Appeals Assistance

BeWell Essentials: Part 6 of 8

BeWell
New Mexico's Health Insurance Marketplace

Introduction

This training reviews important policies and procedures for assisting consumers with eligibility appeals.

Main Topics

- Eligibility appeals
- Appeal submission process
- Important reminders

Decisions that **Can** be Appealed to BeWell

- Applicants or enrollees have the right to appeal certain decisions or determinations made by BeWell. These include:
  - An eligibility determination, such as:
    - An initial determination of eligibility, including the amount of advance payments of the premium tax credit (APTC) and level of cost-sharing reductions (CSR);
    - A redetermination of eligibility, including the amount of APTC and level of CSR; and
    - A determination of eligibility for a Special Enrollment Period (SEP).
  - A failure by BeWell to provide timely notice of an eligibility determination; or
  - An error by BeWell.

Decisions that **Cannot** be Appealed to BeWell

- The following items cannot be formally appealed to BeWell through the appeals process described in this lesson.
  - Denied carrier claims and other carrier appeals;
  - Medicaid eligibility determinations;
  - The inability to change plans once a plan selection has been made;
  - Effective dates of coverage;
  - The ability to shop for a different metal level than what is displaying as an option in Plan Enrollment;
  - Issues with a Form 1095-A;
  - When the consumer files their federal income tax return, they owe back some or all the premium tax credit (PTC) they used during the year to lower their monthly premiums; and
  - Issues with a provider network.

Who Can Help

- Carrier
  - If a consumer's health plan refuses to pay a claim the consumer thinks should be covered; or
    - A consumer may appeal to their carrier.
  - Issues with a provider network
- Internal Revenue Service (IRS)
  - When a consumer files a federal income tax return, they owe back some or all the PTC they used during the year to lower their monthly premiums.
- The New Mexico Health Care Authority (HCA)
  - Medicaid eligibility appeals

Before Submitting an Appeal

- Before submitting an appeal, review the following:
  - Is the consumer being denied because they have access to, or are already enrolled in, other minimum essential coverage (MEC), such as Medicare, Medicaid, or Veterans Affairs (VA) Health Benefits?
  - Did the consumer select they did not want to keep their full price plan in the Rights and Responsibilities portion of the application if they ever became eligible for Medicaid?
  - Was the consumer determined potentially eligible for Medicaid of any type but chose not to allow their application to be transferred to HCA, causing them to not be assessed for the tax credit as well?
  - If the consumer is married, are they listed as filing jointly?
    - Except in the case of domestic violence or abandonment.

Before Submitting an Appeal (Continued)

- Did the consumer submit a financial assistance application to request eligibility for the PTC?
- Is the consumer under 100% of the federal poverty level (FPL) but not eligible for Medicaid due to immigration status?
    - If yes, recommend contacting the Customer Engagement Center (CEC).
- Is the consumer over 65 and not eligible for either Medicaid (usually due to age) or Medicare (usually due to a lack of work quarters)?
    - If yes, recommend contacting the CEC.
- Did the consumer enter their current health insurance through the Marketplace as other MEC by mistake?

Appealing Eligibility Decisions – Timeline

- Appeal requests must be made within 90 days of the date of BeWell's eligibility determination.
  - This is generally the date on the eligibility notice.
- BeWell will work to resolve appeals promptly; however, the appeal process can take up to 90 days.

Appeals – Acknowledgment Notice

- After a consumer submits an appeal request, BeWell will send an Appeal Acknowledgement to the appellant.
- The Appeal Acknowledgement will:
  - Confirm receipt of the appeal request
  - Explain appeal procedures, including:
    - Timelines for processing the appeal
    - The right to request a fair hearing
  - Explain the status of the appellant's health coverage while the appeal is pending
- **Note:** BeWell also provides notice of appeal rights and procedures in the eligibility notice that is sent to the consumer (See 45 CFR §155.515).

Ongoing Coverage During an Appeal

- When a consumer is already enrolled with BeWell, and they submit a valid appeal or have a valid appeal submitted on their behalf, consumers are allowed to maintain their eligibility and enrollment in a qualified health plan (QHP), APTC, and CSR while the appeal is pending.
- Consumers must call the BeWell CEC if they want their benefits to continue while their appeal is reviewed.
    - This will not be completed while the appellant is on the phone.
- **Note:** Be aware that the consumer may be responsible for the cost of their coverage.
    - For example, BeWell may determine the consumer is not eligible for all the PTC they got during their appeal. The consumer may then have to pay back some or all that tax credit when they file their federal tax return.

Informal Resolution Process

- BeWell will work with consumers to informally resolve their appeals as quickly as possible.
- The appellant's right to a hearing is preserved if the appellant is dissatisfied with the outcome of the informal resolution process.
- If the appeal does not advance to a hearing, the informal resolution is final and binding.

Special Accommodations

- The appellant can ask for special accommodations for a disability or request a language or speech interpreter be available during the informal resolution process.
- Accommodations are provided at no cost to the appellant.

Appeals – Request for Information Notice

- When processing an appeal, additional information may be necessary and requested of the consumer to continue with the review.
- This may include proof of:
  - Employer-sponsored insurance (ESI);
  - Medicaid denial letter;
  - Income;
  - Citizenship;
  - SSN;
  - Immigration status;
  - Incarceration status; or
  - American Indian/Alaska Native status.

Appeals – Request for Information Notice

- A Request for Information (RFI) Notice will be sent to the consumer using their preferred method of contact.
- The consumer must provide the requested documents and/or information within 15 calendar days of the date of the notice so BeWell may resolve their appeal correctly and promptly.
- If BeWell does not receive the information, it will decide based on the information available.

Appeals – Decision Notice (Informal)

- If the appeal was determined to be invalid, the consumer may correct the appeal request and resubmit the appeal if the request is received within the initial 90-day appeal timeframe.
- If the appeal was rejected due to a failure to submit information by the deadline, and the consumer can demonstrate that this was due to exceptional circumstances, the appeal request may be considered valid.
- If the consumer disagrees with the resolution in this notice, they may request a hearing on the appeal. They should notify BeWell within 15 calendar days of the notice to request a fair hearing. The hearing will be conducted by the HCA. HCA will contact the consumer to schedule the hearing.

Appeals – Decision Notice (Informal) (Continued)

- When an appeal has been reviewed and there is a proposed resolution to the issue, a notice will be sent to the consumer using their preferred method of contact.
- This notice contains the proposed resolution of the appeal based on BeWell's review of the application and of any information provided.
- Based on the determination, the appeal may be rejected or determined to be invalid, denied, or approved. If invalid or denied, a reason will be provided in the notice.

Fair Hearing

- If the appellant is not satisfied with BeWell's informal resolution, they can request a fair hearing.
    - **Note**: The informal resolution process is optional. Consumers can skip this step and request the fair hearing. A consumer also does not have to wait for the informal decision before requesting a hearing.
- The New Mexico Human Services Department Office of Fair Hearings (OFH) will schedule and conduct the hearing. The appellant will receive a letter with the time, place, and other details of the hearing. The appellant will be able to present their case at the hearing. After the hearing, the OFH will issue a final written decision on the appeal.

Expedited Appeals

- Individuals can request an expedited ("fast-tracked") appeal if the time needed for the standard appeal process would jeopardize life, health, or the ability to attain, maintain, or regain maximum function.
    - For example, if the individual is currently in the hospital or urgently needs medication.
    - See 45 CFR §155.540

Second-Tier Appeals to HHS

- If the appellant does not agree with the decision made by the OFH, they may file a second-tier appeal with the U.S. Department of Health and Human Services (HHS) within 30 calendar days of the date of the OFH notice of appeal decision.
- The OFH decision notice will give the appellant instructions on this step.

Expedited Appeals

- BeWell will evaluate the request for an expedited appeal as soon as possible and promptly notify the appellant if the request is denied.
- If the request for an expedited appeal is denied:
  - The appeal is handled according to standard timelines and procedures.
  - BeWell will promptly notify the appellant, in writing, of the denial. This notice will include:
    - The reason for the denial;
    - An explanation that the appeal request will be handled through the standard process; and
    - An explanation of the appellant's rights under the standard process.

Authorized Representatives

- An appellant can appoint an authorized representative—such as a family member, friend, advocate, or attorney—to act on their behalf during the appeal. (See 45 CFR §155.505(e))
- An authorized representative will be:
  - The primary contact during the appeal;
  - Responsible for providing information and documents; and
  - Responsible for returning phone calls, attending conferences and hearings, and any other actions related to the appeal.
- **Notes**:
  - The appellant must have an authorized representative designated in their BeWell account or must add this person on the paper appeal form.
  - If the appellant decides they no longer want their authorized representative to help with the appeal, they should contact the BeWell Appeals Department.

Appeal vs. Complaint

- When a consumer does not agree with a decision made by BeWell, they may file an appeal.
- When a consumer experiences issues with their account, enrollment, assister, or customer service, they may file a complaint.
    - To file a complaint, visit the BeWell website and click on "Contact Us" at the top of the webpage to access the complaint form.

Appeal Submission Process (1 of 3)

- The appeal should include the following information:
  - Account number, full name, date of birth, and a valid phone number;
  - Relevant plan year;
  - Name(s) of the household member(s) for whom a decision is being appealed;
  - The date of the notice containing the decision being appealed;
    - The decision that the appellant thinks is wrong, and why they think it is wrong.
  - Whether the appeal needs to be fast-tracked, and why;
  - Copies of any documents that support the appeal; and
  - Signature.

Appeal Submission Process (2 of 3)

- Consumers can submit an appeal in any of the following ways:
  - By Phone
    - They can call the BeWell CEC at 1-833-862-3935 (TTY: 711) for assistance.
  - By fax or mail
    - They can fax or mail the appeal and copies of any documentation (consumers should keep a copy for reference) to:
      - Fax: 1-505-216-7776
      - Mail:

        The New Mexico Health Insurance Exchange

        Appeals Department

        P.O. Box 25247

        Albuquerque, NM 87125

Appeal Submission Process (3 of 3)

- In Person
  - Appellants can deliver the appeal and copies of any documentation in person, during business hours, to:

    BeWell

    7601 Jefferson St. NE, Ste. 120

    Albuquerque, NM 87109
- Online, through the consumer's portal on the BeWell website.
  - They can view the Instructions to File an Appeal.
  - Once in the portal, consumers should select "Benefits and Coverages" then "Appeals", and then "New Appeal."
  - Next, consumers should click on "Save and Continue" on each page and click "Submit" when all information has been entered.

Important Reminders

- Assisters (agents, brokers, and enrollment counselors (ECs)) must help consumers understand the process of submitting BeWell eligibility appeals. However, they should not provide legal or other advice in their capacity as an agent, broker, or enrollment counselor (EC) regarding appeals or any other matter.
    - **Example**: Assisters should help consumers understand the difference between an appeal and an expedited appeal; however, they should not advise the consumer about which one is best suited to their circumstances.

Important Reminders

- Assisters should tell consumers they can have a friend, lawyer, or someone else help them with their appeal.
- When appropriate, assisters should provide information about free or low-cost legal help in their area and other state offices that can help with the eligibility appeals process.

Key Points

- Consumers may appeal certain decisions made by BeWell.
- Consumers may request a fair hearing if they do not agree with an informal decision made by BeWell.
- For the 2019 plan year and beyond, the Shared Responsibility Payment ("individual mandate" or "penalty") is $0. Consumers no longer need an exemption.
- Assisters may educate consumers about their rights related to appeals, but they should not recommend that consumers take specific action with respect to these rights.
- When helping consumers, assisters should never provide tax or legal advice regarding exemptions, appeals, or any other matter.


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