Covered Clips

A Summary of News and Activities for the Cover Arizona Coalition

Weeks of June 30th and July 7th

Uninsured Rate Down Five Percentage Points Following ACA Open Enrollment

At the close of the Affordable Care Act's first open enrollment period, an estimated 9.5 million fewer U.S. adults were without health insurance, according to a new Commonwealth Fund survey—the first study to examine coverage trends as well as how people have used their new insurance.

The national uninsured rate for working age-adults dropped from 20 percent in the July–September 2013 period to 15 percent by April–June 2014. Most people with new coverage, either a marketplace plan or Medicaid, said they were optimistic that it would improve their ability to get health care. In fact, a majority of those who had used their new plan to get care or fill a prescription said they would not have been able to do so before.

The largest gains in coverage were experienced by young adults ages 19 to 34, Latinos, and low-income adults. For the poorest Americans, uninsured rates dropped significantly in the 25 states that, along with the District of Columbia, have expanded eligibility for Medicaid. In states that have chosen not to

15%

Current uninsured rate among working-age results in the US, down from 20 percent in July-September

18%

Uninsured rate of young adults (ages 19-34), down from 29 percent in July-September

23%

Uninsured rate among Latinos, down from 36 percent in July-September 2013

expand Medicaid, uninsured rates for this group are largely unchanged.

http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/health-coverage-access-aca?omnicid=EALERT513380&mid=kim.vanpelt@slhi.org

AHCCCS Enrollment Growth Remains Strong

During the month of June, 19,736 were added to AHCCCS in the Proposition 204 Restoration Category (0-100% FPL) and 4,771 were added to Adult Expansion category. To date, 192,268 Arizonans have been added since January. The total AHCCCS population now stands at 1,552,186.

http://www.azahcccs.gov/reporting/Downloads/PopulationStatistics/2014/Jul/AHCCCS_Population_by_Category.pdf

Key Findings on Survey of Marketplace Shoppers

A new national survey conducted of 1,632 shoppers who purchased coverage OR started an application on a health insurance Marketplace found that:

- Marketplace shoppers are largely uninsured.
- Nearly half did not complete the enrollment process.
- 17 percent consulted a navigator during the enrollment process.
- Those who consulted a navigator are more likely to have enrolled in person or on the phone. Having personal contact during the process significantly increases satisfaction.
- Technical errors during the enrollment process was a factor for 40 percent of shoppers who did not complete enrollment.
- One in five said the application process took too long or the Marketplace website didn't have enough information about plans.

Source: 2014 Health Insurance Marketplace Shopper Survey, JD Power, May 2014

Health Net Vows to Improve Health-Care Coverage, Service

From the Arizona Republic

Many Arizonans who chose the lowest-cost insurance plans available under the Affordable Care Act soon learned that securing the health care they signed up for wasn't as easy as flashing an insurance card at the nearest doctor's office or hospital.

Health Net sold the least-expensive plans in Arizona and dominated the market, signing up about 80,000 residents, or two out of every three who enrolled for coverage under the federal health-care law.

While its low monthly premiums appealed to consumers, Health Net's narrow choice of doctors and at-times long phone waits for customer service led to far more complaints than were filed against any other insurer.

The Woodland Hills, Calif., insurer has been named in 89 out of 110 complaints filed with the Arizona Department of Insurance since marketplace coverage began Jan. 1. Consumers most often cited Health Net's inadequate network of providers, lack of access to care, payments not properly credited and policy cancellations.

Complaints to regulators likely represent just a fraction of coverage issues, said Diane Brown, executive director of Arizona Public Interest Research Group. "Mostly, people take those (complaints) directly to the company," she said.

Some doctors, too, expressed frustration because they were listed in Health Net's online directory of network providers but had not yet signed contracts for the insurer's marketplace plans. As a result, they chose to turn away patients.

Health Net representatives acknowledged a rocky beginning for Arizona's marketplace and said the company has worked to bolster its network of doctors and improve customer service.

Since the beginning of the year, Health Net has added more than 1,300 primary-care doctors and specialists and six hospitals to bring the network to 4,500 physicians and 17 hospitals for its

popular Community Care health-maintenance organization plan. The company also has hired 120 extra customer- service representatives, partly in response to the long wait times customers complained about in the opening months of the marketplace.

"We have seen improvements in our service levels," said Brad Kieffer, Health Net spokesman. "We are looking systematically at our own processes. We are seeing these issues decrease. We do expect great improvement as time goes on."

Health-care analysts say that some confusion among health insurers, doctors, hospitals and consumers should be expected during the first year of the marketplace.

Insurance companies may offer several versions of a plan, and doctors' staffs may not ask precise-enough questions before informing a patient that the doctor is a provider.

Also, experts say, consumers may not be familiar with how to use insurers' narrow provider networks of doctors, hospitals, pharmacies and labs. If consumers go outside the network, plans pay little or nothing of their overall bills.

Health Net credits these narrow networks with allowing the company to rein in expenses and charge consumers lower monthly premiums, although it will seek to raise rates nearly 14 percent in 2015. This year, the insurer's lowest-cost HMO plans in Pima, Maricopa and Pinal counties were among the lowest-priced plans across the federal marketplace's 36-state territory.

Other Arizona insurers have faced consumer complaints over narrow networks, but those companies had far fewer marketplace customers and complaints.

Other factors, such as deductibles and co-insurance, also contribute to the overall amount a person pays for health care.

Consumer watchdogs said they expect consumers will become more savvy about how they select a plan as they learn more about how insurance works. The next three-month enrollment period starts Nov. 15 for coverage that takes effect Jan. 1.

Frustrated patients

Joan Gray VanderLaan, 63, of Phoenix said she studied the different plans listed on the federal marketplace, healthcare.gov, to make sure she picked one that was affordable and allowed her a choice of hematologists and oncologists.

But after signing up for Health Net's HMO plan in March, she said she has been unable to find a doctor who will refill her prescription for an oral chemotherapy medication for pre-leukemia. Her former doctor isn't on Health Net's plan, and she said she hasn't had any luck finding a hematologist/oncologist who knows her condition. She said she called 30 doctors before she found a primary-care physician who she hopes will help her.

"Health Net looks terrific on paper, but they don't deliver the goods," VanderLaan said. "I've had a lot of difficulty finding a provider."

She said she has a lot of bone pain and her struggle to find a doctor in a timely manner triggered a bout of depression.

"To tell you the truth, I almost gave up," VanderLaan said. "I had a feeling of hopelessness."

Kieffer said Health Net has sought to communicate directly with each customer, doctor or other provider who has questions or concerns about coverage.

"It we hear of an issue where a member lets us know there seems to be some confusion with a provider, we reach out to the provider," he said.

The confusion and frustration haven't been limited to consumers. Some doctors who were listed as "in-network" on Jan. 1 didn't sign contracts until weeks or months later. Other doctors mistakenly told consumers they were part of Health Net's marketplace networks only to turn away patients in their waiting rooms.

Jean Klien, a real- estate agent, said she picked a Health Net plan because it listed her preferred doctors, including a dermatologist at Spectrum Dermatology in Scottsdale. She even called to confirm over the phone that the provider took Health Net. When Klien drove from her West Valley home to Scottsdale for her appointment, an office worker told Klien that they didn't take her particular Health Net plan.

"They said we take the 'real' Health Net but nothing through the marketplace," Klien said.

Spectrum Dermatology office manager Donna King said the switch to the marketplace has created some confusion. The dermatology practice had contracts "across the board" with all Health Net plans a year ago, but that changed when the federal-marketplace coverage began.

Patients such as Klien began to show up with Health Net insurance purchased through the marketplace, but the practice had no signed contracts.

"I don't know if they got bombarded so fast; we just started hitting walls left and right," King said of her office's efforts to get contracts signed with Health Net. "They are slowly starting to come on board."

Spectrum has completed Health Net marketplace contracts on behalf of four of six dermatologists, and it hopes the insurer will soon complete paperwork for the practice's other two dermatologists. Spectrum office staffers also have been trained to ask more specific questions about insurance to avoid mistakenly informing consumers that they take an insurer's plan.

Pinnacle Oncology in Scottsdale told Health Net patients that doctors no longer could see them because Pinnacle's contract had not been completed. But the contract was recently finalized and those patients can return to treatment, said Susan Toris, Pinnacle's practice manager.

Health Net's Kieffer said the insurer attempts to maintain an accurate database of providers, but he said that's not always possible because circumstances change daily — doctors retire, relocate offices or cap the number of new patients.

To improve the accuracy of the provider directory, Health Net said it is making more frequent updates to better track changes and keep consumers informed.

"It's our responsibility to provide an accurate directory for everybody," Kieffer said. "We hope these issues will decrease significantly."

The Department of Insurance said that it expects all insurers to maintain accurate provider listings. If a customer obtains services from an out-of-network doctor that a health insurer lists as being part of its network, state regulators would expect the insurer to pay the claim at in-network rates, a department spokeswoman said.

Retired Phoenix Firefighter Dwayne Ketchens said he was looking for a comprehensive plan when he picked Health Net's "platinum" plan, the most expensive tier in the health-care marketplace, which purports to offer the most robust coverage.

Ketchens said he called to verify that his doctors were included in his plan, and a Health Net representative told him they were.

But when Ketchens sought an appointment with his primary-care doctor, he was told the doctor didn't take his particular Health Net plan. His pharmacy also said it could not confirm his coverage and made him pay for a prescription, so Ketchens filed a complaint with the Department of Insurance.

"I had to pay for my prescriptions out of pocket," Ketchens said.

Health Net told the Department of Insurance that the insurer had not yet completed a contract with that doctor for Ketchens' particular plan, called CommunityCare open access.

Health Net and Ketchens' doctor have since completed the contract, and the insurer also reimbursed Ketchens for his pharmacy bill, minus the required copayment.

Ketchens said it took two months and multiple calls and complaints before his coverage was squared away. Now, all his doctors and pharmacy accept his plan, and he described coverage for a hospital visit as "stellar."

He said Health Net either was unprepared or overwhelmed when the marketplace opened.

"What I found is they were poorly prepared for the job," Ketchens said. "They are not chintzy. I just wish they were better prepared than they were."

Adjustment period

Consumer watchdogs say that complaints about health-network issues are common in many states. It's a sign that insurers, providers and consumers are all adjusting to the new marketplaces.

"This will sort itself out over the next two to three years," said Timothy McBride, a professor at Washington University in St. Louis who has studied how well consumers understand health insurance. "People will put themselves into plans that they are better suited for."

Brown, of Arizona Public Interest Research Group, said consumers likely will draw on their experiences when selecting a plan for next year.

"Some will choose (plans) based on cost," Brown said. "Some will base (decisions) on network adequacy or other factors. Insurance companies should work hard to lower cost and improve services in order to remain competitive and grow their customer base."

Complaints to state

Arizona health-insurance complaints by provider:

Health Net: 89

Blue Cross Blue Shield of Arizona: 9

Aetna: 7

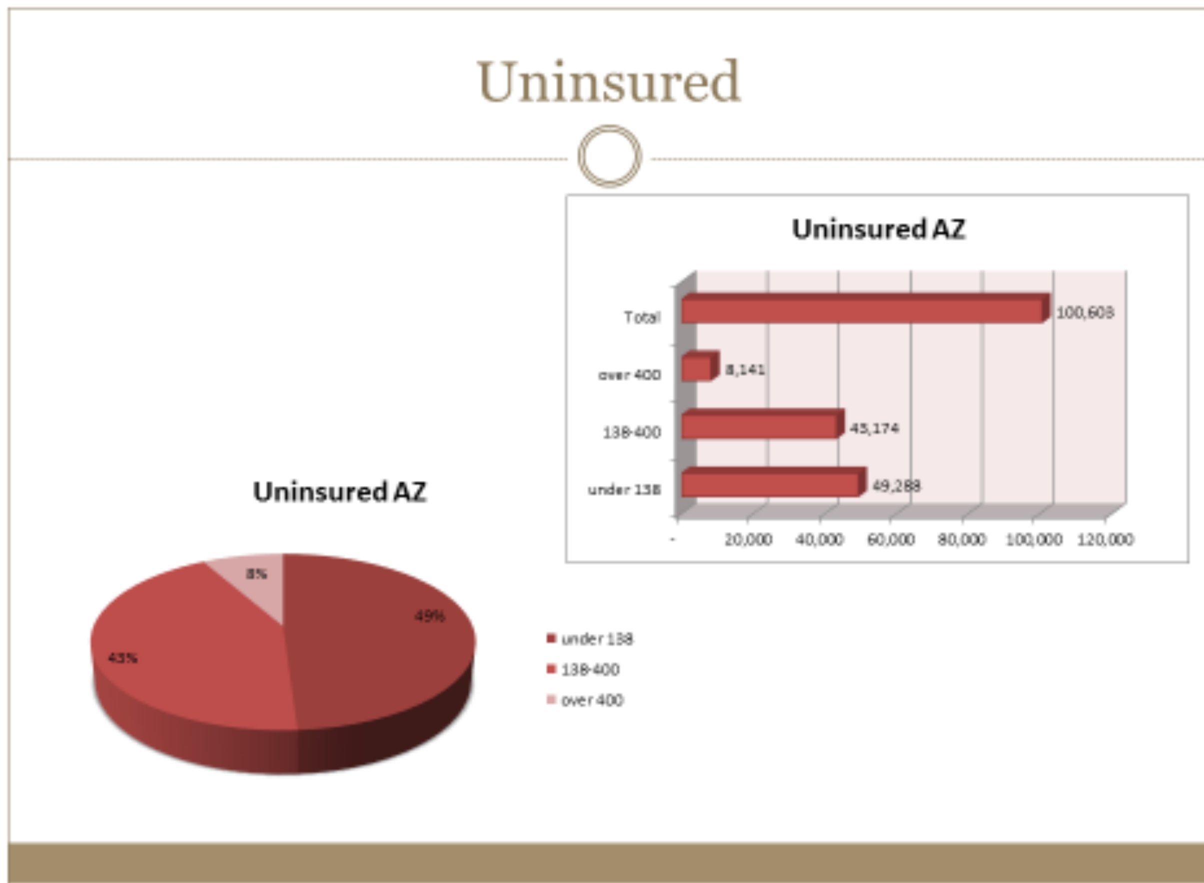
Humana: 3

Cigna: 2

Source: Arizona Department of Insurance

http://www.azcentral.com/story/money/business/2014/07/06/health-net-care-coverage-improvements/12262851/

AMERICAN COMMUNITY SURVEY ESTIMATES FOR ARIZONA ON THE UNINSURED FOR ARIZONA FOR AMERICAN INDIANS AN ALASKA NATIVES



Eligibility Appeals

From CMS:

Assisters should be aware that all consumers who filed an appeal over 30 days ago related to Marketplace eligibility should have been contacted by phone or mail by this point in time. If appellants or their authorized representatives have not heard from the eligibility appeals center, they should directly contact the eligibility appeals center at 1-855-231-1752 to check on the status of their eligibility appeal. Appellants or their authorized representatives may also contact the eligibility appeals center at 1-855-231-1752 with any questions about the eligibility appeals process or to resolve Marketplace eligibility appeals. Be sure to remind appellants or their authorized representatives that they should have their application or appeal numbers handy when contacting the eligibility appeals center.

For more information about how to appeal a Marketplace eligibility decision, please see: https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/.

FAQ on Domestic Violence

From CMS:

Q: If a consumer is a victim of domestic violence and called the Marketplace Call Center to share that they were a victim or survivor of domestic violence prior to June 1, but the Call Center didn't grant them a SEP, what should they do?

A: As an assister, you may be in a position to help a survivor of domestic violence apply for coverage and enroll in a Marketplace health plan and obtain advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs), if eligible. In some situations, a consumer may tell you that they are a survivor of domestic violence and that they assumed or were informed that advance payments of the premium tax credit (APTC) were unavailable to them because they are married and not filing a joint tax return with their spouse. This may occur with consumers who may or may not have attempted to apply.

CMS had established a limited special enrollment period (SEP) to ensure that eligible consumers who are survivors of domestic violence can enroll in a qualified health plan through the Marketplace with APTC. This SEP was available through June 1, by which time the consumer must have selected a plan. To activate the SEP, consumers were to call the Marketplace Call Center and explain that they met the criteria above.

Given the sensitivity of the topic, we know some consumers may have had difficulty conveying that they were victims or survivors of domestic violence. If the consumer called the Marketplace Call Center before June 1, 2014 and told the Call Center Representative that they were a victim or survivor of domestic violence, and the Call Center did not provide them an SEP at that time, the consumer can call back to receive an SEP due to misrepresentation or misinformation on behalf of the Marketplace. The consumer in the situation described above can call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) and state: "I first called the Call Center on (insert date) to enroll in the Marketplace and told the Call Center that I was a victim or survivor of domestic violence. I was not offered a special enrollment period. I'm requesting a special enrollment period on the grounds of misrepresentation or misinformation on behalf of the Call Center because they did not offer me the SEP which resulted in me not being able to get coverage." The Call Center will grant consumers in this situation an SEP that will last 60 days from the date they are granted the SEP.

NEW Tip: Make Sure Addresses Match for Each Person on an Application

From CMS

To make sure to avoid potential issues with the HealthCare.gov system, CMS is recommending that assisters remind consumers that when filling out an application for family members in the same household, consumers should be careful to make sure all of the household's family members' addresses match. This includes making sure to use the same zip code format and/or street abbreviations for all people listed on an application. For example, if the consumer included the 4-digit extension of the zip code for one family member, they should include the 4-digit extension on each family member's address. Conversely, if the consumer listed only the 5-digit zip code, the consumer should keep the address consistent for other family members in that household. Another example - if the consumer lists "Main St." for one family member, they must list "Main St." exactly the same way for all family members. If the consumer begins by using "Main St.," he or she should not enter "Main Street" for any family member in the application.

If the addresses included in the application aren't consistent, there is a risk that the HealthCare.gov system may see these differences as an error and it could cause problems with the insurance policy that family members are enrolled in.

Tips to Resolve Outstanding Application Inconsistencies (Includes a Clarification)

From CMS

CMS continues to work diligently to resolve situations where applications need additional verification, and we need your help to do that.

Consumers with a data matching issue or inconsistency were initially mailed an eligibility notice if they need to send the Marketplace more information. The initial eligibility notice states that the consumer has 90 days to submit additional documentation to verify their application information. Consumers who have an outstanding inconsistency are receiving reminder notices in the mail and via email asking them to submit additional information to resolve their data matching issue(s). Those reminder notices give consumers an additional 30 days to submit their documentation.

The reminder notices state that "if you mail us copies of your documents, make sure to include the printed barcode page that came with your notice." The *initial* eligibility notice contains the barcode, but the reminder notices that consumers are currently receiving do not.

Remember, uploading documents in HealthCare.gov is the fastest way to get the consumer's documents to the Marketplace. If a consumer chooses to mail in documents, they should be sure to include the page from the eligibility notice the Marketplace mailed to them which includes a barcode unique to their application OR if the consumer does not have the barcode, they can include their legal name and application ID with their documents**.** Our processing center can process the documents if you include the consumer's state, identified legal name, and application ID on the submitted copies of documents, even if you do not have the barcode.

To be clear, if a consumer calls the Marketplace Call Center at 1-800-318-2596 (or TTY: 1-855-889-4325) to see if his or her data matching issue or inconsistency has been resolved, and the Call Center cannot confirm that the inconsistency is resolved, we advise the consumer to resubmit his or her documents through his or her Marketplace Healthcare.gov account or through the mail.

Find slides from the CMS presentation on this issue can be found **here**.

FAQ on Matching Issues/Inconsistencies

Q: In what languages are notices being sent to consumers with data matching issues/inconsistencies reminding them to submit their supporting documentation (via mail, email, and phone calls)?

A: Mail and email data matching notices are being sent in English. However, the phone call messages for all consumers (regardless of inconsistency type) are being provided in both English and Spanish. The phone message indicates that the call is from the Health Insurance Marketplace, reminds the consumer to send in his or her supporting documents, and welcomes the consumer to call the Marketplace Call Center if he or she has any questions.

Note: Other notices from the Marketplace, such as the eligibility determination notice or the ID proofing failure notice, are going out in English and Spanish based on the consumer's preferred language.

Overview of the Internal Claims and Appeals and External Review Process

From CMS

As consumers begin to use their health insurance, they may encounter situations where a plan will not pay or will pay only partially for services, contrary to the consumer's expectations. Consumers may come to you for assistance in these situations. In some situations, the consumer may be able to appeal the plan's decision. In cases where the plan upholds the initial decision and rejects the consumer appeal, consumers may be eligible for a second review by an independent 3rd party reviewer.

Our June 26th webinar summarized the internal claims and coverage appeals and external review processes for private health insurance issuers which will help you assist consumers with possible next steps. (NOTE: This overview summarizes technical federal statutory and regulatory requirements, and due to its summary nature, cannot capture all of the details and nuances of the law and should not be considered legal advice.)

The slides from Thursday's presentation will soon be posted on the Resources for Assisters page on Marketplace.CMS.gov.

The June 26th presentation was limited to providing an overview of only the coverage appeals process for the Marketplace and for SHOP and did not include information on the eligibility appeals process which has been discussed in previous webinars. (The eligibility appeals process

is the process by which to appeal an eligibility decision made by the Marketplace. This process begins by submitting an appeal to the Marketplace.)

What is the Coverage Appeals Process?

The coverage appeals process details a consumer's right to appeal a plan's coverage decision once a consumer actually is enrolled in a plan and is using his or her coverage. This process begins by submitting an appeal to the issuer.

The Affordable Care Act requires that all health plans and issuers implement effective appeals processes for coverage determinations and claims. NOTE: The Appeals regulations do not apply to grandfathered health plans. (For a definition of a grandfathered plan, see: https://www.healthcare.gov/glossary/grandfathered-health-plan/.)

Internal Claims

A consumer has the right to make an internal claim, which is a request for benefits including items that require prior authorization of reimbursement. Issuers are obligated to respond within a required period of time.

The regulation provides that insurers must make decisions within 15 days of receipt on pre-service claims and 30 days of receipt on reimbursement claims. In urgent situations, insurers must make decisions as soon as possible consistent with the circumstances of the case, but in no event can they issue a decision later than 72 hours after receipt of the claim.

For example, the insurance company would have up to 15 days to issue a decision to a consumer who requested prior approval for a foot surgery. In cases that involve a claim for reimbursement from a doctor's office, the insurer has 30 days to issue a decision regarding the claim.

Once the claim is submitted, the carrier may issue an Adverse Benefit Determination (ABD), which is a carrier's decision to deny, reduce, or terminate a given benefit.

Adverse Benefit Determinations/Notices

The law outlines what must be included in the adverse benefit determinations or notices the issuer provides to a consumer denying the claim.

Adverse benefit determinations (ABDs) must include:

1. A description of the reasons for the denial, including specific plan provisions and any scientific judgment used;
2. A description of any additional information needed to improve or complete the claim;
3. Sufficient information for consumers to identify the claim. Note: Plans and issuers must provide notice that diagnosis and treatment codes are available upon request and that requests for the codes will not to be viewed as the initiation of an internal appeal or external review;
4. Notification of internal appeals and external review rights;
5. Notification of the availability of ombudsman's or health insurance consumer assistance offices that may be able to assist them with filing appeals and requesting external reviews; and
6. Notification that Culturally & Linguistically Appropriate Services (CLAS) are available if certain thresholds are met.

The law also outlines consumer protections when service areas may include a large number of people who do not speak English as a primary language. The issuer must provide culturally and linguistically appropriate services (CLAS) when 10% of the consumers in the claimant's county are literate only in the same non-English language or languages. This is referred to as the CLAS threshold.

If the CLAS threshold is met, plans and issuers are required to provide:

- Oral language services and assistance with filing claims and appeals in the applicable non-English language;
- Notices in any applicable non-English language, upon request; and
- In the English versions of all notices, a statement in any applicable non-English language indicating how to access the language services provided by the plan or issuer.

Internal Appeals

A consumer has the right to ask an insurer to review its previous decision to deny a claim or request an internal appeal. All denials involving claims for service are eligible for appeal—including those involving rescissions, eligibility issues related to a claim, denials based on medical necessity and experimental and investigational denials. (Rescissions are any cancellation or discontinuance of coverage that has a retroactive effect. This does not include cancellations of prospective or future effect or retroactive cancellations due to a failure to timely pay premiums or contributions towards the cost of coverage.)

Consumers have 180 days from receipt of the denial to file an appeal. All appeals must be submitted in writing unless it is an urgent situation. In those cases, oral requests are permitted. Only one level of appeal is permitted for the individual market. That means that all Qualified Health Plans (QHPs) can have only one level of internal appeal. In the group market, including job-based coverage, up to two levels of internal appeal are permitted. However, the total time for both levels of appeal may not exceed the time period allowed for the one level of appeal in the individual market.

For a post-service claim appeal, decisions must be made within 60 days of receipt, and insurers may take no longer than 72 hours in urgent care situations to issue decisions, though it may be less, depending on the circumstances of the case.

Full and Fair Review

Claimants have a right to a full and fair review during an internal appeal, meaning a claimant must have the opportunity to see and respond to any evidence or reasoning under consideration and the reviewers conducting the appeal must not have been involved in the initial decision on the claim.

Concurrent Care Pending the Outcome of an Appeal

Concurrent care decisions are occasions when the appeal occurs while the care is being provided such as those situations when consumers are under a doctor's care and are receiving an ongoing course of treatment. If an insurer has already approved an ongoing course of treatment over a period of time or a number of treatments, the insurer must provide the patient with an opportunity for an appeal BEFORE they reduce or terminate the ongoing treatment.

For example, if a patient with cancer was pre-authorized for nine sessions of chemotherapy and has begun treatment, the insurer cannot reduce the number of sessions or refuse to pay for the sessions without providing the patient with an opportunity to appeal that decision. Coverage must continue until the appeal has ended.

Urgent Care Appeals

An urgent care situation is one where issuing a decision within the standard timeframe could seriously jeopardize the claimant's life, health or ability to regain maximum function; or would subject the claimant to severe pain, based on the opinion of a doctor familiar with the consumer's condition. In these cases, claimants may file for an appeal orally, and the issuer

may provide oral notice of the decision. If the decision is provided orally, it must be followed by a written notice within 3 days. Individuals in urgent and concurrent care situations may be able to initiate an expedited internal appeal and an expedited external review simultaneously.

Following the internal appeal, the carrier can either reverse or uphold the denial. If the carrier upholds its decision, it will issue a final internal adverse benefit determination. Consumers may be able to request an external review.

Deemed Exhaustion

Some states require that consumers complete or exhaust the internal appeals process prior to requesting an external review. However, in certain situations consumers must be able to receive an external review even if they have not completed all of the health plan's internal appeals processes. Consumers must be able to receive an external review even if they have not completed all of the health plan's internal appeals processes if:

- The issuer waives the internal appeal requirement;
- The consumer simultaneously requests an expedited internal appeal and expedited external review; or
- The issuer fails to comply with all internal appeals requirements (NOTE: there are exceptions that are clearly defined by the law).

State External Review

In addition to establishing the internal claims and appeals processes across private health insurance markets, the Appeals regulation issued in 2010 and amended in June of 2011, established a set of 16 minimum consumer protections for state external review laws. The minimum consumer protections were based on the External Review Model Act drafted by the National Association of Insurance Commissioners (NAIC). States with external review laws that meet the 16 minimum consumer protections are referred to as having a NAIC-Parallel process.

The Departments of Health and Human Services (HHS), Labor, and Treasury allowed for a transition for those states that do not have processes currently in place that meet NAIC-parallel process standards by establishing a set of temporary standards (NAIC-similar) that relaxed some of the requirements of the NAIC-Parallel process. States with external review laws that meet these temporary standards may continue to operate their external review processes until January 1, 2016, at which time they must meet the higher standard for external reviews.

Plans and issuers in states with laws meeting neither the NAIC-Parallel nor NAIC-Similar process standards must participate in a federally administered external review process, either the HHS-administered or private accredited Independent Review Organization (IRO) process.

Federal External Review (HHS-administered Federal External Review and the Private Accredited IRO Process)

Federal external reviews are available for adverse benefit determinations involving medical judgment and rescissions. Medical judgment includes but is not limited to determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, and experimental and investigational treatments, as determined by the external reviewer. Rescissions of coverage are eligible for external review without regard to whether or not the rescissions have any effect on any particular benefit at that time.

Please note medical judgment DOES NOT include determinations involving only contractual or legal interpretation without any use of medical judgment. For example, issues of whether a service is a covered benefit under a contract, a deductible has been reached, or whether a consumer is eligible for coverage.

The Appeals regulation defines the Federal external review process requirements more broadly than the state external review process, but the protections are similar to those in the NAIC Uniform Model Act. The Appeals regulation requires that the Federal external review process include: a description of external review initiation; procedures for preliminary review of claims; minimum qualifications for IROs; a process of approving IROs; random IRO assignment; standards for IRO decision-making; and rules for providing notice of a final external review decision. The Federal external review process must also include: requirements for expedited review of adverse benefit determinations; standards for evaluating claims involving experimental or investigational treatments; binding IRO decisions; IRO reporting requirements; and notice of right to external review (on ABDs and within plan or policy documents).

The HHS-administered External Review Process

The HHS-administered process includes the minimum consumer protections in the NAIC-Parallel Standards. (Note that although the name is similar, the HHS-administered external review process is one of two processes under the overall federal external review process). The Federal government pays the cost of the appeal and there is no filing fee for consumers. It applies for health plans subject to the federally administered external review process that do not choose to participate in the private accredited IRO process.

The Private Accredited IRO Process

Plans or issuers choosing to use the Private Accredited IRO process must contract with at least three IROs and rotate external review assignments among them. Plans may use an alternative process for IRO assignment, but the plans must document how any alternative process constitutes random assignment and how it ensures that the process is independent and unbiased. There must also be no financial incentives to IROs based on the likelihood that the IRO will support the denial of benefits.

How to Request an Appeal or External Review

The adverse benefit determination should include information about consumer's rights to appeal or external review and offices that can assist consumers with requesting appeals or external reviews. Generally, requests for appeals should be directed to the plan in writing except in the case of urgent situations as described above.

If a consumer lives in a state that runs its own external review process, most requests for external review go to the state, which may be either the state Department of Insurance or the state Department of Health. However, in some states, the requests go to the plan and are then assigned to an IRO by the state. If the plan is in a federally-administered process, then the request should go to either the plan or if in the HHS-administered process, to the HHS-administered external review contractor.

Remember: the adverse benefit determination should include the state-specific information to steer the consumer to the correct point of contact for appeals and external review.

Complaints

Consumers can lodge a complaint if:

- A plan is not permitting a consumer to complete the appeals or external review processes; or
- A plan is not following the procedures outlined above.

NOTE: this list is not exhaustive. Complaints regarding the internal claims and internal appeals processes and State-administered external review programs should be directed to the state (either the Department of Insurance or state Department of Health). For Federally-administered external reviews, complaints should be directed to CCIIO.

For More Information

- The Appeals regulation and subsequent guidance can be found on the CCIIO website: http://cciio.cms.gov/resources/regulations/index.html#ea.
- Questions and answers about grandfathered status may also be found on the CCIIO website: http://cciio.cms.gov/programs/marketreforms/grandfathered/index.html.
- For more information about how to appeal a Marketplace **eligibility decision**, please see: https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/. Eligibility appellants or their authorized representatives may contact the eligibility appeals center at 1-855-231-1752 if they have questions about the **eligibility appeals** process or want to resolve eligibility appeals.

FAQs: Data Matching Issues/Inconsistencies, Coverage Appeals, Marketplace Eligibility Appeals

Data Matching Issues/Inconsistencies

Q: If a consumer already uploaded their supporting documents to resolve a data matching issue or inconsistency before the due date, but is still getting a notification via email that their data matching issue is not resolved, what should the consumer do?

A: If a consumer has uploaded or mailed in documents, but the Marketplace hasn't sent a notice telling the consumer the result or status of his or her data matching issue, the Marketplace is most likely still processing the consumer's information.

If it has been a while, the consumer may want to upload or mail in the proper documentation again, ensuring to take the steps outlined above. In some instances, consumers may have forgotten to include the barcode or their legal name or application ID which may have made it difficult for the Marketplace to associate the information with the right application.

For example, if a consumer submitted documents to resolve a data matching issue more than a month ago, however, they received another notice to submit documents and the Call Center does not have a record of whether the inconsistency has been successfully resolved, the consumer should resubmit their documents to resolve their data matching (or inconsistency) issue.

Over the next few weeks, we are reaching out again to consumers – via mail, email and phone calls – to encourage them to provide supporting documentation so we can resolve any remaining issues with their application as soon as possible. Because we are reaching consumers in multiple ways, there may be some issues with the timing of the notices in relation to when the consumer submitted the documents.

Note that all consumers will receive the 30 day notice regardless of whether they have submitted a document or not.

Q: If a consumer was asked to provide information to resolve an income data matching issue and his or her documents aren't processed or received, will his or her subsidy revert to the determination based on 2012 tax data, if any? If no tax or other electronic data is available, will a termination notice be sent?

A: Consumers are not terminated from their insurance coverage if they have a data matching issue with their income. However, consumers that are unable to resolve their income data matching issue with the Marketplace will no longer receive Advanced Payments of the Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR) if there is no income data available through available data sources, or the FFM will use data from data sources to redetermine APTC/CSR eligibility. Consumers will be eligible to receive a tax credit when they file their taxes if their income places them in the eligible income range.

COVERAGE Appeals

Q: What can be appealed? How long does a consumer have to request an appeal? How does a consumer file an appeal?

A: All denials, reductions, terminations, or failures to provide or make payments (in whole or in part) for a benefit can be appealed, including rescissions, issues of eligibility for coverage, medical necessity denials and experimental/investigational denials. A consumer has 180 days from receipt of denial to file an appeal. A consumer should file an appeal with the plan, in writing, unless it is an urgent matter, in which case a consumer can verbally request an appeal. Loss of coverage due to non-payment of premiums is not subject to the coverage appeals regulation.

Q: What is an adverse benefit determination?

A: An adverse benefit determination (ABD) means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. An

adverse benefit determination must happen in order for a consumer to take action and request an appeal. For example, a consumer can appeal an issuer's decision once the issuer denies their claim for treatment for a foot injury.

Q: Who gets to decide which external review process is followed for plans subject to Federally-administered external review?

A: The plan. Plans must choose or elect the process to follow either the HHS-administered process or the private IRO process. Consumers themselves cannot select which external review process will be used as it is the plan that elects the process. The selected process determines how a consumer should request an appeal or external review.

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Have something you want us to possibly add to next week's newsletter? Email Kim VanPelt at kim.vanpelt@slhi.org. As always, special thanks to Meryl Deles for much of the content.