Eligibility Appeals Framework

The mission outlined in SB11-200 states that the Colorado Health Benefit Exchange (COHBE) should increase access, affordability and choice for individuals and small employers purchasing health insurance in Colorado. When consumers and employers come to view and enroll in health plans on COHBE, they will be required to report information that COHBE will then use to determine what coverage options they have available to them. These options may include: eligibility for subsidies to help decrease the out-of-pocket costs associated with health insurance, eligibility for state medical programs such as Medicaid and CHP+ or eligibility to be exempt from the requirement to purchase health insurance.

It will be essential for COHBE to develop smooth and efficient processes to clarify and verify self-reported information provided by consumers and employers. COHBE will have the technology infrastructure built to pull data from trusted sources to verify whether or not the information reported by an individual matches data available to the Exchange and then communicate back to that individual what programs they may be eligible to participate in. There will be times when the automated verification process does not return accurate information about a person or a person will disagree with an eligibility decision. In these cases, COHBE has the obligation to provide a fair and objective path for consumers and employers to provide additional documentation for COHBE to use to verify the eligibility results as well as an appeals process if the verification does not provide the expected results. This framework outlines the guiding principles COHBE will use related to appeals management.

Background:

Throughout this document an **appeal** refers to an application for review by a higher authority, or a formal question as to the correctness of a ruling or decision. The process of clarifying and verifying information provided by the consumer or employer is NOT considered an appeal; it is considered part of the normal **verification** process that COHBE will perform prior to enrollment.

Notices will be the method by which COHBE draws attention to, makes known or announces a decision or change that has impact to the individual or employer by email or in writing. The initial eligibility determination will be provided to the customer during their online application process. If the customer chooses to appeal the determination, the verification and appeals processes will be performed manually. The result of the verification and appeals processes will be provided to the customer through a notice.

Under federal law, COHBE must allow individuals the right to appeal an eligibility decision and provide clear instructions about how to file an appeal. Furthermore, additional regulations clarify the appeal process that must be available to employers and employees in the SHOP exchange.[1] The Department of Health and Human Services (HHS) will issue additional guidance related to appeals management. COHBE will review any additional guidance from HHS when it is released, along with other applicable law, and ensure its policies are compliant.

[1] 45 CFR Parts 155, 156, and 157, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers

Eligibility for programs will be based a number of factors such as age, income, citizenship status, incarceration status, disability, and Native American status.

Guiding Principles:

- **COHBE will provide oversight and develop a process to handle appeals in the areas in which it has control**. Examples of areas in which COHBE *will* handle both verifications and appeals could include:
    - Eligibility determinations related to subsidy assistance for individuals and employers;
    - Eligibility determinations related to employer size;
    - Eligibility determinations based on life event changes (e.g. new dependent, income change, marital change, etc.).

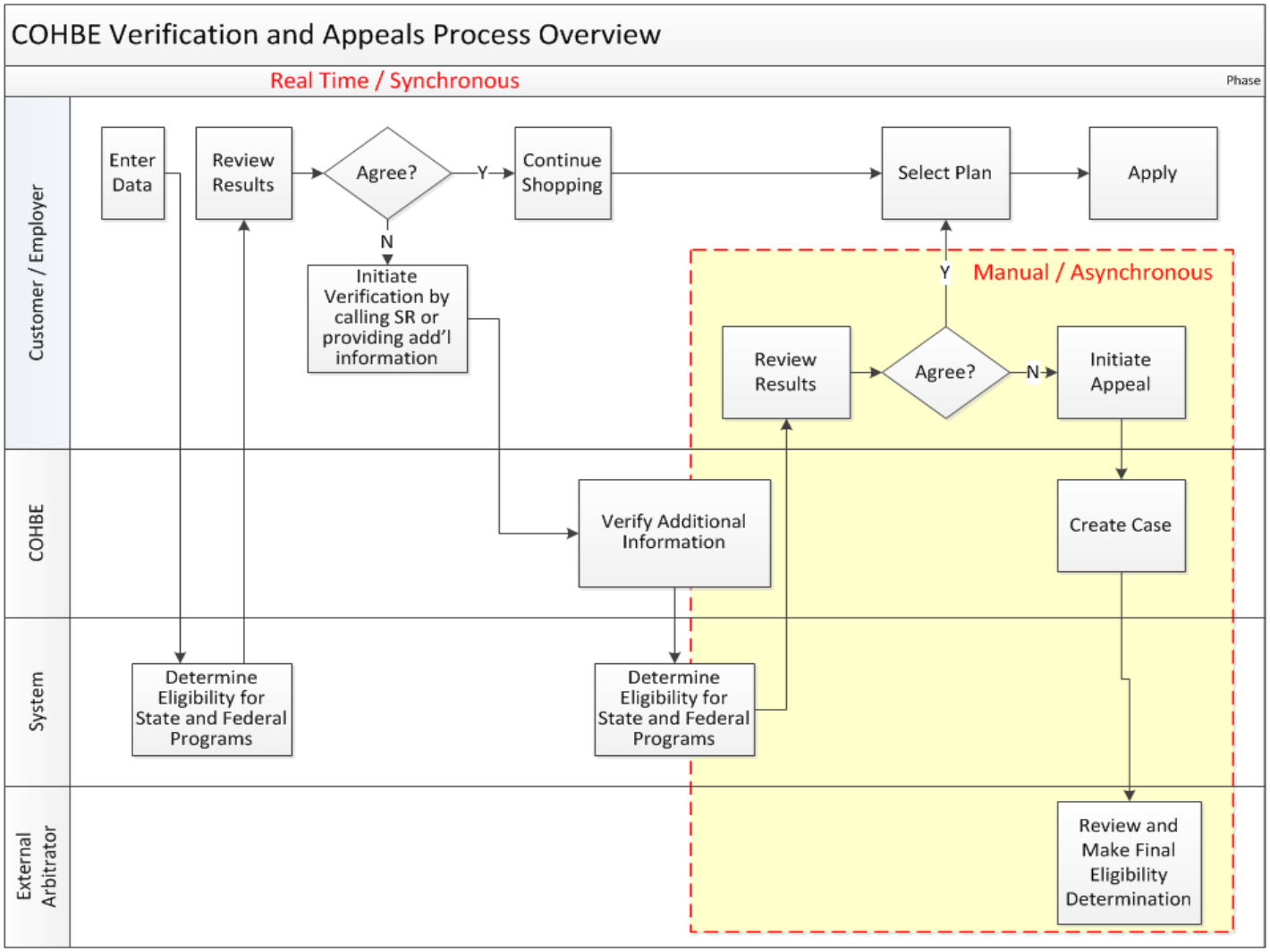
  COHBE *will not* handle appeals related to:
    - Failure to pay for coverage; this will be handled by carriers who will be responsible for notifying COHBE;
    - Final eligibility determinations for state medical programs; this will be handled through the existing HCPF appeals process;
    - Failure of a carrier to pay a claim.

- **COHBE will try to direct people to the programs for which they are eligible as soon as possible.** COHBE will initially direct consumers to eligible programs based on **self-reported information** (i.e. self-attestation**)**. For example, if someone reports a low income or disability that indicates they are likely eligible for Medicaid or CHP+, they will be directed to Health Care Policy and Financing (HCPF) where the information entered during prescreening would be prepopulated into the PEAK website or they could visit a local office to complete their eligibility application. If someone reports a household income that indicates they could be eligible for advanced premium tax credit or cost-sharing reductions, they will continue through the eligibility determination process in COHBE. If a person reports a household income greater than 400% FPL, he or she can move directly to shopping and comparing health plans on COHBE. Once a person provides additional information on a formal application, this information will be verified through external data sources and a determination will be communicated back to the individual. In the case where there is a mixed family (i.e. some members of the family are eligible for state medical programs and some members are eligible for subsidies), individuals in the family that are eligible to shop on the Exchange will complete their shopping and enrollment process in COHBE before information about the family is transferred to PEAK to complete enrollment for members in Medicaid and/or CHP+.

- **COHBE will adopt best practices from public and private sectors to ensure the verification and appeals process is automated as much as possible.** COHBE will use an internal verification process to clarify discrepancies that arise between self-reported information and what is verified through trusted data sources. Appeals will only be escalated to a manual process when the discrepancies are too large and additional documentation provided by the person is not sufficient.

- **COHBE will have a defined process for individuals and employers to verify their information and appeal eligibility decisions.** Figure 1 below outlines the process individuals will go through when they enter their information on the COHBE website to determine eligibility for various programs and cost sharing assistance. The "System" in the diagram refers to both the Exchange systems and any external data sources COHBE will use to validate self-attested information. These data sources may include the IRS, Department of Labor, Department of Motor Vehicles, etc.

Figure 1. COHBE Verification and Appeals Process Overview



- If the verified information is different from the self-reported information by a certain degree (e.g. 10 percent or 20 percent below verified income), the individual will be asked to provide additional documentation to support what was reported. This documentation will be reviewed by COHBE and an eligibility determination will be made and communicated back to the individual through a formal notice.

- If the person disagrees with the determination specified in the notice, he or she can ask for an in-person hearing with a COHBE representative.

- If the person is still dissatisfied with the eligibility determination after the hearing, his or her case will be reviewed by a final arbitrator. The specific qualifications and criteria for the arbitrator have not yet been identified. It is COHBE's intent to try to solve a large majority of verifications and appeals without the need for external arbitration.