Health Law and Policy Update:
August 9, 2013

T-minus 53 Days: Beginning October 1, individuals and small businesses will be able to sign up for health insurance through Connect for Health Colorado, Colorado's new health insurance marketplace. Coverage begins January 1, 2014.

This week's updates:

- Exchange faces important decision regarding formal appeals
- Fix clears the way for Congressional members and staff to buy insurance on Exchanges

Exchange faces important decision regarding formal appeals

As Connect for Health Colorado (C4HCO) - Colorado's health insurance exchange - prepares to open its doors for business on October 1, a number of key decision have yet to be made, including how to handle eligibility appeals. Federal law requires C4HCO to provide a formal eligibility appeals process for individuals, families and small businesses applying for coverage that adheres to federal constitutional due process requirements. However, C4HCO has the option of establishing its own state-based appeals process or handing the appeals function over to the federal government to administer. CCLP published a fact sheet this week urging C4HCO to establish a state-based appeals process using the Colorado Office of Administrative Courts (OAC), which already handles Medicaid appeals and is equipped to meet the very stringent constitutional due process protections required for these types of appeals.

Background

The U.S. Department of Health and Human Services issued proposed regulations governing exchange eligibility appeals and appeals coordination with Medicaid in January 2013. Even though these regulations are not finalized, we know that individuals shall have the right to appeal the following:

- An initial determination of eligibility for Advance Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR), including the amount of APTC/CSR.
- A redetermination of eligibility for Advance Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR), including the amount of APTC/CSR.
- A failure by the Exchange to provide timely notice of an eligibility determination.
- An eligibility determination for an exemption made pursuant to §1311(d)(4)(H) of the Affordable Care Act.

We also know that exchange appeals must comply with the standards set forth for conducting fair hearings for Medicaid appeals. These standards have become known as the *Goldberg v. Kelly* standards, which are based on a landmark 1970 Supreme Court decision, and are afforded the highest level of constitutional protection. These standards include:

- Right to a face-to-face, pre-termination evidentiary hearing.
- Right to timely and adequate notice detailing the reasons for action.
- Right to an effective opportunity to defend by confronting adverse witnesses.
- Right to present arguments and evidence orally before the adjudicator.
- Right to retain legal representation.
- Requirement that adjudicator explain the basis of her/his determination and indicate the evidence relied on.
- Requirement that adjudicator must be impartial - shall not have participated in initial determination.

Exchange appeals must also comply with accessibility requirements set forth in 45 CFR § 155.205(c). These requirements include providing language access services and other requirements pursuant to the Americans with Disabilities Act. The Colorado OAC already adheres to these strict due process requirements for Medicaid appeals and is therefore equipped to do so for exchange appeals.

Finally, the federal government requires coordination between exchange and Medicaid eligibility appeals. This is essential because eligibility for tax credits in the exchange is dependent on receiving a formal denial for Medicaid-in other words, the decisions are integrally linked. Moreover, if the dispute is over an applicant's income, the outcome of the appeal could result in the applicant being eligible for either Medicaid or tax credits in the exchange. For example, if an applicant named Joan attests to an income that would make her eligible for Medicaid but the system's data-verified income for Joan suggests she is eligible for a tax credit in the exchange, then the outcome of an appeal could send Joan to either system. Federal law requires the exchange and Medicaid agency to facilitate Joan's seamless transition between the systems so that Joan is enrolled in the appropriate system and is not asked to provide duplicative information or documentation that she already provided.

Options for Colorado

Colorado has two choices regarding how to coordinate Medicaid and C4HCO appeals: integrate or bifurcate. A bifurcated approach (handing exchange appeals over to the federal government or a third party) could result in applicants like Joan facing two appeals processes, with differing and burdensome procedural requirements. Under this approach, C4HCO would likely face additional administrative burdens in order to

reconcile appeals decisions between C4HCO and Medicaid. An integrated approach using the Colorado OAC, however, would ensure that applicants like Joan would not have to navigate two separate appeals processes. It would also result in administrative efficiencies by using an existing infrastructure that is equipped to handle these types of appeals.

We strongly believe C4HCO should develop its own eligibility appeals in the Colorado Office of Administrative Courts for the following reasons:

- **Observe Significant Constitutional Protections.** The OAC, which already handles Medicaid appeals and is equipped to meet the very stringent constitutional due process protections (discussed above) required for those appealing exchange eligibility determinations.
- **Reduce Procedural Burdens**. Exchange eligibility appeals also trigger an automatic appeal of Medicaid eligibility. Managing both C4HCO and Medicaid appeals in the OAC would reduce the serious threat of dueling hearings, conflicting decisions and needlessly confusing procedures for the consumer.
- **Leverage Existing Infrastructure.** The OAC has the necessary infrastructure to process such appeals - it manages the case records pursuant to HIPAA and due process requirements; it manages all client correspondence; it has access to foreign language and disability services; and it has developed rules of procedure governing fair hearings.
- **C4HCO Retains Authority.** C4HCO would retain authority over its appeals process by contracting with the OAC.
- **Improve Administrative Efficiencies.** There would be considerable efficiencies in having one adjudicator review evidence submitted to the OAC for Exchange and Medicaid eligibility appeals.
- **Reduce Consumer Frustration.** Handling C4HCO appeals through the OAC would reduce the likelihood of consumers getting lost in multiple appeals processes with differing rules of procedure and multiple points of contact.
- **Tailor to Colorado's Unique Structure.** A state-based appeals process can be streamlined to fit within Colorado's unique structural framework.

In a future update we will discuss the added benefits of developing a coordinated informal dispute resolution process, which could likely prevent many disputes from rising to the level of a formal appeal.

Fix clears the way for Congressional members and staff to buy insurance on Exchanges

Members of Congress and their staff are required, under the Affordable Care Act, to purchase health insurance through either the federal exchange or their own state's exchange thanks to a late amendment to the ACA sponsored by Senator Charles Grassley, R- Iowa. A problem arose several months ago, however, when Congressional Members and staff realized that they might not be eligible for any assistance from the federal government in paying for the cost of health insurance. Currently, the federal government pays about 72 percent of the cost of health insurance for lawmakers and their staff and it was not clear whether that would continue under the ACA. In addition, because Members and staff work for a large employer that contributes to the cost of their health insurance (the federal government) they will not be eligible for advance premium tax credits. Advance premium tax credits are designed to make health insurance affordable for people making less than 400 percent of the Federal Poverty Level. ($94,300 a year for a family of four). The question of whether lawmakers and their staff would have any assistance in purchasing health insurance was resolved this week when the Office of Personnel Management, issued a proposed rule that says the federal government may continue to contribute to their insurance premiums.

According to an article by TPM, Jon Foley, OPM's director of planning and policy. said of the fix: "These proposed regulations implement the administrative aspects of switching Members of Congress and congressional staff to their new insurance plans - the same plans available to millions of Americans through the new Exchanges," The TPM article went on to say that according to the White House, the proposed regulation "will provide for the implementation of the Grassley Amendment, making it clear that these employees will enroll in Marketplace plans, will not qualify for premium tax credits, and, like private sector employees, will not lose their employer contributions for these health plans. ... The Administration is focused on making this law work right."

Despite the fix, some members may end up paying more for health care than they do now. Unlike the Federal Employees Health Benefit Program, where plans generally charge enrollees the same rate, plans sold on Exchanges Marketplace are allowed to adjust their rates based upon tobacco use, geographic location, and age. Read more about this topic from these sources:

- New York Times
- Fact Sheet released by OPM

- Federal News Radio
- Roll Call