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POLICY BRIEF

OPTIMIZING CONSUMER PROTECTIONS IN STATE HEALTH INSURANCE EXCHANGES

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By Samuel Salganik, JD, Elisabeth R. Benjamin, MSPH, JD, Marissa Geoffroy, JD, and Arianne Slagle, MPA

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About the Authors

Samuel Salganik, JD, was a Skadden Fellow at CSS's Community Health Advocates program while he authored this report. He is now Legal Counsel to the Rhode Island Insurance Exchange. He attended Columbia Law School and Brown University.

Elisabeth R. Benjamin, MSPH, JD, is Vice President of Health Initiatives at CSS. Previously she directed the Reproductive Rights Project at the New York Civil Liberties Union and the Health Law Unit at the Legal Aid Society of New York. She attended Columbia Law School, Harvard School of Public Health and Brown University.

Marissa Geoffroy, JD, is a Helpline Counselor at CSS's Community Health Advocates program. She attended New York University School of Law and Brown University.

Arianne Slagle, MPA, is Director of Health Policy at CSS. She attended New York University's Wagner School of Public Service and the University of Michigan.

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Community Service Society | Fighting Poverty Strengthening New York

105 East 22nd Street
New York, NY 10010
PH 212.254.8900
www.cssny.org

Executive Summary

Under the Affordable Care Act (ACA), many states will establish Health Insurance Exchanges to guide and enroll millions of consumers and small businesses into coverage. Robust consumer protections will be pivotal to the success of these Exchanges. Previous experiences with major health transformations, such as the offer of drug coverage to Medicare beneficiaries, have underscored the need for strong consumer protections. These protections span the spectrum from basic customer service, through informal dispute resolution, to formal appeals, when necessary. A vigorous consumer protection system should ensure that the public's experience with Exchanges is positive, that gaining coverage will not be burdensome, and that there will be a fair and easy dispute procedure to resolve the problems that inevitably will arise. The more effective these consumer protections are up front, the less frequently it will be necessary to resort to time-consuming or complex formal appeals processes.

Exchanges will serve multiple functions. They will guide consumers as they apply for tax subsidies to purchase health insurance or enroll into public coverage, and will help consumers select plans that are right for themselves and their families. Often these functions will be performed online, through the Exchange's website, using a simple, streamlined application. But, at the end of the day, glitches and disputes undoubtedly will arise, and Exchanges should adopt efficient and expeditious processes to resolve them.

This report makes recommendations about front-end consumer supports and protections, intermediate informal dispute resolution methods, and, ultimately, formal appeals procedures that comply with long-standing due process protections, as well as new requirements under the ACA.

To illustrate how a consumer protection regime should work, this report outlines two case scenarios of typical Exchange consumers. The first scenario involves an individual with a tax subsidy dispute. The second scenario concerns a family that is potentially eligible for public coverage. Both scenarios describe how an Exchange should offer customer service and informal dispute opportunities to obviate the need for a formal appeal. These scenarios illustrate the very real prospect of consumers experiencing multiple appeals conduits, and demonstrate the need for an Exchange to establish a process that avoids offering dueling state and federal appeals systems.

A vigorous consumer protection system should ensure that the public's experience with Exchanges is positive, that gaining coverage will not be burdensome, and that there will be a fair and easy dispute procedure to resolve the problems that inevitably will arise.

The report concludes with a series of recommendations that seek to promote accessible, convenient, and effective resolutions of problems and disputes. In order to avoid large numbers of cumbersome appeals, consumers should be afforded access to robust consumer support systems, described in detail in the report, at every stage of the process. The Exchange should maximize informal dispute resolution mechanisms, and formal appeals should exist as a last resort. The Exchange's appeal system should offer flexibility to the consumer with regard to venue and format. To the extent that the federal appeals system is also implicated, the consumer should be required to exhaust the state appeals process first, in order to avoid the confusion and inefficiency of dueling hearings. State appeals processes should be coordinated across insurance affordability programs (Medicaid, Children's Health Insurance, Basic Health Program, and Exchanges). Finally, states should adopt a system of quality assurance, monitoring, and reporting across the continuum of Exchange functions.

A robust consumer protection and appeal system will ensure that Exchanges operate smoothly and efficiently as millions of American residents gain coverage and realize the enormous potential of the ACA.

Introduction

The Affordable Care Act (ACA) seeks to extend access to quality, affordable health insurance through Health Insurance Exchanges, beginning in 2014. Exchanges will be marketplaces where consumers and small businesses can investigate coverage options, make health plan comparisons on an apples-to-apples basis, apply for federal tax credit subsidies to make coverage affordable, and enroll into Qualified Health Plans (QHPs). Exchanges will also serve as important enrollment portals for public health insurance programs such as Medicaid, Child Health Plus,[1] and a Basic Health Plan (BHP) should the State create one. In New York State, a little over one million consumers are likely to enroll in health coverage through the State Exchange.[2]

The stakes are extraordinarily high. An Exchange's failure to implement a robust consumer protection system could result in loss of coverage, incorrect denials of coverage, or the over-charging of consumers. The success or failure of health reform in New York and elsewhere will depend to a large extent on the consumer protections and experience offered by state Exchanges, including their ability to provide consumer-friendly websites and to administer complicated cases effectively.

Acquiring coverage and subsidies through the Exchange is meant to be a simple task for consumers, akin to reserving a plane ticket or hotel on Orbitz or Expedia. Necessary eligibility information will be verified electronically, with little need for paper applications.

But achieving front-end simplicity entails significant back-end complexity. While electronic data matching will help streamline enrollment, errors and inconsistencies will occur. To compound matters, approximately half of the Exchange's enrollees may need to update their personal information more than once per year due to changes in employment status and income fluctuation.[3] With so many people using this system in so many different ways, it is inevitable that problems will arise.

This report analyzes the consumer protections that New York's Exchange must afford in order to ensure the ACA's promise of a streamlined, consumer-friendly health plan enrollment and renewal process. The first section outlines the primary functions and enrollment process for the Health Insurance Exchange. Section two highlights the potential disputes that may arise throughout the process of securing and keeping coverage. Section three describes case scenarios of two hypothetical Exchange insurance applicants who experience enrollment problems. This section uses these scenarios to illustrate unresolved policy decisions, review the legal requirements, and provide recommendations for the State's Exchange. The report concludes with a summary of recommendations for protecting consumers and resolving conflicts in New York's Exchange.

Enrollment through the Health Insurance Exchange

The Exchanges will offer a set of QHPs organized into four different tiers based on their actuarial values (AV): Bronze (60 percent AV), Silver (70 percent AV), Gold (80 percent AV), and Platinum (90 percent AV).[4] Similar to electronic tax filing programs, such as Turbo Tax, the Exchange website will allow consumers to view and compare plan details in a simple and standardized manner. Essentially, for the first time, consumers will be able to purchase and enroll easily into health plans, without assistance, directly through the Exchange. However, many will seek the help of the Exchange call center, a Navigator, a Consumer Assistance Program (CAP), or a broker. The Exchange will be required to be accessible to all, including people with disabilities or limited English proficiency (see box).[5]

Additionally, the Exchange will: (1) determine eligibility for Premium Tax Credits (PTCs) to defray the cost of coverage (see box); (2) determine eligibility for cost-sharing reductions to assist with co-pays, deductibles, and co-insurance costs; and (3) provide an enrollment gateway for public health insurance programs, including Child Health Plus, an expanded Medicaid program, and a Basic Health Plan, if adopted.

To facilitate eligibility and enrollment, the Exchange is required to offer a single streamlined application.[6] Eligibility screening for public programs, PTCs, and cost-sharing reductions will rely primarily on household

income and will require a fairly sophisticated real-time data matching and verification system in order to ensure both data accuracy and a mostly automated enrollment process.

This application process will consist of four main steps: (1) application submission; (2) verification of eligibility; (3) determination of eligibility; and (4) subsidy and plan selection. Throughout this process, consumers applying via the internet should see a progression bar on the screen that indicates where they are in this application process.

First, to begin the application process, a consumer will access the Exchange via a web-based portal, by telephone, by mail, or in person at a local office, often with the help of a Navigator, CAP, or other enrollment assister. Each consumer will create a new account that will need to be registered along with a password to allow the applicant to pause and revisit the application at any time, and to save important information and notices. The applicant will enter household information, as well as information specific to each person for whom the applicant is seeking coverage. This will include information on expected income for the upcoming year, residency, health status, and other sources of coverage available.

Second, the Exchange will electronically verify the consumer's information, such as income tax or employment data, on a real-time basis against state or federal data sources.[7] The Exchange will determine whether the applicant's attestation and the data verification are "reasonably compatible" so as to not slow down the enrollment process; however, significant discrepancies will require resolution through customer service mechanisms.[8] Once all data has been entered by the applicant and verified against existing data sources, the applicant should be able to see a summary of this data with any discrepancies

Consumer Assistance Programs and Navigators

The ACA established **Consumer Assistance Programs,** or ombudsprograms, which provide education about coverage options, enroll consumers into coverage, file complaints and grievances with plans and regulators, and educate consumers about their rights and responsibilities. CAPs have been funded in over 40 states and territories since 2010.

Community Health Advocates (CHA) is New York's statewide CAP. CHA serves 50,000 New Yorkers annually. A sister program, called the Small Business Assistance Program, offers similar assistance to small businesses.

Each Exchange must operate a **Navigator** program. Navigators are charged with providing public education and information, helping consumers and small businesses enroll into coverage on the Exchange, advising consumers about their enrollment options and PTCs, and providing referrals of complex cases to Consumer Assistance Programs.

New York has not yet created a Navigator program, but existing resources within the State already provide similar services, including the State's Facilitated Enrollment program, Community Health Advocates, local Chambers of Commerce, and insurance brokers.

Source: T. deJung, C. Tracy, and E. Benjamin, *Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York*, NYS Health Foundation, September 2011.

Making Coverage More Affordable

Premium tax credits (PTCs) are federal subsidies that will reduce the cost of private insurance for consumers who have incomes between 100 percent and 400 percent of the Federal Poverty Level (FPL)—or $19,000 to $76,000 per year for a family of three in 2012—and who are ineligible for Medicaid.

PTCs will be awarded on a sliding scale based on applicants' income and the cost of the second least expensive Silver level plan available in their area. Applicants may apply the PTC amount to any plan in any tier of their choice.

Typically, PTCs will be paid in advance based on the applicant's estimated income for the upcoming year. Any PTCs claimed in advance will be reconciled with actual income earned at the end of the tax year, which may result in money refunded by or owed to the IRS.

People earning between 100 percent and 250 percent of FPL who enroll in a Silver-level plan are also eligible for a cost-sharing subsidy, which will effectively raise the actuarial value of their health plan by lowering out-of-pocket costs. This subsidy is not transferrable to other plan tiers.

New York's Exchange Advances

On April 12, 2012, Governor Cuomo issued an Executive Order to establish a New York Health Insurance Exchange housed within the State Department of Health (SDOH). SDOH will work closely with the Department of Financial Services, which regulates the State's insurance markets, to operate the Exchange.

• SDOH has retained Computer Sciences Corporation to act as the System Integrator, building the Exchange's IT systems on top of pre-existing assets, including the web interface—the main point of contact for consumers seeking to access the Exchange. New York expects to have its IT systems and portal ready for enrollment in the fall of 2013.

• New York plans to rely on the Enroll UX2014 project to guide the development of the consumer portal on the Exchange's website. Enroll UX2014 is the product of an 11 state public-private partnership.

• New York is streamlining the existing Quality Assurance Reporting Requirements, the health plan performance data collection system, and creating and All Payer Claims Database to support the Exchange's health plan rating system and other business operations.

• The New York Health Options call center, currently run by MAXIMUS, will be expanded to have the capacity to handle both the customer service function for the Exchange and the electronic eligibility determination system. It currently serves enrollment and renewal assistance for the State's Medicaid and Child Health Plus programs, handling 80,000 calls per month.

• The State has commissioned a series of policy studies on several aspects of the Exchange planning and design, such as the Essential Health Benefits package, the Basic Health Plan option, and the impact of merging the small group and individual markets.

Sources: *See* New York State Exchange Establishment Level 1 Funding application, June 29, 2012, available at: http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/project_narrative_level1_funding.pdf; *see also,* www.healthcarereform.ny.gov/research_and_resources/; www.healthcarereform.ny.gov/health_insurance_exchange/.

flagged in order to allow him or her to make any necessary corrections. The applicant must then click to submit the data.

Third, when possible, the Exchange will make an automatic, real-time, determination of eligibility based on the information provided. Depending on the applicant's income, this will include eligibility for public insurance programs, PTCs, and cost-sharing subsidies. However, in a significant number of cases, automatic determinations may not be possible and the Exchange may seek additional information from the applicant.

Finally, the consumer will select a plan, choose the level of subsidy he or she wishes to accept (if applicable), enroll, and make his or her first payment (if applicable).

Ideally, for most applicants, these steps will take less than an hour. Yet it is inevitable that glitches will arise at each phase. The discussion below addresses how to best anticipate and address these situations.

Consumer Problems Likely to Arise in Securing and Keeping Coverage

Historically, problems have occurred when large numbers of consumers have enrolled into new health care programs. This was the experience for Medicare consumers with the launch of the Part D drug program and for some Medicaid beneficiaries during the transition to managed care. This section anticipates the types of problems consumers may experience in the Exchange.

Consumer enrollment and retention problems will vary widely, but conceptually break down into three groups that correspond with the different times of the year during which consumers will be addressing their health coverage issues: (1) initial enrollment and annual renewal; (2) mid-year changes, when consumers are required to report status changes that affect their eligibility; and (3) end-of-year reconciliation with the IRS for consumers who enroll into QHPs and claim PTCs.

Disputes at Initial Enrollment and Annual Renewal

At initial enrollment, consumers will provide the Exchange with the personal information necessary to make eligibility determinations for either public health insurance programs or QHPs with federal subsidies. This information must then be verified using existing data sources, including income data from the Internal Revenue Service (IRS). If the data provided by applicants does not match existing sources, the following types of disputes may arise:

- PTC eligibility or the amount of PTCs.[9]
- PTC denials due to the availability of affordable employer-sponsored insurance.[10]
- Inability to enroll due to a lack of open enrollment or special enrollment period.[11]
- QHP or Medicaid denials based on state residence.[12]
- Medicaid denials based on income.[13]
- Medicaid or QHP denials based on immigration status.[14]
- Applicants who are found eligible for Medicaid but want to enroll in a QHP instead.[15]
- The amount of a Child Health Plus premium.[16]
- Eligibility for cost-sharing subsidies, or disputes around the level of subsidy.[17]
- Exemption denials from the individual mandate.[18]
- QHP denials based on incarceration status.[19]
- General administrative mistakes such as name misspellings.[20]

Consumers using the Exchange will renew their coverage annually through an administrative renewal process, with a new eligibility determination generated every year.[21] All of the disputes related to initial enrollment can also arise at the time of renewal.

Disputes Arising at Mid-Year Changes

At any point during the coverage year, household changes may require additional interactions with the Exchange. Disputes about mid-year changes may include:

PTC-Level Dispute

Carmen Schultz attests to income at $33,000 per year (300 percent of FPL), but the Exchange's data source indicates her income is $38,000 per year (350 percent of FPL).

The discrepancy affects the amount of Carmen's PTC.

Carmen now has a dispute to resolve.

Medicaid Eligibility Dispute

Phil Brown worked for years as a store clerk, earning $22,000 per year (200 percent of FPL). He was recently laid off and just found a new job paying him $12,000 per year (110 percent of FPL). At his new income level, Phil is eligible for Medicaid.

Phil applies for coverage through the Exchange and attests to income of $12,000 per year. But the Exchange's data sources indicate his income is $22,000 per year. At that income, Phil would be eligible for a QHP with a PTC and cost-sharing subsidies, but he would not be eligible for Medicaid.

Phil now has a dispute to resolve.

Immigration Status Dispute

Marco Diaz wants to apply for coverage, but the Exchange's data, verified against federal data, indicates he is undocumented. Marco has applied for asylum and believes he is lawfully present.

Marco now has a dispute to resolve.

Enrollment Period Dispute

Mona Khan did not enroll through the Exchange during open enrollment because she had coverage through her job at the time. But Mona lost her job and coverage on May 1 and attempted to enroll into coverage on June 30, the last day of her 60-day special enrollment period (SEP). Mona's unemployment and other income put her at 200 percent of poverty, thus eligible for PTCs and cost-sharing subsidies.

However, the Exchange claims that Mona submitted her application on July 1, the 61st day. According to the Exchange, Mona missed her SEP and cannot enroll into a QHP through the Exchange until the next open enrollment period.

Mona now has a dispute to resolve.

• Changes to income (e.g., loss of job, change in number of hours worked, promotion, bonus).

• Changes to household composition (e.g., marriage, divorce, birth of a child, or death of a family member).[22]

• Special enrollment period (e.g., due to a loss of job-based coverage, birth, or marriage).[23]

• Change in immigration status.

• Terminations from QHPs (e.g., for nonpayment of premiums).[24]

• Terminations from Medicaid, Child Health Plus, or Basic Health Plan (e.g., due to changes in income).[25]

• Change of address outside of plan's or Exchange's service area.[26]

• Administration of cost-sharing subsidies.

Disputes Arising at the End-of-Year Reconciliation with the Internal Revenue Service

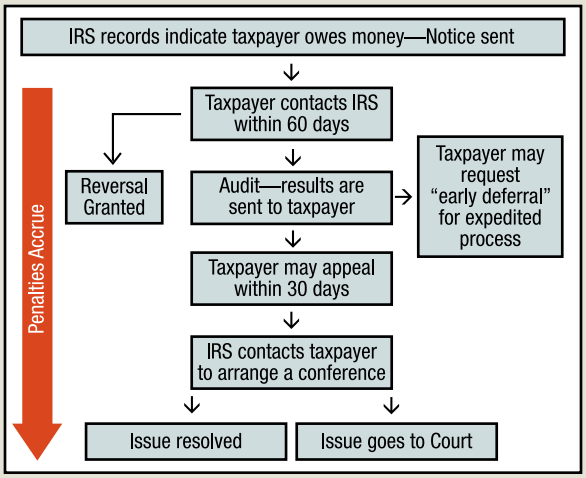
For consumers who enroll into QHPs and receive PTCs advanced throughout the year, the end of the year may also generate disputes. The Exchange will ask a consumer to estimate his or her income at the time of enrollment. However, many consumers will be unable to forecast accurately their income at the beginning of the year, making it difficult to estimate the correct amount of PTC to advance to the applicant.

The ACA addresses this issue by revisiting the PTC calculation at the end of the tax year, once the consumer's actual income for that year is known. At this point, the consumer and the IRS must reconcile the advances awarded against the final level of PTCs for which the consumer was eligible. If the consumer's income increased during the year or was higher than expected, then he or she may owe money to the IRS. For taxpayers with incomes below 400 percent of FPL, the amount owed is capped, based on a sliding scale, from $300 to $2,500.[27] If the consumer's income decreased during the year, then the IRS may owe the consumer money and will return it in the form of a tax refund. This process is called "reconciliation."[28]

The Exchange will play little or no role in the reconciliation

The IRS End-of-Year Dispute Procedure

The IRS dispute resolution mechanism has informal and formal components. Typically, when the IRS determines a taxpayer owes money, it sends a notice to the taxpayer explaining the deficiency amount and how it was calculated. The notice offers the taxpayer 60 days to contact the IRS in writing to appeal. If the dispute is unresolved, the IRS forwards the case for audit. Following the results of the audit, the taxpayer is notified that he or she has 30 days to initiate a more formal protest. For disputes regarding less than $25,000 (which the vast majority of reconciliation cases are likely to be), the formal protest can be a simple letter requesting reconsideration. In response, the IRS contacts the taxpayer to arrange a conference, usually within 90 days. The full process can take up to a year.



Unless the taxpayer pays the disputed amount up front and then protests for a refund, interest and penalties accrue throughout this period. The burden is also on the taxpayer to prove that the IRS is incorrect, though this burden is reversed if the case proceeds to court. Despite these drawbacks, New York's Exchange is unlikely to have much influence over the reconciliation process because it occurs in the existing IRS framework.

Sources: Internal Revenue Service, "Your Appeal Rights and How to Prepare a Protest If You Don't Agree," Publication 5 (Rev. 01-1999), Catalog Number 460741, *available at:* http://www.irs.gov/pub/irs-pdf/p5.pdf; *see also,* http://www.irs.gov/Individuals/Appeals...-Resolving-Tax-Disputes; http://www.irs.gov/Individuals/Understanding-your-CP11A-Notice.

process. Instead, reconciliation will play out between consumers and the IRS as part of the annual tax return process. Disputes will be handled through the IRS's normal tax dispute procedures (see box).

How Will the Exchange Resolve Disputes?

Developing consumer protection systems that resolve disputes quickly and effectively is a difficult task because the Exchange is a gateway to two fundamentally different types of insurance programs (public vs. private insurance), each with its own appeals rules. Two key questions emerge when considering these overlapping systems: (1) Will appeals from all Exchange decisions provide the full due process protections required by *Goldberg v. Kelly*? (see box); and (2) What disputes will be heard by a federal appeals system, as opposed to a state-based Exchange system?

State and federal regulators are struggling to determine the extent to which Exchange appeals will include the formal due process protections available in Medicaid Fair Hearings. Some experts suggest that the Exchange will perform a Medicaid determination as a first step in processing every application and urge that PTC applicants receive full Fair Hearing rights for all eligibility disputes.[29] But many applicants will not have intended to apply for Medicaid; these applicants may be surprised to see a Medicaid denial notice, and may feel out of place in a Medicaid appeals system designed for traditional welfare programs. (See Jake Kirby scenario below.) In addition, not all state-based Exchanges will be performing Medicaid determinations; some will merely assess and forward an application to the Medicaid agency.[30]

One option is to reserve the Fair Hearing process for applicants who attest to income within the Medicaid threshold and to provide a streamlined appeals process for all others (i.e. enrollees and applicants for PTCs, Child Health Plus and the Basic Health Plan). The Massachusetts Connector—which also serves several programs with a single application—offers a less formal appeals process for some disputes and full Fair Hearing rights for others.[31]

The ACA also calls for a federally-administered appeals process with federal hearing officers.[32] State Exchanges will have to design their dispute and appeals systems in alignment with this federal process. But federal regulators have not yet explained how this federal process will interact with state-based Exchanges.[33] Congress designated this federal appeals system for QHP applicants, not for Medicaid or Child Health Plus applicants. Federal regulations will have to address several issues, such as:

- Will consumers have the option for both state and federal hearings?
- If both state and federal hearings are available, would the hearings happen serially or simultaneously?
- What notices will be issued to consumers concerning state and federal appeals systems?
- How will the federal appeals system handle disputes that

Goldberg v. Kelly

In 1970, the Supreme Court announced in its seminal *Goldberg v. Kelly* decision that welfare recipients have a constitutional right to a full evidentiary hearing before the termination of their benefits. For those in "brutal need" of benefits to survive, the Court reasoned, only a formal hearing with a neutral decision-maker offers sufficient protection.

Goldberg's protections are now enshrined in numerous federal and state laws. Today, Medicaid Fair Hearing appellants have the right to:

- An independent decision-maker.
- Examine all adverse evidence in advance.
- Cross-examine adverse witnesses.
- Bring witnesses.
- Present facts and arguments orally.
- Maintain their benefits unchanged while awaiting the hearing.

New York's Office of Temporary and Disability Assistance (OTDA) holds more than 100,000 *Goldberg*-compliant Fair Hearings every year, with roughly 20 percent of those related to Medicaid.

Sources: *Goldberg v. Kelly,* 397 U.S. 254 (1970); 42 C.F.R. §431.200 et seq.; Presentation of Mark Lahey, Acting Principal Hearing Officer at the Office of Administrative Hearings, at the New York Public Welfare Association conference, February 2011.

implicate Medicaid or Child Health Plus in addition to QHP issues?[34]

The next section of this report addresses these issues by exploring the experience of two hypothetical Exchange applicants.

Case Scenarios: Building a Consumer Protection Regime in the Exchange

The success of an Exchange will depend greatly on ensuring effective consumer protections in resolving issues and disputes that arise during the enrollment process. The following two hypothetical case scenarios illustrate how a consumer-friendly Exchange might address an applicant's issues as he or she moves through the enrollment process. There is wide latitude for state flexibility on some issues, and federal guidance is awaited on others. This section explores design options and recommendations based on information available at the time of publication.

Case Scenario One: QHP Applicant Jake Kirby of Rochester, NY

Jake Kirby, age 33, is single with no children and wants to enroll into insurance coverage through New York's Insurance Exchange. Jake logs onto the Exchange website, registers for a new account, and enters his expected income for the year at $33,000, or about 300 percent of FPL. At that income level, Jake is eligible to enroll into a QHP and receive PTCs to help him pay for it. If he chooses to enroll in the second least expensive Silver-level plan, to which his PTCs are benchmarked, he will pay a monthly premium of $261.[35]

But the Exchange's electronic verification system finds that Jake's tax data lists his income at $38,500 per year, or about 350 percent of FPL. At that income level, he is still eligible for PTCs, but at a lower level, which will leave him with a premium of $305 per month. The discrepancy is worth $44 per month, or $528 for the year.

How will the Exchange respond to this problem? What rights will be afforded to Jake?

Strong Communication with Consumers

To be an effective tool for securing and retaining coverage, an Exchange must have a strong system of communicating with consumers. Essentially, it should provide consumers with a variety of mechanisms and options with which to send and receive information. At minimum, these should include options for communications via:

- Telephone/TDD/TYY
- Email
- In person
- Computer pop-ups
- Online live chat/instant messaging
- Fax
- Paper mail
- Text messaging

Consumer Protections at Pre-Determination

First, the Exchange must automatically determine whether the discrepancy in Jake's income is large enough to be relevant. Under federal rules, differences between an applicant's stated income and the income listed in federal or state databases may not be large enough to be relevant and the Exchange will accept the applicant's attestation.[36] If the difference is large enough, the Exchange must resolve the inconsistency in order to effectuate enrollment.[37] While federal regulations provide the sequencing for resolving inconsistencies, they allow states flexibility for implementing enrollment in an online environment.[38]

One way to resolve inconsistencies is to build in an electronic list of "reasonable explanations" as to why the data does not match up.[39] To ease the consumer experience and to increase enrollment efforts, this list of pre-approved reasonable explanations will need to be automated to the greatest extent possible. It also must be broad enough to encompass a variety of situations. (For a suggested list of "reasonable explanations," see Appendix A.) For example, Jake may be able to indicate that his work hours were recently reduced. If this is the case, the Exchange will be able to award Jake PTCs immediately according to his attested annual income of $33,000.[40]

Once Jake has entered all of his information, he should receive a summary of what he has entered and how it compares to existing data sources. At this point, the discrepancy in his income information should be flagged. If Jake was able to provide a reasonable explanation for this, and the discrepancy is resolved, then the summary should say so.

If the discrepancy is not resolved, then Jake should be told how to get basic customer service. A "pop-up" prompt should encourage him to contact the Exchange's call center or use alternative means of contact for customer service, such as through an online "live chat."[41] Jake should be told how to reach local Navigators or CAPs if he needs further help understanding or resolving the issue.[42] He should also be informed that any discrepancies may affect his eligibility for public programs or subsidies, but that he will have an opportunity to provide documentation in support of his attested income level.

Consumer Protections at Pre-Determination

Legal Requirements

- Offer consumer support online and through call center. (45 C.F.R. §155.205)
- Verify income attestation against federal and state data sources. (45 C.F.R. §155.320)
- If discrepancy between attestation and data source is less than 10 percent, then award PTCs based on attestation. (45 C.F.R. §155.320(c)(3)(v))
- Support a Navigator program. (45 C.F.R. §155.210)
- Refer consumers to CAPs. (45 C.F.R. §155.205(d))

Recommendations

- Allow a PTC award based on applicant's provision of a reasonable explanation for discrepancies.
- Automate the reasonable explanation process as much as possible to allow instant enrollment.
- Enhance customer support after a discrepancy is identified.
- Allow live-chat assistance.
- Encourage applicants with discrepancies to contact CAPs or Navigators.

Consumer Protections at Initial Determination

If Jake submits his information with a reasonable explanation, then the Exchange will award advance PTCs according to his attested annual income of $33,000. However, if he is unable to provide a reasonable explanation, the Exchange must still process his application. Federal regulations provide guidance for Exchanges to follow.

First, federal regulations require an Exchange to allow Jake to enroll into a QHP with PTCs based on his declared income of $33,000 for up to 90 days while Jake finds and submits documentation supporting his attestation.[43] This 90-day document submission period is discussed in more detail below.

Second, the Exchange must also issue a "plain language" notice of its determination that informs Jake of his appeal rights and refers him to available consumer assistance resources.[44] Since Jake is applying online, this notice should appear on-screen as a pop-up and should also be emailed to him. Further, Jake should have the option (by merely checking a box) to have the notice mailed to him as well, as he may not have a printer. These notices should be automatically stored in a folder on Jake's Exchange account, so that he, the Exchange, or an authorized assistor, such as a navigator or CAP, can review them later.

The notice should contain enough information so that Jake can easily identify the source of the inconsistency and rectify it. The Exchange's notices should use a chart that clearly indicates the discrepancy, for example:

	Income	
Household	***You say***	***Our records show***
Jake Kirby	$33,000 a year	$38,500 a year

Consumer Protections at Initial Determination

Legal Requirements

- Provide applicant with "plain language" notice. (45 C.F.R. §§155.205(c), 155.230, 155.315(f)(2)(i))
- Provide information on appeal rights and consumer assistance resources available. (45 C.F.R. §§155.230, 155.355)
- Award PTCs for 90 days based on attestation. (45 C.F.R. §155.315(f)(4))

Recommendations

- Include a chart or other visual representation that clearly indicates the basis of the eligibility determination and the nature of the inconsistency.
- Provide the notice as a pop-up and email, and offer applicant the option of a mailed paper notice.
- Save notices in the consumer's Exchange account so they may be reviewed later.

Consumer Protections During the 90-Day Document Submission Period

Under federal rules, Jake will have 90 days to submit documentation—via the Exchange website, by mail, or in person—to try to resolve the data inconsistency.[45] To make this process as consumer-friendly as possible, the Exchange should also accept submissions by email, fax, or in person at any Exchange, local Social Services District (DSS), Navigator, or CAP office convenient for Jake.

During the 90-day document submission period, the Exchange is required to award Jake PTCs based on his attested $33,000 annual income. Jake will be able to have his PTCs advanced on a monthly basis at this level if he confirms that he understands the risk that these amounts may be recouped through end-of-year reconciliation based on his actual earned income.[46] If Jake is unable to resolve the inconsistency in income during this 90-day period, then the Exchange must re-determine his PTCs based on the income information available through the data matching source.[47]

Jake should be given the option of enhanced customer support during this 90-day period. Ideally, Jake would get a primary contact person within the Exchange call center, who he can easily reach directly by telephone and email. The call center should be set up to allow other workers to access his account if his primary Exchange contact is unavailable. Jake should also be reminded about the availability of help from CAPs and Navigators.

The State must carefully consider the Exchange's responsibilities during this time. Federal regulations do not specify the speed with which the Exchange must respond to documentation submissions, or the frequency with which reminder communications should be issued. The Exchange should send regular reminders to an applicant during this 90-day period. The Exchange should also respond promptly to all documents submitted by Jake, with written responses (potentially by email) available to back up any telephone contact regarding follow-up on minor issues such as illegible faxes or email attachments that could not be opened. Jake should receive a formal written notice when a document submitted is deemed acceptable or not acceptable.[48]

Consumer Protections During the 90-Day Document Submission Period

Legal Requirements

- Offer an applicant 90 days during which he or she can submit documentation supporting the income attestation. (45 C.F.R. §§155.315(f), 155.320(c)(3)(vi)(C))
- Applicant may submit documents through the Exchange website, by mail, or in person. (45 C.F.R. §155.315(f)(2)(ii)) 45 C.F.R. §155.405(c))
- PTCs awarded based on applicant's attestation during the 90-day period. (45 C.F.R. §155.315(f)(4))

Recommendations

- Allow applicant to submit documents by email, in person or by fax.
- Allow applicant to make in-person submissions at any Exchange, Navigator, or CAP office.
- Regularly remind applicant about the 90-day process.
- Regularly remind applicant about the availability of assistance from Navigators and CAPs.
- Provide the applicant with a primary contact person at the Exchange call center, reachable directly by telephone and email.
- Ensure that other call center staff can assist applicant if the contact person is unavailable.

Consumer Protections Post-Determination and Formal Appeals

If Jake is not able to reach a satisfactory result during the 90-day document submission period, he may wish to escalate his dispute by filing a formal appeal. Federal regulations and guidance issued so far give little detail as to how the appeals process might look, but seem to indicate that an appeals system must be available through the Exchange.[49]

The question remains as to the extent to which applicants like Jake will be given full Medicaid Fair Hearing rights. The Exchange's first step in reviewing Jake's application will be to perform a Medicaid determination (see box). Since Jake will be denied Medicaid before his PTCs are determined, it is possible that Jake will have Medicaid Fair Hearing rights.[50] If future federal regulations require Jake be granted access to a Medicaid Fair Hearing, this process should be flexible so as to allow him the option of pursuing an appeal in person, by telephone, on paper, or online. Appendix B contains recommendations for upgrades to New York's Fair Hearing system to prepare it for an influx of Exchange-related appeals, if needed.

However, Jake is not eligible for Medicaid based on his own attestation and reviewed data sources and may not have the right to request a Medicaid Fair Hearing. There is no factual

Medicaid "Determination" Exchanges vs. Medicaid "Assessment" Exchanges

Federal regulations provide two options for Exchanges to handle Medicaid determinations.

One option is for an Exchange to perform Medicaid determinations on its own (a "determination" Exchange). Alternatively, an Exchange can merely "assess" applicants for Medicaid eligibility, then forward likely Medicaid-eligible applications to the state Medicaid agency for a full determination ("assessment" Exchanges).

New York's Exchange is expected to perform Medicaid determinations and will be a "determination" Exchange.

Sources: 45 C.F.R. §155.302; 42 C.F.R. §431.10; New York State Exchange Establishment Level 1 Funding application, June 29, 2012, available at http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/project_narrative_level1_funding.pdf.

dispute for a Fair Hearing to resolve. He also may have come to the Exchange to find health coverage generally, and may not even be aware that he applied for Medicaid. If New York is not required to offer Jake a Fair Hearing about the amount of his PTCs, then the Exchange should offer an alternative state-based appeals system.[51] A wide range of options are available to the State as it designs this system.[52]

Federal regulations do not dictate whether appeals must be handled by state workers or if they can be outsourced to a vendor. If New York opts to use an outside vendor for appeals, strong oversight will be needed—including regular audits. The State will also have to decide whether Jake will be allowed to present his appeal in person, by telephone, or only through written submissions on paper or online. Because many New Yorkers work and will not want to pursue an appeal in person, the Exchange should allow Jake flexibility in choosing his appeal venue, with the default choice being a written appeal, absent a special request. Six of 15 states surveyed by CSS conduct hearings by telephone as the default option. Six additional states conduct telephone hearings in some circumstances. Two states allow written submissions in some circumstances.[53] The State should build an Exchange appeals system that preserves the most important protections of the Fair Hearing system but also allows consumers greater flexibility and provides faster resolutions.

The ACA also allows Jake the opportunity to appeal this case to a federal appeals system.[54] The federal government has not yet provided details as to how this system will be structured. Still to be decided, for instance, is whether Jake would be required to exhaust his state-based appeals before bringing his dispute to the federal system.[55] Also still unknown is whether Jake will be able to present his case in person. Guidance on this is expected soon. The federal government should allow states to require exhaustion of their own appeals processes before allowing an applicant access to the federal system, thus avoiding the prospect of dueling hearings that may engender confusion for consumers and Exchange staff alike. In the event that New York adopts its own robust system, the State should exercise the option of requiring exhaustion.

Consumer Protections at Post-Determination and Formal Appeals

Legal Requirements

- Access to federal appeals procedure. (ACA § 1411(f)(1), 42 U.S.C. §18081(f)(1) (2012))

Recommendations

- No Medicaid Fair Hearings for an applicant who is ineligible for Medicaid based on his or her own income attestation.
- Flexible Exchange appeals system allowing option of appeals in person, by telephone, on paper, or online, while preserving important Fair Hearing due process protections.
- Strong oversight and auditing if the state opts to use a vendor for appeals.
- If the state is required to offer Fair Hearings to all Exchange applicants, then reform the Fair Hearing system to support the Exchange's goal of consumer-friendly enrollment.
- Require exhaustion of state appeals before access to federal appeal system.
- Revisit recommendations following guidance to be issued by federal regulators.

Case Scenario Two: Medicaid Applicants Anne and Carl Green of Brooklyn, NY

Anne and Carl Green of Brooklyn both apply for health insurance through the Exchange's website. Anne has no income. Carl recently lost his job as a maintenance manager for a local school, where he earned $30,000 annually. He has since taken on work as a handyman, and expects to earn $18,000 this year. However, like Jake Kirby, Carl's expected income of $18,000 per year cannot be verified by the Exchange's electronic verification system. The data sources used by the Exchange for income verification still show him earning $30,000.

With a household income of $18,000 per year (115 percent of FPL), the Greens are eligible for Medicaid—free comprehensive health insurance with minimal cost-sharing. With an income of $30,000 per year (200 percent of FPL), the Greens would be eligible for a QHP with PTCs and cost-sharing subsidies. In the second least expensive Silver plan, the Greens' premium would be $95 per month or $1,140 annually, and their other out-of-pocket costs would be limited to $3,967 per year.[56] This dispute could be worth thousands of dollars to the Greens.

How will the Exchange and Medicaid respond to the Greens' problem? What rights will they be afforded? How is the Greens' situation different from that of Jake Kirby, who attested to income above the Medicaid limit?

Consumer Protections at Pre-Determination

In this case, like Jake Kirby's, the Exchange will consider the discrepancy in the Greens' income large enough to be relevant. But unlike Jake, the Greens' income discrepancy affects their eligibility for Medicaid.[57] The Greens will need to resolve the inconsistency.

At this point, the Exchange can best support easy automated enrollment by providing a drop-down menu of pre-approved "reasonable explanations" for the inconsistency.[58] If the Greens select one of the choices, then the Exchange should automatically enroll them into Medicaid once their data is submitted.

If none of the drop-down choices fits the Greens' situation, the ACA's Medicaid-related regulations appear to envision a period during which the Greens can pause the application process to collect documents to submit.[59] In this case, the Exchange should issue a notice giving the Greens the option to submit documentation supporting their claimed income amount. To ensure the Greens' ability to reasonably acquire the documents and facilitate timely enrollment into coverage, the Medicaid document submission period should last at least two weeks.

At this point, the enrollment process can no longer be entirely automated, since an Exchange staff member will need to review these documents before the application can proceed. The review period should take no longer than five business days. The Exchange should notify the Greens that their documents are under review, inform them that they have an Exchange primary contact person, and provide the Greens information about how to reach their contact person with questions. The Exchange primary contact person should respond promptly to any inquiries by the Greens and be able to refer the Greens to a Navigator or CAP for extra assistance.

This document submission period also must be carefully coordinated with other Exchange deadlines, such as the annual open enrollment period for QHPs.[60] If a consumer starts the application process during the open enrollment period, then his or her right to enroll into a QHP should be preserved based on when the application was opened. Otherwise a consumer may lose his or her right to QHP enrollment while searching for documents (which may not materialize) needed to enroll into Medicaid.[61]

Open Enrollment Periods

Consumers will normally only be allowed to enroll in coverage through the Exchange during annual "open enrollment periods." The first such period will run from October 1, 2013 through March 31, 2014. In the following years, enrollment will only be open from October 15 through December 7.

Consumers can enroll outside of these periods only if they have a "special enrollment period." These arise after status-changing events like losing job-based coverage, births, marriages, and divorces. (45 C.F.R. §§155.410, 155.420)

Consumer Protections at Pre-Determination

Legal Requirements

- Offer consumer support online and through call center. (45 C.F.R. §155.205)
- Verify income attestation against federal and state data sources. (45 C.F.R. §155.320; 42 C.F.R. § 435.948; 42 C.F.R. § 435.949)
- Support a Navigator program. (45 C.F.R. §155.210)
- Allow consumers a "reasonable period" to submit documents if necessary. (42 C.F.R. §435.952(c)(2)(iii))

Recommendations

- Allow Medicaid enrollment based after an applicant provides a reasonable explanation for discrepancies. (42 C.F.R. § 435.952(c)(2)(i))
- Allow an applicant two weeks to submit documents to support his or her attestation of income.
- Require a response from the Exchange within five business days of an applicant's document submission.
- Enhance electronic customer support after discrepancy is identified (e.g., pop-ups, live-chat options).
- Give consumer one Exchange contact person, reachable by direct dial telephone and email.
- Refer applicants with discrepancies to CAPs or Navigators.

Consumer Protections at Initial Determination

If the Greens utilize the proposed two-week document submission period, the Exchange will wait to receive these documents before making an eligibility determination. If they are able to submit documents proving their income within that time period, they will be found eligible for Medicaid and receive a notice telling them so. If the Greens cannot produce documents within two weeks, the Exchange may still allow them to enroll into Medicaid based solely on their attestation.[62] New York should take advantage of this option as much as possible.

If the Exchange does not allow the Greens to enroll into Medicaid based on their attestation, then at the end of this two-week period, they should receive a Medicaid denial notice with full Fair Hearing rights. As described below, the Fair Hearing system handling this case should also have the competency and authority to deal with non-Medicaid ACA issues. The notice should include contact information for CAPs and Navigators who can assist them and should inform them of the basis of the Exchange's determination, as shown below:

	Income	
Household	***You say***	***Our records show***
Anne Green	$0 a year	$0 a year
Carl Green	$18,000 a year	$30,000 a year

Even without Medicaid, the Greens are still eligible to enroll into a QHP with PTCs. Like Jake Kirby, federal regulations require the Exchange to permit the Greens to enroll based on their attested income of $18,000 per year for 90 days.[63] During the 90-day period, the Greens can submit documentation to clear up the discrepancy (discussed below). Any notice issued to the Greens must also explain this right.

Consumer Protections at Initial Determination

Legal Requirements

- Provide applicant with "plain language" Medicaid denial notice. (45 C.F.R. §§155.205(c), 155.230 ; 42 C.F.R. § 435.907)
- Provide notice of Fair Hearing rights. (45 C.F.R. §§431.206)
- Provide information on appeal rights and consumer assistance resources available. (45 C.F.R. §155.230, 155.355)
- Allow enrollment into QHP with PTCs and cost-sharing subsidies based on attestation for 90 days. (45 C.F.R. §155.315(f))

Recommendations

- Include a chart clearly indicating the basis of the determination and the nature of the inconsistency.
- Provide notice as a pop-up and email, and offer applicant the option of a mailed paper notice.
- Allow Medicaid enrollment based on an applicant's attestation alone if no pre-approved reasonable explanation can be provided. (42 C.F.R. §435.945)

Consumer Protections During the 90-Day Document Submission Period

If the Greens choose to enroll into a QHP, like Jake Kirby, they must still resolve their income inconsistency. They will be given a period of 90 days during which they may receive PTCs based on their attested income of $18,000 per year while they gather satisfactory documents to prove their income.[64]

If they succeed, the Exchange should find them eligible for Medicaid coverage and should give them a revised notice.[65] If the Greens are unable to resolve this discrepancy within the 90 days, their PTCs should be reduced based on their Exchange-verified income of $30,000 per year and they will receive a notice telling them so that includes information on their right to appeal the PTC calculation they have received.[66]

Reducing the Greens' PTC amount based on their Exchange-verified income will increase their premiums

from $30 per month or $360 annually, to $95 per month or $1,140 annually.[67] This would be a significant financial hardship for the Greens, who at their income level are unlikely to have significant savings to fall back on.[68] If the Greens accurately reported their income and merely failed to submit documents, the IRS can refund the difference in premiums at annual reconciliation.

The Greens can also refuse to enroll into a QHP. In this case, they will not be covered and may be subject to a financial penalty for violation of the individual mandate.[69]

These choices and the potential consequences of each scenario will have to be explained to the Greens in a clear and comprehensible manner through a written notice.

Consumer Protections During the 90-Day Document Submission Period

Legal Requirements

- 90-day period during which an applicant can submit documentation supporting his or her income attestation. (45 C.F.R. §§155.315(f), 155.320(c)(3)(vi)(C)
- Submission of documents through the Exchange website, by mail, or in person. (45 C.F.R. §155.315(f)(2)(ii) ; 45 C.F.R. § 155.405(c))
- PTCs awarded based on income attestation during the 90-day period. (45 C.F.R. §155.315(f)(4))

Recommendations

- Adopt a unified document submission process for private and Medicaid coverage (enroll applicants into Medicaid if they submit documents during the 90-day document submission period indicating that they are eligible).
- Allow the applicant to submit documents by email, mail, in person, or fax.
- Allow an applicant to provide documents in person at any DSS, Navigator, or CAP office.
- Clear, comprehensible notice of options available to the applicant, and potential consequences of each.
- Regularly remind the applicant about the 90-day process.
- Regularly remind the applicant about the availability of assistance from Navigators and CAPs.
- Provide the applicant with a primary contact person at the Exchange call center, reachable by direct dial telephone and email.
- Ensure that other call center staff can assist applicant if his contact person is unavailable.

Consumer Protections Post-Determination and Formal Appeals

Since the Greens' income attestation puts them within the Medicaid limit, they have a right to a Fair Hearing. However, because the data match puts their income at the PTC level, they also have a PTC dispute. A single hearing should resolve both the PTC and Medicaid disputes. The prospect of dueling hearings must be avoided because it is a burden for consumers and a waste of administrative resources.

The Greens' case is also complicated because they have been offered appeal rights at two different points in time: (1) immediately after failing to provide documentation necessary for Medicaid enrollment during their two week time period; and (2) during or after their 90-day PTC document submission period. This added complication makes it especially critical that both Medicaid and PTC issues can be handled by a single hearing process, so that issues that arise later in the process can be consolidated.

New York has several options to consider for handling these integrated PTC/Medicaid hearings. One possibility is to build a special unit of the Office of Temporary and Disability Assistance (OTDA)—the agency that handles Medicaid hearings in New York—that is trained on PTC issues. This unit could even be stationed together with the Exchange, with most hearings taking place by telephone instead of in person. The advantage of this would be in integrating OTDA's expertise with Medicaid into the Exchange hearing structure. Another possibility is to use the new PTC hearing infrastructure and deputize a special unit to handle appeals that relate to Medicaid, including all of the due process protections guaranteed by *Goldberg*.

It Could Be Worse…

The Greens could face a more complex and financially burdensome scenario.

If the Greens attest to income below 100 percent of FPL, the situation becomes even more complex. Applicants below 100 percent of FPL are not eligible for PTCs, so the Greens may have no right to 90 days of PTCs based on their attested income. It may be very difficult for a family at that income level to pay higher premiums while they gather their documents, adding barriers to enrollment.

The intersections between PTCs, Medicaid, and Child Health Plus create intricate complications. New York must make sure that consumers do not fall through these cracks.

In either scenario, this unit should also have the capacity and competency to address coverage issues facing children, including hearing disputes about the Child Health Plus program.

The Greens should have the option of having their hearing held in person, by telephone, on paper, or online. They should also be referred to the statewide CAP for help with their appeal, should they need it.

The prospect of dueling hearings must be avoided because it is a burden for consumers and a waste of administrative resources.

The Greens may also have access to the federal appeals system since their dispute includes a PTC issue.[70] Their case thus illustrates another opportunity for dual—or triple—hearings. A requirement that the Greens exhaust their state-based appeals before accessing the federal system would mitigate this problem. However, federal regulators have yet to issue guidance on the federal appeals process and it appears unlikely that this unit would handle the state-based Medicaid aspects of the Greens' dispute.[71]

Consumer Protections Post-Determination and Formal Appeals

Legal Requirements

- Access to Medicaid Fair Hearing. (42 C.F.R. §§431.200 et seq., 18 NYCRR Part 358)
- Access to an Exchange-based PTC hearing. (Regulations forthcoming per 77 Fed. Reg. 18336 (Mar. 27, 2012))
- Access to a federal appeal system. (ACA § 1411(f)(1), 42 U.S.C. §18081(f)(1) (2012))

Recommendations

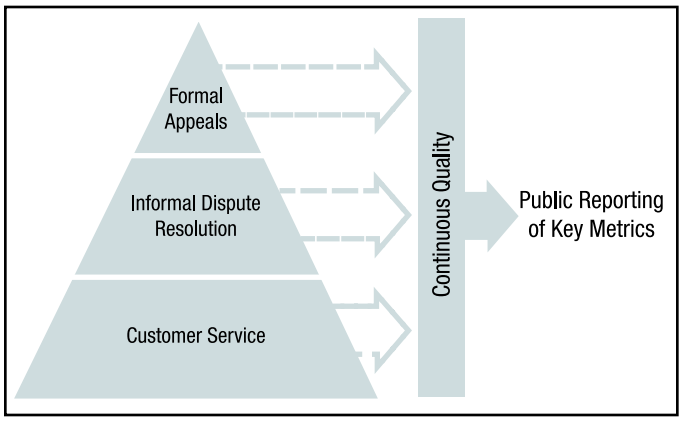
- Allow the applicant to pursue a unified appeal that can resolve Medicaid, Child Health Plus and PTC issues.
- Create a unified and integrated appeals system that can handle Medicaid, Child Health Plus, and PTC issues arising out of a single application.
- Adopt a flexible appeals system allowing option to appeal in person, by telephone, on paper, or online.
- Require exhaustion of the state appeals system before accessing the federal appeals system.

Recommendations

New York's Exchange faces important challenges in creating a consumer-friendly environment for resolving problematic applications. This report explores some of the thorniest issues, including the relationship between Exchange disputes and the Fair Hearing system, and the interaction between the Exchange and to-be-created federal appeals systems. As can be seen by the case scenarios provided, even a seemingly simple situation can quickly turn complex depending on how a potential dispute is handled. It is important that New York State's policy decisions are consistent with federal regulations and also meet the need for consumer accessibility and convenience.

Applicants seeking to enroll into coverage through the Exchange will have a number of consumer protections at their disposal to address problems encountered. These resources can be categorized into four different areas: (1) basic customer support, which can be accessed at any point in the enrollment process; (2) informal dispute resolution, to be accessed for moderate-level problems once basic customer service outlets have been exhausted; (3) formal appeals, which should be accessed only as a last resort when problems cannot be resolved informally; and (4) a continuous system of quality assurance, monitoring, and reporting of all consumer protections processes.

This system of dispute resolution can be visualized as a pyramid in which the intensity escalates as one moves upwards through the system. The bottom is composed of basic customer service functions where consumers can get status updates, find answers to simple questions, and have simple administrative mistakes resolved. Consumers will access these services through the web portal, by telephone, and in person. The middle level consists of informal dispute resolution, where consumers can get problems solved that require some level of judgment and the application of policy to facts. The top of the pyramid is the formal appeals process. Each level should incorporate a comprehensive system of continuous quality assurance and monitoring which can identify trends and respond quickly to emerging problems or issues. These metrics should be publicly reported on a regular basis.



Many consumers will interact with the Exchange's basic customer service tools at the bottom of the pyramid, but relatively few will likely ever pursue a formal appeal. If the Exchange effectively resolves problems at the lower levels of the pyramid, fewer people will need to escalate their disputes. This will save the State both time and resources, and enhance the consumer experience.

The scenarios described by the cases of Jake Kirby and the Greens illustrate the need for strong consumer protections at each level of the customer service framework. The following recommendations will ensure that the Exchange's system of consumer protections and dispute resolution is at once consumer-friendly, effective, and efficient.

Customer Service Recommendations

✓ **Strong Customer Support:** Invest in strong customer support tools to reduce the need for formal appeals. This should include:

- Clear, concise notices available in a variety of formats including via computer pop-up, email, and paper mail in multiple languages.
- Access to live, real time customer service options in person and via telephone, email, or online live chat in multiple languages.
- Establish user-friendly protocols to work with a consumer's designated representative.
- Strong linkages to Navigator and CAP programs with strong language capacity.

✓ **Consumer-Friendly Electronic Enrollment Process:** Consumers who apply online should have a variety of options available to them to ease the enrollment process. These should include:

- Creation of an electronic account on the Exchange where consumers can store their communication preferences and information.
- The ability to pause and restart an application at any time without losing information already entered.
- A progression tracker bar at the top of the screen to let consumers know how far along they are in the application process.
- The ability to go back and correct information already entered at any point prior to data submission, similar to the Enroll UX2014 model.
- The ability to see a summary of data already entered alongside state or federal data matches, along with any discrepancies in data highlighted, prior to data submission.
- All notices received throughout the enrollment or dispute resolution process should be automatically stored in an electronic folder in the consumer's account for future reference.

✓ **Maximize Access to Automated Enrollment:** Where policy choices exist, the State should seek to reduce the need for paper submissions and thus increase the number of New Yorkers who can enroll easily online. For example:

- When a discrepancy is identified, allow the consumer to select from a pre-approved list of reasonable explanations. If one such explanation applies, allow enrollment based on attestation.
- Allow Medicaid enrollment based on income attestation when possible.

Informal Dispute Resolution Recommendations

✓ **Strong Informal Dispute Resolution:** The Exchange should provide enhanced consumer support when document submission is required, including:

- Access to a dedicated Exchange representative, reachable by telephone and email, who is responsible for their case.
- Easy referrals to Navigators or CAPs.
- When consumers contact their representative or submit documents, the Exchange should respond promptly and keep a record in the applicant's account of all interactions.
- Regular deadline reminders to applicants conveyed in the medium of their choice (e.g., mail, email, telephone calls, text messages).

Formal Appeals Recommendations

✓ **No Dueling Hearings:**

• Consumers should not have simultaneous access to federal and state appeal systems. Instead, states should be allowed to require consumers to exhaust the state appeals system before getting access to the federal appeals system.

• Consumers should not have simultaneous access to Fair Hearings and some other Exchange-based appeal process.

✓ **Develop an Integrated State Appeals System for Exchange Applicants:** When applications raise issues related to Medicaid, QHPs, PTCs, cost-sharing subsidies, or Child Health Plus, all issues should be resolved by a single appeals system. If an applicant attests to facts which make him or her ineligible for Medicaid, the State may not be required to offer a Fair Hearing. Federal rules, however, may require that Fair Hearings be granted to many Exchange applicants. Whether through the Fair Hearings or not, the State must offer a new appeals system that is:

• Integrated, serving all programs offered through the Exchange;

• Flexible, allowing appeals in person, by telephone, through written submission, or online;

• Fast, providing certainty to applicants as quickly as possible; and

• Uses independent hearing officers that are fully trained in Medicaid, Child Health Plus, Basic Health Plan, PTC, and QHP eligibility and issues.

✓ **Strong Oversight of Exchange Appeals System:** If the State elects to use a vendor for its new Exchange appeals system, it must implement strong quality assurance and oversight measures.

• The State should audit a significant portion of all appeals to ensure accuracy, consistency and fairness.

• Complaints to the Exchange regarding the appeals process should be investigated promptly.

Quality Assurance, Monitoring, and Reporting Recommendations

✓ **Constant Improvement:** The State must revisit this process regularly to ensure that it is serving consumers effectively.[72] This should include a strong consumer complaint system and the regular collection of key dashboard metrics such as:

• Average hold times at the call center.

• Average response time after calls or emails to dedicated representatives.

• Number of dropped calls and interrupted web sessions.

• Number of consumers pursuing alternative customer service outlets, such as email and live chat.

• Average rate of discrepancies rectified informally.

• Number of appeals and types of disputes.

• Number of Fair Hearings and outcomes.

• Number of paused applications and identification of any trends in the process of where people are pausing applications.

• Number of applicants who utilize the 90-day document submission period, and case outcomes.

• Income bands most likely to need 90-day document submission period.

• Number of applicants in federal appeals process.

• How many refunds and penalties from IRS.

• Number of successful applications and time required to complete them.

• Number of referrals to Navigator and CAP programs.

✓ **Disparities Tracking:** To allow for identification of emerging trends among specific populations and to target future outreach efforts, the Exchange should track metrics by:

• Race and Ethnicity

• County of residence

• Household income

• Insurance type and plan

• Age

• Gender

• Sexual orientation

• Primary language or preferred spoken language and preferred written language

• Disability status

✓ **Regular Reporting:** The State should make data available on the preceding metrics in the following media:

• A dedicated, easy to locate and navigate website or web page that is regularly maintained and updated.

• Annual public reports available via print or online.

• Monthly electronic reporting of selected metrics available online.

• Annual presentations of findings and trends to State

regional advisory committees and stakeholder groups.

• Electronic data on all metrics available online for export via Excel spreadsheet or SPSS.

• An online data manipulation tool to allow consumers and advocates to access simple statistics quickly and create quick charts and graphs.

✓ **Strong Complaint Mechanism:** The State should encourage suggestions and complaints from consumers and develop a system to respond to them promptly.

New York State is rapidly implementing the Affordable Care Act. The opportunity to design an effective, consumer-driven Exchange is a fleeting one. Yet the consumer experience and the protections offered by the State's Exchange, including its ability to provide a consumer-friendly website and to administer complicated cases effectively, will be critical to the success or failure of the Affordable Care Act in New York. With this in mind, the recommendations laid out in this report provide a solid framework for policy makers to approach this difficult task and ensure that New Yorkers have a reliable, easy-to-use Exchange.

Appendix A: List of Potential "Reasonable Explanations" for Inconsistencies in Data

One method to limit the number of inconsistencies that have to be addressed by the Exchange is to build and adopt a broad list of "reasonable explanations" as to why an applicant's information does not correlate with state or federal data bases. To ease the consumer experience and to increase enrollment efforts, this list of pre-approved reasonable explanations should be integrated into a "drop down" menu on the Exchange website. Below is a list of potential reasonable explanations.

Income-Related:

• Lost job
• Decrease in hours
• Multiple employers
• Self-employed
• Do not file taxes
• Have not filed taxes yet
• Homeless
• Victim of domestic violence
• Victim of natural disaster
• Fluctuating income
• Work on commissions
• Income from capital gains
• Income from dividends
• Income from royalties
• Seasonal worker
• Divorce or marriage
• Death in family
• Victim of identity theft

Household-Related:

• Birth or adoption
• Child moved away from home
• Death in family
• Divorce or marriage
• Recent change of address

Immigration-Related:

• Recent change of status
• Identity theft

Appendix B: Improving Eligibility Appeals for New York's Current Programs

This report focuses on the Exchange, but the ACA also presents an opportunity to improve the eligibility appeals systems for New York's existing health insurance programs. New York's Medicaid Fair Hearing system, for instance, includes strong *Goldberg*-compliant due process protections, but is perceived to be slow and inflexible. At the other end of the spectrum, Child Health Plus (CHP) and HealthyNY applicants are afforded no appeal notices or formal hearings. Neither of these two of extremes serves New York consumers well.

Current Systems and Criticisms

Medicaid: New York's current Medicaid Fair Hearing system faces several persistent criticisms. First, the process of requesting a hearing, scheduling it, producing a decision, then implementing the decision, can take several months even in the best case.[73] A new applicant typically remains uninsured during this process. Second, New York's Medicaid Fair Hearings require the consumer to appear in person—often at a local district social services office—on a weekday during business hours. Wait times at the hearing site are unpredictable, so appellants often must take a half- or full-day off work or arrange for child care. Even the more informal "conference" process requires an in-person appearance, with exceptions only rarely available.[74] Third, fair hearing notices are long and difficult for the average applicant to understand. Fourth, it is nearly impossible for a consumer to get through to the fair hearing call center to cancel or reschedule.[75] These issues and others make the fair hearing process a frustrating one for tens of thousands of the New Yorkers.

CHP: Unlike Medicaid, New York's CHP program offers applicants relatively few procedural protections. New York's CHP program relies on managed care plans to handle enrollment and eligibility determinations. These plans also handle the few CHP appeals that take place. CHP applicants must typically pay their first month's premium before being enrolled into the plan, and written communication from the plans is typically limited to invoicing, not formal notices about how their eligibility and premium was determined. These statements often tell enrollees to call member services if they have questions about their premiums, but no formal appeal rights are described or provided. If a CHP enrollee disagrees with his or her plan's premium determination, then the enrollee may have no formal recourse beyond complaining to the plan itself. Not surprisingly, New York's CHP program reports few appeals; this can be interpreted as either the result of a successful enrollment system or of a failure to notify applicants of their appeal rights.[76]

HealthyNY: Like CHP, HealthyNY applicants are not provided formal eligibility determination notices and have no access to a formal appeals system. HealthyNY applicants have two avenues for raising disputes: They can complain to the Department of Financial Services (DFS) Consumer Assistance Unit, or they can file a standard grievance with their plan. Denied applicants, though, are not routinely informed about either of these options, and DFS has only received 117 such complaints since initiation of the program in 2001.[77]

Improving These Systems

A consumer-friendly Exchange appeals system should communicate clearly with applicants, and must also be flexible and fast. New York's insurance eligibility appeals systems can serve consumers better by adopting the following recommendations:

Venue: Consumers should be given the choice of presenting their case on the telephone, by written submission, online, or in person. New York requires most Medicaid hearings to take place in person, but many states hold Medicaid hearings by telephone.[78] Some consumers may also prefer to appeal through written submission, a result which does not violate *Goldberg* if offered at the consumer's option.[79]

Notices: Appeal notices must be clear, concise, and understandable to the average applicant. Today, New York's Medicaid Fair Hearing notices are at least four pages long, and contain many legal and technical terms. The process of revising Fair Hearing notices will be difficult because they have been developed through numerous court cases over the years.[80] But the ACA presents an opportunity to create a clean slate and develop more consumer-friendly

notices.

Right to Review Evidence: Consumers should always be able to access the Exchange's electronic files forming their complete case record. New York's Fair Hearing system allows appellants to request an "evidence packet" by fax or mail.[81] But the request process can be cumbersome for consumers, particularly without the help of an advocate. Packets containing the Medicaid agency's evidence are then mailed to the consumer or an advocate. The Exchange should ensure that the consumer's entire file is kept electronically and linked to the consumer's online account at the Exchange, so that a consumer or advocate has easy access to the necessary records.

Decision-Maker: The individuals deciding Exchange-based appeals must be independent and fully trained on the ACA, including issues related to PTC and QHP eligibility. Close cooperation between these decision-makers and the Exchange will also be necessary. The State can achieve this in a number of ways. One option is to have a special unit of OTDA trained on the ACA and stationed with the Exchange. Another option is to use neutral decision-makers other than OTDA. The regulations implementing *Goldberg* only require that the decision-maker not have had any involvement in the initial disputed determination.[82] For the sake of conserving administrative resources and serving consumers efficiently, it is imperative that a single hearing—with a single decision-maker—can handle every eligibility issue an applicant may face following an Exchange-based application.

Timing: Disputes must be handled quickly and efficiently. Appeals by written submission should be decided within 30 days. In-person or telephone appeals should be scheduled to take place within 30 days of request with decisions issued within 15 days thereafter. Decisions should be implemented within 10 business days.

Aid-Continuing: The appeals system must be equipped to handle traditional Medicaid aid-continuing in addition to analogous ACA requirements applying to PTCs and cost-sharing reductions. *Goldberg* requires that Medicaid enrollees be allowed to maintain their benefits unchanged while awaiting their hearing. In the PTC context, regulations call for a 90-day document submission period to resolve inconsistencies. During this period, the Exchange must award PTCs based on the applicant's attestation.[83] If the inconsistency is not resolved during this period, though, then the Exchange must re-determine the PTC award based on the electronically-verified data.

The ACA calls for Exchanges to create a first-class consumer experience for health plan enrollment. But once glitches arise, the systems currently in place in New York cannot meet that goal. New York should take this opportunity to improve them. The success of health reform depends on it.

Notes

[1] Child Health Plus is the name of New York's State Children's Health Insurance Program (SCHIP).

[2] F. Blavin, L. Blumberg, M. Buettgens, and J. Roth, "The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State," Urban Institute, March 2012, available at: www.healthcarereform.ny.gov/health_insurance_exchange/docs/2012-03_urban_institute_report.pdf.

[3] B. Sommers and S. Rosenbaum, "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," 30 HEALTH AFFAIRS 238-36, February 2011.

[4] *See* Patient Protection and Affordable Care Act ("ACA") § 1302(d), 42 U.S.C. § 18022(d) (2012). A plan's actuarial value is the percentage of total costs for covered benefits that the plan is expected to cover on average for enrollees, after considering cost sharing features such as deductibles, co-payments, and co-insurance.

[5] 45 C.F.R. §155.205(c) (2012).

[6] 45 C.F.R. §155.405 (2012).

[7] 45 C.F.R. §§155.315, 155.320 (2012).

[8] 45 C.F.R. §155.315(f) (2012); 42 CFR 435.952 (2012); 42 CFR 435.956 (2012).

[9] 26 C.F.R. §1.36B-3 (2012) and 45 C.F.R. §155.310(d)(2)(i) (2012) (describing substantive rules for PTC calculations); ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (2012) and 45 C.F.R. §155.355 (2012) (describing related appeal rights).

[10] 45 C.F.R. §155.305(f) (2012) (substantive rule); 26 C.F.R §1.36B-2(a)(2) (2012) (substantive rule in NPRM form); ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (2012) (federal appeal rights); 45 C.F.R. §155.355 (2012) (appeal rights).

[11] 45 C.F.R. §§155.410, 155.420 (2012) (substantive rules on open and special enrollment periods); ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (federal appeal rights); 45 C.F.R. §155.355 (2012) (appeal rights).

[12] *Id.*

[13] Substantive eligibility rules for Medicaid found at 42 C.F.R. Part 435 and 18 N.Y.C.R.R. Part 360. Appeal rights found at 42 C.F.R. §§431.200 et seq. and 18 N.Y.C.R.R. Part 358.

[14] 45 C.F.R. §155.305(a) (2012) (substantive rules); 45 C.F.R. §155.355 (2012) (appeal rights); ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (2012) (federal appeal rights).

[15] Applicants found eligible for Medicaid will be prohibited from choosing to enroll into a QHP with PTCs instead. 45 C.F.R. §155.305(f)((1)(ii)(B) (2012).

[16] New York has a sliding scale for CHP premiums, depending on the applicant's income. For a table of premiums by income level, *see* www.health.ny.gov/health_care/child_health_plus/eligibility_and_cost.htm (last visited Aug. 27, 2012). Appeal rights for CHP applicants are described at 45 C.F.R. §155.355 (2012) and 42 C.F.R. Part 457.

[17] 45 C.F.R. §155.305(g) (2012) (substantive rules); ACA §1411(f)(1), 42 U.S.C. §18081 (2012) (federal appeal rights); 45 C.F.R. §155.355 (2012) (appeal rights).

[18] ACA §§5000(d) and (e), 26 U.S.C. §§5000A(d) and (e) (2012) (substantive rules on exemptions and exclusions from mandate); ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (2012) (federal appeal rights); 45 C.F.R. §155.355 (2012) (appeal rights).

[19] 45 C.F.R. §155.305(a) (2012) (substantive rules); 45 C.F.R. §155.355 (appeal rights). ACA §1411(f)(1) does not appear to give federal appeal rights for disputes regarding incarceration status.

[20] The ACA and implementing regulations do not clearly establish formal appeal rights for general administrative mistakes.

[21] *See, e.g.*, 45 C.F.R. §155.335 (QHP annual redetermination); 42 C.F.R. §435.916 (2012) (periodic Medicaid renewal).

[22] 45 C.F.R. §155.330 (2012) (eligibility redetermination during a benefit year); ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (2012) (federal appeal rights); 45 C.F.R. §155.355 (2012) (appeal rights). The bullet points following are from CSS' concept paper on this topic.

[23] 45 C.F.R. §155.420 (2012) (special enrollment periods); ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (2012) (federal appeal rights); 45 C.F.R. §155.355 (2012) (appeal rights).

[24] 45 C.F.R. §155.430 (2012) (substantive rules on mid-year terminations); ACA §1411(f)(1), 42 U.S.C. §18081 (2012) (federal appeal rights); 45 C.F.R. §155.355 (2012) (appeal rights).

[25] *See, e.g.*, 42 C.F.R. §435.916 (2012) (Medicaid).

[26] 45 C.F.R. §155.420(d)(7)(2012).

[27] 26 C.F.R. §1.36B-4(a)(3) (2012).

[28] 26 C.F.R. §1.36B-4 (2012).

[29] National Health Law Program, Comments to CMS regarding Notice of Proposed Rule Making concerning the Exchange, October 31, 2011 (stating that "because a determination of eligibility for advance payments of premium credits presumes a finding of ineligibility for Medicaid, every decision by the exchange is effectively a denial of Medicaid benefits. This means that the Exchange appeal process will have to be coordinated with the Medicaid process and provide all due process protections that are required under Medicaid."), available at: http://www.healthlaw.org/images/stories/Exchange%20Eligility%20Comments%20Aug%202011%20NPRM%20FINAL.pdf.

[30] Federal regulations give Exchanges the option of performing a Medicaid determination on every application, or merely "assessing" each application for likely Medicaid eligibility and then forwarding to the state Medicaid agency for a full determination. *See* 45 C.F.R. §155.302 (2012). New York has indicated that its Exchange will perform Medicaid determinations, not assessments. *See* New York State Exchange Establishment Level 1 Funding application, June 29, 2012, available at: http://www.healthcarereform.ny.gov/health_insurance_exchange/docs/project_narrative_level1_funding.pdf.

[31] For appeals regarding matters which can have no bearing on Medicaid eligibility, such as the availability of affordable employer-sponsored coverage, the Massachusetts Connector utilizes its own less formal appeals system. Appeals regarding matters that might affect Medicaid eligibility, such as income, are handled by the Medicaid Fair Hearing system. *See* 956 Mass. Code Regs. 3:14, 3:17 (2012), available at: https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/956CMR3.00CommCareRegs.pdf.

[32] ACA §1411(f)(1), 42 U.S.C. §18081(f)(1) (2012).

[33] The preamble to the United States Department of Health and Human Services' (HHS) August 17, 2011 notice of proposed rulemaking on Exchange functions states that HHS "intend[s] to propose the details of the individual eligibility appeals processes, including standards for the Federal appeals process, in future rulemaking." 76 Fed. Reg. 51223 (Aug. 17, 2011). In the comment and response section preceding the corresponding final rule, issued March 27, 2012, HHS again noted that it "intend[s] to address the content and manner of appeals of individual eligibility determinations in future rulemaking." 77 Fed. Reg. 18324 (Mar. 27, 2012).

[34] The section of the ACA creating the federal appeals system only covers eligibility verification systems for QHPs, PTCs, and cost-sharing subsidies. Medicaid is not within its scope. ACA §1411, 42 U.S.C. §18081 (2012). Also still to be decided is whether such a system would be available to all disputes of QHP applicants, or merely certain disputes, such as those stemming from federal data matching. Section 1411(f)(1) calls for the federal appeal systems to adjudicate appeals "of any determinations under subsection (e)." Section 1411(e) deals exclusively with data verification procedures, thus the federal appeals system may not be empowered to hear other disputes, such as the Special Enrollment Period dispute described in the box earlier in this report. Similarly, the federal appeals system developed under §1411(f)(1) may not have authority to hear disputes related to incarceration status because this status is not verified electronically pursuant to §1411(e).

[35] 26 C.F.R. §1.36B-3 (2012) (describing calculation of premium tax credits).

[36] Exchanges can accept attestations that differ from information obtained in a data match if the two numbers are "reasonably compatible." States have some flexibility in detailing what this means in practice. The regulations only provide that an attestation must be considered reasonably compatible with the data match if the difference does not affect the amount of PTCs for which the applicant is eligible. 45 C.F.R. § 155.300(d) (2012). If an applicant is eligible for an "alternate verification process," for instance if they attest that their income recently decreased, then the Exchange must accept as true any attestation that is less than 10 percent different from that indicated by the data match. 45 C.F.R. §155.320(c)(3)(v)) (2012).

[37] 45 C.F.R. §155.320(c)(3) (2012) (describing verification procedures).

[38] *See* 45 C.F.R. §§155.315, 155.320 (2012). These provisions describe electronic data verification procedures and methods to work through inconsistencies, but leave many unanswered questions and opportunities for state flexibility.

[39] "Reasonable Compatibility Flexibility: Exploring Models to Help States Resolve Inconsistencies in Income for Medicaid, CHIP and Tax Credit Eligibility," Robert Wood Johnson Foundation, Presentation for the National Association for State Health Policy, June 28, 2012, available at: www.nashp.org/webinar/reasonable-flexibility-exploring-models-help-states-resolve-inconsistencies-income (last visited Aug. 27, 2012).

[40] Federal regulations do not explicitly authorize the award of

PTCs following the submission of a "reasonable explanation" with no further documentation. But States should be free to take this route if they choose to. The procedures laid out at 45 C.F.R. §155.320(c)(3)(vi) call on Exchanges to utilize the 90-day document submission period of 45 C.F.R. §155.315(f) in these situations. That provision requires Exchanges to offer applicants 90 days to submit documentation "or otherwise resolve the inconsistency." The use of a pre-approved list of reasonable explanations is a consumer-friendly way to resolve inconsistencies while streamlining the enrollment process. It is also analogous to inconsistency resolution methods allowed under the ACA Medicaid regulations. *See* 42 C.F.R. §435.952(c)(2)(i) (2012) (allowing resolutions of discrepancies when applicant submits "[a] statement which reasonably explains the discrepancy"). Further, the regulations clearly allow for state flexibility in creating and implementing a verification and data collection plan. 45 C.F.R. §155.315(h) (2012).

[41] For a thorough review of new technology methods that an Exchange can use to better serve consumers, including pop-up notices, live chat, and online accounts for important notices, *see* T. Brooks and J. Kendall, "Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP, and Exchanges," Maximizing Enrollment, July 2012, available at: www.statereforum.org/sites/default/files/maximizing_enrollment_-_consumer_assistance_-_july_2012.pdf (last visited Aug. 27, 2012).

[42] The ACA requires each Exchange to operate a Navigator program to help consumers and small businesses enroll into coverage. Navigators will be drawn from the ranks of community-based nonprofits as well as groups such as chambers of commerce, unions, or licensed brokers. 45 C.F.R. §155.210 (2012).

[43] 45 C.F.R. §155.315(f) (2012).

[44] 45 C.F.R. §§155.205(c), 155.230, 155.315(f)(2)(i) (2012).

[45] *See* n. 43, *supra.*

[46] 45 C.F.R. §155.315(f)(4) (2012).

[47] 45 C.F.R. §155.315(f)(5) (2012).

[48] *Cf.* 45 C.F.R. §155.315(f)(5)(i) (2012) (requiring notification if Exchange is unable to resolve the inconsistency by the end of the 90-day period).

[49] HHS's proposed rule of July 15, 2011, called for "appeals of individual eligibility determinations" to be a mandatory core function of every Exchange. 76 Fed. Reg. 41915 (July 15, 2012) (proposed rule at 45 C.F.R. §155.200(d)). But this requirement was deleted from the final rule of March 27, 2012, with an explanation in a comment response that HHS "intend[s] to address the content and manner of appeals of individual eligibility determinations in future rulemaking." 77 Fed. Reg. 18324 (Mar. 27, 2012). Without providing details on the appeals process, the final rule does require notices sent to applicants after eligibility determinations to outline appeal rights. 45 C.F.R. §155.355 (2012). HHS's State Exchange Blueprint also appears to require state-based Exchanges to have capacity to "support the eligibility appeals process and to implement appeals decisions." HHS, "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges," available at: www.cciio.cms.gov/resources/files/hie-blueprint-081312.pdf (requirement 3.11).

[50] *See,* n. 29, *supra.*

[51] Regulations do not yet outline the extent to which Exchange applicants will be granted full Fair Hearing rights.

[52] There are at least seven dimensions along which dispute resolution systems can vary: (1) Notice requirements (e.g., Must the consumer receive written notice of his or her appeal rights? When?); (2) Procedure for requesting an appeal (e.g., by telephone, mail, or online, etc.); (3) Scope of decisions/actions subject to review (Will all decisions by subject to appeals? Or only some?); (4) Nature of the hearing (Will it take place in person? Or by telephone? Or merely by paper? Can the appellant review adverse evidence in advance? Is the decision-maker limited to using evidence presented in the record?); (5) Decision-maker (Will the "judge" be a State employee?); (6) Time frames (What is the time limit for requesting an appeal? For scheduling the hearing? For issuing a decision? For implementing a decision?); and (7) Aid-continuing (Does the appellant have the right to continue with benefits unchanged while awaiting the hearing?).

[53] B. Rappoport, Memorandum prepared for the Community Service Society of New York, July 2012.

[54] *See* n. 32, *supra.*

[55] *See* n. 34 *supra* and accompanying text.

[56] 26 C.F.R. §1.36B-3 (2012) (describing calculation of PTCs); 45 C.F.R. § 155.340 (describing administration of cost-sharing subsidies).

[57] States have several options with respect to determining "reasonable compatibility" between attestations and data sources for Medicaid applicants. Even if the difference is less

than 10 percent, for example, a state can choose to consider that not "reasonably compatible" if the difference affects the applicant's eligibility for Medicaid. For more information about data verification procedures under federal Medicaid rules, *see, e.g.,* 42 C.F.R. §§ 435.945, 435.948, 435.949, 435.952 (2012); "Reasonable Compatibility Flexibility: Exploring Models to Help States Resolve Inconsistencies in Income for Medicaid, CHIP and Tax Credit Eligibility," Robert Wood Johnson Foundation, Presentation for the National Association for State Health Policy, June 28, 2012, available at: www.nashp.org/webinar/reasonable-flexibility-exploring-models-help-states-resolve-inconsistencies-income (last visited Aug. 27, 2012); D. Bachrach and K. Serafi, "Federal Requirements and State Flexibilities for Verifying Eligibility Criteria," Feb. 2012, available at: www.statereforum.org/sites/default/files/state_network_-_manatt_eligibility_verification_analysis.pdf (last visited Aug. 28, 2012) (published before final verification rules issued).

[58] 42 C.F.R. §435.952(c)(2)(i) (2012).

[59] 42 C.F.R. §435.952(c)(2)(iii) (2012).

[60] *See* 45 C.F.R. §§155.410, 155.420 (2012) (open enrollment and special enrollment periods).

[61] The relevant regulations do not appear to preclude an Exchange from preserving an application date for the purposes of QHP open enrollment while an applicant searches for documents necessary for a Medicaid application. *See* 45 C.F.R. §§155.410, 155.420 (2012) (open enrollment and special enrollment periods).

[62] 42 C.F.R. §435.945(a) (2012).

[63] 45 C.F.R. §§155.315(f), 155.320(c)(3)(vi)(C) (2012). States have the option of conducting on-going post eligibility verification to ensure program integrity. D. Bachrach and K. Serafi, "Reasonable Compatibility Straw Models: Federal Requirements and State Options for Constructing a State's Financial Reasonable Compatibility Standard," State Health Reform Assistance Network, August 2012, available at: http://www.statenetwork.org/wp-content/uploads/2012/08/State-Network-Max-Enroll-Manatt-Reasonable-Compatibility-Straw-Models.pdf (last visited September 10, 2012).

[64] *Id.*

[65] Federal regulations describing the 90-day document submission period do not require that Exchanges enroll applicants into Medicaid if they submit documents showing Medicaid eligibility. But this seems the logical course to follow. These applicants probably cannot be provided PTCs because Medicaid-eligible applicants are precluded from receiving PTCs. 45 C.F.R. §155.305(f)(1)(ii)(B) (2012). Further, there are no open enrollment periods for Medicaid. Thus the best path for Exchanges to follow in this situation is to enroll such applicants into Medicaid.

[66] *See* n. 47, *supra.*

[67] If the Greens choose to enroll in a Silver-level plan under their attested income they would be eligible for an additional increase in the actuarial value of their plan from 70 percent to 94 percent. However, under their Exchange verified income, their actuarial value will be reduced to 87 percent. ACA §1402 (c)(2).

[68] Many New Yorkers with incomes below 200 percent of poverty have significant amounts of debt, with little or no disposable income left to pay for health insurance premiums: 23 percent report having fallen behind in rent or their mortgage payments; 30 percent report no savings; 17 percent report having medical debt; and 42 percent worry that their income is not adequate to meet their family's expenses or bills. *See* Community Service Society of New York, "The Unheard Third Survey," 2012 (forthcoming publication).

[69] 26 U.S.C. §5000A (2012). The Greens may also have the right to seek an exemption from the individual mandate based on affordability. ACA §§ 1311(d)(4)(H), 1411.

[70] *See* n. 32, *supra.*

[71] The section of the ACA creating the federal appeals system only covers eligibility verification systems for QHPs, PTCs, and cost-sharing subsidies. Medicaid is not within its scope. ACA §1411, 42 U.S.C. §18081 (2012).

[72] Regulations require Exchanges to regularly revisit the "appropriateness and usability" of applications, forms, and notices. 45 C.F.R. §155.230(c)(2012).

[73] Regulations allow the State a total of 90 days from the date the hearing is requested until the final decision is implemented. 18 N.Y.C.R.R. §358-6.4 (2012). But these deadlines are routinely missed. For example, a Community Health Advocates Helpline Counselor recently requested a Fair Hearing for a client on August 2, 2011, and received a notice five months later, on January 5, 2012, scheduling a Fair Hearing for January 19, 2012. Regulations allow for expedited Fair Hearing scheduling in urgent situations, but these are rarely held. 18 N.Y.C.R.R. §358-5.2 (2012).

[74] Telephone hearings are only available if the appellant physically cannot travel to the hearing site. 18 N.Y.C.R.R. §358-3.4 (2012). Informal conferences are only allowed by telephone at OTDA's discretion when an in-person meeting is "not feasible." 18 N.Y.C.R.R. §358-4.2(i) (2012).

[75] *Fishman v Daines*, 743 F.Supp.2d 127, 147 (E.D.N.Y. 2010) (alleging that "calling the fair hearing line is futile" because fewer than 5 percent of callers make it past the busy signals and long hold times).

[76] Personal communication with Gabrielle Armenia, New York State Department of Health.

[77] Personal communication with Laura Dillon, New York Department of Financial Services.

[78] States conducting all or many Fair Hearings by telephone include Massachusetts, Minnesota, and Oregon. *See* 130 C.M.R. § 610.013 (2012) (Massachusetts); Minn. Stat. § 256.045(4) (2012) (Minnesota); Oregon Office of Administrative Hearings, "Representing Yourself," available at: cms.oregon.gov/OAH/Pages/Representing_Yourself.aspx (last visited Aug. 30, 2012) ("Many administrative hearings [in Oregon] are held by telephone.")

[79] *See, e.g.,* Murphy v. Terrell, 938 N.E.2d 823 (Indiana Ct. of App. 2010) (citing *Goldberg*); *Armstrong v. Magill* (Tennessee Ct. of App., 2004: 2004 WL 1462631).

[80] *See, e.g., Rosen v. Tenn. Comm'r of Fin. & Admin.*, 280 F. Supp. 2d 743, 829-32 (M.D. Tenn. 2002).

[81] The 18 N.Y.C.R.R. §358-3.7 (2012); *see also* Rivera v. Bane, Index No. 45305-92 (Sup.Ct. N.Y. County Feb.28. 2005) (Stipulation of Settlement and Order).

[82] 42 C.F.R. §431.240 (2012).

[83] 45 C.F.R. §§155.315(f) (initial applications), 155.330(e) (mid-year redetermination), 155.335(f) (annual redetermination) (2012).

Community Service Society
Fighting Poverty
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New York

105 East 22nd Street
New York, NY 10010
PH 212.254.8900
www.cssny.org