace had denied them a special enrollment period. Well in that case that is a matter over which we have subject matter jurisdiction and we would be able to accept the appeal.

Jill, if we can go back just a second. I wanted to just post another question about who can request an appeal, for it to be a valid appeal request. The question is, if I'm the second or the third person on the eligibility determination notice. So I'm not the first person. But I'm the second person let's say – I'm the spouse of the person but I'm on that eligibility determination, I'm just not the first one on there. Am I a proper person or party to request an appeal? Or do I have to go only through the first person?

Yes. You absolutely can file an appeal in that circumstance. Essentially you are appealing your own eligibility determination.

So one nuance here I wanted to talk about is that we know there is this timeliness issue. You have 90 days to submit your appeal request. What happens if you are appealing on day 90? And you didn't necessarily articulate a reason that we have the authority to adjudicate as part of an appeal? In that situation, we're not going to tell that person – well sorry, not only did you not submit a valid appeal, but you don't have any time to cure the defect in your appeal request. What we're going to instead do is, provide that consumer an additional 15 days to be able to get back to us to cure, to restate their appeal and hopefully articulate a reason that we are allowed to accept their appeal.

Moving on to slide 7. Once we have reviewed the appeal request and determined that it is a valid appeal, meaning it's timely, it's been requested by the right person and it's about a matter over which we have jurisdiction. What will that consumer get from the Marketplace appeals center? They will get something called an acknowledgment notice. Essentially what we're telling them, we have accepted their appeal. We are assigning them an appeal case ID, a number that begins with APL – it's usually APL dash and then some number. So that's going to enable them to uniquely identify their case. We will lay out for that consumer what to expect throughout the appeals process. And give them instructions on submitting information to us if they so choose. We also tell them that they should from this point forward, any time they are sending information to us, to include their appeal number on their documentation.

Before I move on to the next slide, I just want to mention one quick thing that is new for us or folks may be seeing more of. You will notice in the acknowledgment notice we're sending, that we are now giving consumers information about how to request eligibility pending appeals. This is a requirement. This is something that essentially gives consumers who are appealing, the ability to ask for the assistance that they were getting prior to the change in their eligibility for that same level of assistance to continue during pending their appeal. They will be informed of their right to ask for eligibility pending appeal and there are time frames specified in their acknowledgment notice for them to do just that.

Slide 8. Here we talk about informal resolutions. It shouldn't come as a surprise to anyone that we have a preference for resolving our appeals informally. Informal resolution, for us typically involves us looking at all of the evidence in the consumer's eligibility record. Anything that the consumer may have submitted when they got their eligibility determination from the Marketplace. Basically what they said in their application. We are obviously looking at their eligibility determination notice that they are

appealing and anything else that might help give us a sense of what is going on. We are also looking closely at the appeals request that they submitted to see what arguments they're presenting to try to pin down what exactly they believe is wrong with their eligibility. We are considering any evidence that they may be submitting or additional documents they may be submitting that they want us to consider as part of their appeal.

We will interact with consumers by phone as well as mail. At the conclusion of informal resolution, we are sending what's called a notice of informal resolution that essentially lays out for the consumer what exactly we found in our review. What our understanding of the issue and then obviously proposing resolution to the consumer on how we would address their appeal. They can express dissatisfaction with that informal resolution resolve. And if they do that, they simply need to ask for a hearing. That moves us to the next stage of the appeals process.

There are some questions. First of all, there are 90 days to ask for an appeal? Is that 90 business days or 90 calendar days?

That is 90 calendar days and it's counted from the date of the eligibility determination notice that they are appealing.

Excuse me everybody, I'm going to do a little shop talk year. Somebody is asking about eligibility pending appeal, you want to save that one for later?

Sure I touched on that a little earlier.

OK so let me ask this one then. When with somebody who is asking for an eligibility appeal, when would they be able to keep their same advance premium tax credit during the pendency of the appeal? Could you go over that again?

I will go over that in a bit more detail. As I mentioned earlier, we are now informing consumers of their ability to ask for pending eligibility appeals. That information is included in their acknowledgment notice. Keep in mind, the opportunity to ask for eligibility pending appeal is limited by regulation to individuals who are appealing from a redetermination of eligibility. That presumes that the person had been enrolled in coverage and had been receiving some either APTC or APTC CSR. That really is the basis upon which we would determine someone eligible for eligibility pending appeal.

It would not include individuals who are appealing an adjustment that occurred because of an expiration of a data matching issue. We know these are appeals we often see in our inventory. They are consumers obviously who have applied to the Marketplace, get an eligibility determination for APTC CSR and have a data matching issue that is unresolvable or for some reason doesn't get resolved and so they experience an adjustment in their eligibility, often losing their premium tax credits and cost sharing reductions. That is not a situation where we are able to continue someone's eligibility for APTC CSR. It was provisional pending the resolution of that inconsistency. I wanted to clarify that up front. Not everyone is going to be eligible for eligibility pending appeals. Let's say someone is eligible and they get an acknowledgement notice that tells them how to request eligibility pending appeal, they will be informed that they should call us in a certain time frame to request it and when they request it, we will actually notify their issuer that they are to continue the APTC CSR that they had been getting all the way back to the effective date of the adjustment. So it actually would have a retroactive effect for them. They would continue getting that APTC CSR until we reach a decision on that appeal.

Hopefully that answers the question. We can go back to it if we need to.

The next stage of appeal is the hearing. As the slide indicates, hearings are slightly more formal than an informal resolution. These are conducted by telephone and presided over by a federal hearing officer. Appellants and instructed or consumers are instructed to call in at the appointed time of their hearing. They are given written notice in advance of their hearing so they know exactly when that hearing is taking place and how to call in for that hearing. As this slide indicates, there is an ability for consumers to ask that their appeal be expedited and they can do that anytime during the appeal but certainly we see most often that occurs at the outset. The standard we apply here is that they can ask for or they qualify for an expedited appeal, is the standard timeframe for adjudicating the appeal jeopardizes the appellant's life, health, or ability to attain, maintain, or regain maximum function – so it's a fairly broad definition.

So Jill, if I need surgery pretty soon, would that qualify me for having my appeal done faster?

Yes.

What if I have a cold?

This is a fairly broad definition. If you have a cold, we might ask you a few questions about that. Even people with colds, we want to know if it's bacterial that could worsen and develop into something more serious. I don't think we necessarily want to make any assumptions about this. Obviously, we are trying to be sensible and reasonable here. We want to preserve this right to people who need it. We would just ask people to be mindful of that. As a general rule, I think surgeries, in my mind sort of stands out as a reason, I wouldn't necessarily discount say a cold as disqualifying someone from an expedited appeal but I think we would just look at that more carefully.

If there are questions – if somebody says they believe they qualify, but under the standard they qualify for expedited treatment but it's not clear. We would call them, we would be in touch with them to ask more questions to reach our determination about whether they can be expedited?

Yes. Absolutely.

Moving on to slide 10. This is where we get to an appeal decision. After the hearing concludes, the hearing officer will be considering the evidence in the record as well as testimony provided by the appellant and any of the appellant's witnesses. They will be rendering their appeal decision. Our goal – and obviously this is what the regulation contemplates – is that we would be issuing decisions within 90 days of our receipt of the appeal request or as administratively feasible. All of us would like to be able to meet that 90 day goal. For those of you who have been involved in appeals, you may have seen it take longer than that but just know that is certainly our goal. The decision itself is final and binding. You've basically exhausted your administrative appeals right at this stage.

Two questions here, Jill. When I'm in my hearing, is my hearing officer going to tell me what my decision is during the hearing?

We hope not.

Why not? Why wouldn't we do that?

We don't want officers to come into the hearing prejudiced in any way. We want them to be prepared and understand what is currently in the record. And have a sense of what questions they need to ask. We don't want them to drawing premature conclusions. We find that there is new information that is uncovered through the hearing and that needs to be considered. Frankly, we want to give the hearing officers the ability to consider all of the evidence before reaching conclusions and issuing decisions.

When you say the decision is final and binding and it exhaust administrative remedies, what if I get my decision and I think it is wrong?

You are certainly entitled to feel that way. The regulation contemplates is the ability for a consumer to ask for judicial review. Beyond that, our regulation just don't expand on how one goes about seeking judicial review and what the court of jurisdiction would be. In time, maybe that will be known. But for the time being, that's not.

So now we're on slide 11. We have an appeal decision, and let's just say for the sake of argument that this is an appeal decision that finds in favor of the appellant. There is some relief that's been provided by the decision. It needs to be implemented. As the slide indicates, if the decision finds that the contested eligibility determination was incorrect when it was made by the Marketplace the appellant can decide to have the decision implemented retroactively back to the date of the contested eligibility determination or prospectively. Really what we're saying here is that an appellant really does need to raise his or her hand if they want to have their decision implemented retroactively.

They do that by calling the Marketplace appeals center and asking for a retroactive effective date. There are situations where consumers may want to consider having a decision implemented retroactively. For example if they weren't enrolled and they couldn't afford to be enrolled without the benefit of APTC and they have a decision that grants them APTC on a retroactive basis then in that circumstance they want to ask to have their decision implemented retroactively and as such they can do that. Certainly they will be required to pay any premiums they may owe for those prior months after the application of the APTC they were awarded in their decision. I think what's also important to note here, it's not as if consumers can ask for any effective date. We are constrained by our regulation which essentially says, you can have your decision going to affect prospectively the first day of the following month of your decision or retrospectively back to the date of the contested eligibility determination. In our process we look at is what would have been the effective date available to that consumer if the Marketplace had not made a mistake in the eligibility determination had been correct at the time it was made? Those are the effective dates that are offered to that consumer if they are choosing retroactivity. It's not as if they can just pick and choose what date they want their decision to go into effect.

As I just mentioned – next slide - this is effectuation of eligibility appeal decisions. The consumer may owe some money to the Marketplace plan. If they are enrolling in Marketplace coverage for an earlier date or they haven't paid their past premium balances. Or they can be owed a refund by their Marketplace plan. For example if they had been enrolled for a prior period and had been getting APTC and now their decision awards them more APTC so in that circumstance now the Marketplace would be responsible for making that consumer whole and refunding those amounts.

Jill, how long should an appellant expect an effectuation putting into effect an appeals decision would take?

We issue guidance to help insurance issuers about retroactive appeals decisions and the timeliness associated with them. The regulatory standard we go by is, they have 15 days to take action to implement that decision. The way this is communicated to the issuer is through a HICS case. In cases where we believe there needs to be an expedited handling of that decision, and of course this would include expedited appeals, issuers are required to take action to implement within 72 hours. Beyond take action to implement, I don't know if we've ever sort of drilled down to figure out exactly what this means but I will say that in our notice to consumers when we're retro-effectuating their appeal decision, I think we set out an expectation that within 30 days they should be expecting – that will be made whole. Or they will be contacted about the implementation of their decision.

What if I waited my 30 days and nothing's happened and I haven't heard anything? What do I do?

Call the Marketplace call center because that's a complaint we need to hear about and escalate accordingly.

Are there any special words I need to use to convey my concern?

I think simply my issuer isn't effectuating my appeal decision.

Magic words.

Yes that would work for us. Moving on to the next slide, 13 – where can consumers get help with their appeal? Certainly they can call the Marketplace call center. It is available 24/7. Once they submit their appeal, they can be in touch with the Marketplace appeals center. Both of those call centers have TTY numbers available.

Jill, is there anyone I cannot designate as my authorized representative?

No.

So I can authorize anybody?

Yes.

What if I authorize, and you know we've seen this, my Senator. My United States Senator.

Yes we have seen that. I think this is an area where we're going to be doing some additional work to improve upon our processes. Right now as you are saying Hillary, anybody can be appointed as an authorized representative but what we are not currently doing and we want to get into the habit, is essentially sending some sort of notice sent to the authorized representative who is accepting that responsibility to basically inform them that the appointment has been made and what that means exactly. Essentially, in serving in this role you are agreeing to stand in the shoes of the appellant. So it's a fairly serious responsibility and we will be directing appeals correspondence to that individual. We really want to make sure they have a full understanding and awareness of all of the duties serving as an authorized representative.

I will step in here with one little tip for the assisters. You can help the consumers to understand this. There have been situations where appellants' have really expected that their United States Senator is going to show up and speak for them in their hearing. It's hard on everyone when a hearing officer has to say, well your senator has not appeared. Do you want to proceed today? Do you want to put this appeal over for a little while so you can find someone else to be your authorized representative? It's hard. And you can really help consumers to be realistic with who they select as their authorized representative.

Terrific. I won't spend any time on the last slide. Maybe we can leave the remaining time for questions but here we'll just leave it to look at, key points to remember in the appeals process.

Q&A

We do have some more questions. We will go back to the beginning so to speak with some questions about what kinds of problems can be appealed. The first one I want to ask is, can somebody who is denied advanced premium tax credits, because of their expected contribution towards the premium, appeal that? In other words, is the rule about somebody's expected contribution appealable?

Yes.

Can you talk about what that appeal would look like?

Sure. In that situation – we see these a fair amount. We call them benchmark cases, essentially the consumer's expected premium contribution is less than the amount of the premium tax credit that they would be eligible for. In essence, even though they technically qualify for APTC, they are getting zero dollars in APTC. That is absolutely appealable. They would essentially be contesting the amount of premium tax credits they're getting. We look at the appeal to find out what is going on in making sure we have all the information about their eligibility is correct. In particular, we would be looking at sources of income and making sure that information is correct and then, an informal resolution, beginning to draw conclusion about that.

Let me ask that same question in a different way. Is the basis of their appeal is they don't think the expected contribution rule is appropriate? They don't think it is a good rule, what would happen to that appeal?

In that situation, we get all kinds of appeals. I think sometimes we get appeals from people saying I hate Obamacare. In that situation, unfortunately, we just don't have the ability to consider that for subject matter jurisdiction. This is an eligibility standard. If they simply don't like the law, that's not a reason why we can accept that appeal request.

Another way of saying that – would be that an administrative appeal is not the right venue to contest the legality of a law or a regulation?

Precisely.

That would likely be dismissed unless it was something else in the appeal request?

Correct.

Similar question. Can an appeal be brought to contest what a consumer believes to be an incorrect premium charge by an issuer?

No.

One more question about can something be appealed, what if the consumer wants to appeal that their qualified health plan denied them the amount of physical therapy visits that the doctor ordered?

That is not an eligibility appeal. That is a coverage appeal. They are very distinct. There are separate appeal rights afforded to those individuals. They should presumably look at their plan brochure for information about how to appeal coverage determinations.

Next is a question about expediting an appeal. Is it ever possible to have an appeal move faster because somebody's financial situation is very grave?

Potentially. I think what we would be looking for – is whether the consumer would be articulating an argument where in essence, not being able to pay for – or not having the financial wherewithal to pay for their coverage would essentially create a loss of coverage and certainly a loss of coverage is problematic for people who have medical needs that must be met. It could very well – it kind of depends on how this is articulated.

Would you say if somebody said, I need my appeal to go very, very fast because I have no money. That's all I said.

Right. In that situation we would likely have to deny the request for an expedited appeal. It's possible, in that situation, down the line, they might make us aware of the situation – let's say they have some sort of health event and at that point in time they can get in touch with us and articulate a reason why they need their appeal expedited and we would certainly consider that.

Next question has to do with minor children and whether a minor child could be designated as an appellant's authorized representative.

I will let you answer that, Hillary.

I don't think there is an iron clad rule on this actually. As far as I know there's not. I think we would subject this to a reasonableness standard. It is probably not reasonable to authorize your five-year-old and I think any parent will know what I'm saying here. On the other hand your minor child who is 17 3/4 years old, who might be more articulate in English and have familiarity with the family situation I think we probably would give that some reasonable consideration. Again I think the answer is there is no ironclad rule that you have to be 18 or over. We will look at this reasonably and an authorized representative steps into the shoes of the appellant and anyone who is appealing wants to make sure that the person is stepping into their shoes is doing that in a very responsible and serious way.

So while we're on that question of who can speak for you, do want to talk a little bit about interpreters for people who may be limited in their English-speaking ability?

Absolutely. We as a Marketplace are required to make sure that our programs are accessible to people with English difficulties. If a consumer needs a translator or other services we will make those available upon request.

Great. The next question has to do with distinguishing between casework and appeals. You mentioned setting up a HICS ticket. HICS is the health insurance case management system used to manage casework around Marketplace issues. How can you distinguish between what the caseworkers do about problems that consumers have and an appeal?

I know that the health insurance casework system or HICS is used by multiple parties. We have functionality in that system that is specific to our appeals duties. We can distinguish our communication with issuers from other communication. We code those cases as appeal decisions or request for eligibility pending appeal and the issuer should know when reviewing or opening their cases that this involves an appellant and it is not one of their other cases that might come through that casework.

I will just add a couple of tips again for assisters. Caseworkers try to solve problems and that is a very broad mandate that our caseworkers in the Marketplace have, whether in a regional office or here in our central office. An appeal is a very stylized way at looking at what has become a problem. Where we are asking in an appeals context, did the Marketplace make a correct decision or an incorrect decision when they issued their eligibility determination? That's a much narrower band. And it's one of the reasons that Jill spent so much time going over what is appealable. There's a definite scope to an appeal. Is not about solving every problem. That's one way to think about the distinction between what a caseworker does and someone who is adjudicating a Marketplace eligibility appeal would do to address the situation. And we have time for one more question.

I didn't understand that 90 day deadline for asking for an appeal. Maybe the reason I didn't understand it was, because of the language barrier. Are there any exceptions that can be made to that timeframe for asking for appeal over that 90 days?

Great question. What will happen is when we receive an appeal request and we see it wasn't timely, we move to at least under current law to dismiss that appeal. Whenever we dismiss an appeal, we send with that dismissal notice a vacate request form or what we call a request to reopen your appeal. A consumer can certainly express good cause reasons as to why they weren't able to submit their appeals request timely and in this situation you just described if someone had a language barrier and didn't understand or couldn't read in English their notice that told them they had 90 days to file their appeal, then certainly that would be considered when we review that vacate request and whether we need to vacate the dismissal and proceed with reopening the appeal.

Great. In closing, I want to say a few things. There were a lot of questions posed. We didn't get to nearly all of them. The Consumer Support Group will give us all of your questions we didn't get to. To the extent possible we will try to answer them, bearing in mind, we have tremendous bandwidth struggles so we will try and answer them with one caveat. The questions about specific individual appeals, we would encourage you, if you are the authorized representative or consumer, be in touch with the appeals center about those specific questions, we were not able to answer those. We are obligated to protect the privacy of all appellants. We will not answer those kinds of questions. We want to thank you for posing some really wonderful questions that we hope enriched the presentation Jill gave.

Thank you very much.

Thank you so much Jill and Hillary. That was wonderful. I know you guys got through a lot of questions during the presentation and after. I think everyone really appreciated that so thank you very much. As

Closer

Hillary said, they will follow up with answers to the questions we didn't get to. We will also try to follow up on some of the bigger themes and issues we heard about in an upcoming assister newsletter. As a reminder our webinars are recorded and are posted online – there's a link on your screen. If you would like to sign up for our listserv, please email and send a request to our assister listserv inbox and finally thank you again everybody for all of your hard work and we hope you all have a wonderful weekend.