CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Debby Higgins
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2:30 p.m. ET

Operator: Good afternoon, my name is (Tanya) and I'll be your conference operator today. At this time I would like to welcome to the Stakeholder and Partnership Conference Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you'd like to ask a question during this time, simply press star then the number one on your telephone keypad. If you'd like to withdraw your question, press the pound key. Thank you.

Debby Higgins, you may begin your conference.

Debby Higgins: Thank you so much, (Tanya). Hi, everybody and welcome to today's Stakeholder and Partner Education Series Webinar. We're going to have two presentations for you today. (Stacey Platte) from the Division of Training will provide information on Medicare in the Marketplace and (Hilary Dalin) from the Office of Marketplace Appeals will discuss Marketplace Eligibility Appeals.

The call is going to be muted while the speakers are presenting. And after each speaker, you're going to have an opportunity for questions and answers. And (Tanya), who's our host today, will give you instructions on how you can ask questions. If you have questions during the presentation, you can feel free to send them via the chat Q&A box that you should see on the left hand side of your screen. Just type your question in the box and click.

The presentations for today's call will be posted soon on marketplace.cms.gov. But in the meantime, we do have two fact sheets in the

bottom left hand corner that you might find helpful and one fact sheet is Medicare and the Marketplace and the other is on Marketplace Appealsr. So feel free to download them.

So with that, I am going to turn the call over to (Stacey Platte).

(Stacey Platte): All right. Thanks so much, (Debby). And good afternoon, everyone. I'm happy to be here today to talk a little bit about Medicare in the marketplace. We've done a number of webinars over the past year so that have dealt with the marketplace in general to educate people about the general benefits of the marketplace and how it works and who's eligible. And now we want to take a little bit of time just to focus specifically on Medicare and the marketplace and how they can interact and what folks maybe eligible for.

So looking at this next slide, the things that we're going to focus on are the information and the topics that you'll need to know to help you explain the marketplace to different groups of people who may have Medicare or maybe becoming eligible for Medicare soon. We're going to talk about the situations in which they may be able to get coverage through the marketplace. And we'll also talk about the folks who won't be able to get coverage through the marketplace. And then we'll touch on a few additional topics at the end including Medicare prescription drug coverage, the small business health options program and also options that maybe available related to standalone dental plans in the marketplace.

So if you've probably heard, the marketplace is a new way for consumers to get health coverage. It's the new place for them to shop for it and buy health insurance if they're interested and eligible. But generally speaking, it's not a place for someone with Medicare to look for health coverage. So that's the message that we've been trying to get out there so far. And I'm sure the message that you've been sharing with the beneficiaries that you come in to contact with as well.

So Medicare, we want to emphasize, isn't part of the marketplace. It's entirely separate. The marketplace while it does offer many private insurance options, it isn't a place where people would go to get Medigap Policies or Part

D plans or any kind of other insurance generally speaking to supplement their Medicare coverage. Folks who have Medicare are covered through Medicare coverage and they won't need to do anything related to the marketplace for the most part.

It is against the law as you may have heard for someone who knows that a beneficiary has Medicare to sell them a marketplace (trans). So basically ensurers and insurance companies, they're prohibited from selling health insurance coverage to beneficiaries that duplicates what they would already have through the Medicare program if they know that someone has Medicare. And that is true whether someone has Medicare Part A or Part B or both.

The marketplace, it doesn't change Medicare plan choices or benefits whether someone gets their Medicare through original Medicare or Medicare Advantage Plans, they don't have to make any changes to their coverage. They are all covered.

People with Medicare, they already have minimum essential coverage. So they are covered and they won't have to pay a fine for not having adequate health insurance coverage. You may have heard about that provision with the Affordable Care Act that people need to either have health insurance coverage that meets a certain set of minimum standards or they need to have an exemption from that requirement or pay the fine. But people with Medicare Part A, they do fall into that first group. Part A is considered to meet that level of minimum essential coverage. So people with Medicare Part A are already covered in that regard and they don't need to do anything to meet that requirement.

One thing to know is that for those few folks who have Part B only, and that's not too many folks of Medicare, Part B only is not considered minimum essential coverage. So if you do encounter anybody who falls into that category, that would be something to let them know if they – if they do have Part B only and they don't have any other coverage that would meet the minimum essential coverage requirements then they would either need to have a coverage exemption or they may be required to pay a fine with their next tax return.

Of course we know there may be folks who retire before they're 65 and eligible for Medicare. And they may not have another source of insurance. So the marketplace may be a good plan – a good place, excuse me, for them to go to buy a plan. And depending on their income and their family size, they may also be eligible to get lower cost to help them purchase a plan through the marketplace.

So we're going to look at a few different groups of folks here and go through each situation with you. So, the first group of folks we're going to look at are people who are becoming eligible for Medicare soon but are not eligible yet. And these folks can get a marketplace plan as I just mentioned before their Medicare coverage begins. And then once they are eligible for Medicare, they have a couple of options. They can either choose to cancel the marketplace plan when their Medicare coverage starts and just line that up so that the end of their marketplace coverage aligns with their Medicare initial enrollment period. Or they can choose to keep their marketplace plan in addition to their Medicare coverage. But if they do choose to do that, there are a couple of things for them to know and one of them is that once their Part A coverage starts and once they have that level of minimum essential coverage, they won't be able to get lower cost on their marketplace coverage through a premium tax (cut) or cost sharing reduction.

We also want to make sure that we let folks know that if they are considering keeping their marketplace coverage, once they become eligible for Medicare, we want to make sure that they understand that if they don't sign up for Medicare during their initial open enrollment period, that seven months period surrounding their month of eligibility, they may have to pay a late enrollment penalty for as long as they have Medicare if they don't sign up when they're first eligible because a marketplace plan won't count as credible coverage, for instance, to exempt them from that late enrollment penalty for Part B.

All right. There are also a group of folks who maybe in a limited situation where they could choose to go with marketplace coverage instead of with Medicare. And this is only possible in a couple of limited situations and so we want to make sure that you understand what those situations are in case

you encounter folks in these circumstances. So the first situation is folks who are not yet enrolled in Medicare, they're eligible but they haven't enrolled either because they'd have to pay a premium for their Part A coverage or because they're not collecting social security or retirement benefits and they were not already automatically enrolled into their Medicare coverage.

So for those people, they are eligible but they're not yet enrolled, they can choose to delay their Medicare coverage and go with the marketplace plan. The other situation is people who have already enrolled but they're paying a premium for their Medicare Part A. Those folks even though they're already enrolled, they can drop their Part A and their Part B to get a marketplace plan if they would like to do so. In that situation, people would already be paying the high premium for the Medicare Part A and also their Part B premium and they may find that the marketplace in some situations maybe an option for them as well and especially if they're eligible for lower cost.

So a couple of considerations, we want to make sure that folks really understand if they do choose to make that decision to go with the marketplace instead of Medicare. Again, we want to make sure that folks know that a late enrollment penalty would apply if they enroll in Medicare later if they wait until after their initial enrollment period end. And if they do do that, they'll be able to enroll only during the general enrollment period which runs every January through March with delayed coverage effective on July 1st.

All right. One other thing to mention here is related to the lower cost that people may be eligible for through the marketplace in the form of premium tax credits to lower their monthly premiums and also cost sharing reductions to reduce the amount they may pay out of pocket for their deductibles or their copayments or coinsurance. If someone doesn't have Part A or has dropped Medicare Part A because they would have to pay for a premium, they may be eligible for the tax credit and the cost sharing reductions if they do meet the eligibility requirements for those programs.

So, if someone didn't have Part A and they met the requirement of falling within 100 percent to 400 percent of the federal poverty level for their – for their household size, and they may be eligible for a tax credit through the

marketplace if they're enrolled in a qualified health plan. And then also the income limit for the cost sharing reductions would be between 100 percent of the federal poverty level and up to 250 percent of the federal poverty level for their family size if they were enrolled in a silver level plan through the marketplace.

All right. You may also talk with people who have disabilities who are receiving social security disability payments but have not yet qualified for Medicare. So there's that 24-month waiting period. When someone is entitled to get the social security disability benefits and then once they've met that 24-month waiting period, they will be enrolled into Medicare Part A and Part B. And the thing we want to just make sure that these folks know is that if they are getting on the SSCI payments and they are in their 24-month waiting period, they can go ahead and apply for a marketplace plan to cover them during that 24-month waiting period until they're eligible for Medicare coverage.

A lot of times folks are uninsured during that waiting period so this could be a good new option for them and they wouldn't be subject of course to any preexisting conditions exclusions if they were applying for a marketplace plan since those plans can no longer deny coverage or charge premiums based on health conditions. So if someone is in that waiting period, you may want to encourage them to take a look and see what their marketplace options would be. And they may also qualified for premium tax credits and reduce cost sharing until their Medicare coverage starts.

You may also encounter folks who are eligible for Medicare but are still working. And they may be working for a small employer who is offering coverage through the new small business health options program or SHOP marketplace. And this is a new marketplace for small businesses to use to offer health coverage to their employees. And it's treated differently from the coverage that someone would purchase on their own through the individual marketplace. It's treated like a – like a regular employer plan. So, if someone is eligible for Medicare and they are enrolled in SHOP coverage through their employer, the regular Medicare or secondary payer rules would apply. It would be treated as any other coverage from an employer group health plan.

People who are in that situation and they're eligible for Medicare and they do have coverage through their employer or their spouse's employer through the SHOP program, they will have that eight-month special enrollment period to sign up for Part B after their coverage through their employer end. And if they don't sign up for Part B during that special enrollment period, then they would have that late enrollment penalty again as long as they have Medicare and would need to sign up again during the general – the general enrollment period.

A couple of other topics we wanted to talk about include Medicare prescription drug coverage. And we've gotten a number of questions about whether the prescription drug coverage that is sold by plans in the individual marketplace or in the small business marketplace is required to be creditable for Part D. And the answer is, no. That prescription coverage isn't required to be creditable. It would be treated like any other prescription coverage that would be required to give notice each year letting their members know whether or not the prescription drug coverage through the plan is creditable.

And then also a note about standalone vision and dental coverage for adults, as you may have heard, that is the requirement for – vision and dental coverage is a requirement for children in the marketplace but it's not a requirement for adults. Although there are some standalone plans that may offer that coverage to adults. So it is covered by some marketplace plans and we've gotten a number of questions about whether people with Medicare can join those plans. And the answer to that is generally speaking, no. People who live in a federally facilitated marketplace meaning that the marketplace is run either by the federal government or the state is running the marketplace and partnership with the federal government, they won't be eligible to join the standalone plan. Because to join a standalone dental plan, for instance, they would need to also join a qualified health plan which they won't be able to do if they have Medicare.

Now the caveat to that is if you're residing in a state-based marketplace so as that your state is operating its own marketplace, the rule is maybe a little bit

different. So you'd want to check with your state and see if that's something that they would allow because they do have the option to allow you to do that.

All right. So we have a couple of scenarios here just to kind of apply those concepts and then we can open it up for any questions that you might have. The first scenario here involved Jim. He has Medicare Part A only. He didn't enroll in Part B during his initial enrollment period so he went ahead and signed up for Part B this January during the general enrollment period. And his coverage for Part B will begin on July 1st. So we have a question here of whether he can enroll in a marketplace plan, whether he waits for his Part B to take effect. And the answer to that is, no. Jim does have Medicare Part A which is considered minimum essential coverage. And it's illegal for anyone to sell him a marketplace plan if he already has Medicare. So, Jim in this scenario, he would not be able to buy a marketplace plan while he wait for his Part B to take effect.

Moving on to the next scenario, this scenario is about Barbara. She works part time and she isn't getting social security retirement benefits yet. Her employer doesn't offer health coverage so she went ahead and enrolled in a marketplace plan through the individual marketplace. Her Medicare initial enrollment period is going to end next month but she has decided that she'd like to keep her marketplace plan and wait until later to sign up for Medicare coverage. So there are a few questions here, will Medicare – or excuse me – will Barbara have a late enrollment penalty when she signs up for Medicare Part B? What about Part D? And what else would she want to consider? What else might you want to tell her?

And in this situation, we would want to let Barbara know that she – if she enrolls in Medicare after her initial enrollment period ends, she would have that late enrollment penalty for Medicare Part B if she signed up later. With regard to Part D, it would depend on whether or not the prescription drug coverage that she had through her individual marketplace plan was creditable or not. And the plan would send her a letter each year to let her know that.

We'd also want to make sure that she knew that she can choose to keep the marketplace coverage after she enrolls in Medicare. But in that case, she

wouldn't be eligible for any tax credits and there is no coordination of benefits between Medicare and an individual marketplace plan. But it would be her choice in that case which way she would like to go with her coverage.

So this is the website marketplace.cms.gov. There are a lot of resources here for professionals and for people who help – people who have questions about the marketplace. There are training presentations here. And this presentation will be posted there as well very shortly. There are official resources that might be helpful including fact sheets and publications and video tutorials.

Here are a few ways you can connect with the marketplace. If you're interested, you can sign up for updates@healthcare.gov. You can connect with us on social media or also through our blog at healthcare.gov.

And with that, I will turn it over to (Debby) for questions.

Debby Higgins: OK. (Tanya), you can open the line up and after you've queue up – we'll locate some Q&A that we received on chat and see if we can get respond to some of those.

(Stacey Platte): Sure.

Operator: Certainly. At this time I would like to remind everyone in order to ask a question, press star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of (Leslie Fried) from NCOA. Your line is open.

(Leslie Fried): Hi, it's (Leslie Fried). Actually I have two quick questions. One is could you discuss what notice plans QHPs have to give individuals who they know are aging into Medicare regarding that they should be signing up during their initial enrolment period. And the second is I was confused about your comment regarding the standalone vision or dental plans because you said that in the federal plan – the federal marketplace, the only way to get – I thought what you said is the way to get dental or vision is through a QHP. And so

then that wouldn't be a standalone. So I maybe I misunderstood what you said. And those are my questions.

(Stacey Platte): OK, thank you. I'll address the second one first. So regarding the federally facilitated marketplace, the way to get vision or dental coverage would be through a standalone plan. The problem that arises in the federally facilitated marketplace is that you can't enroll in a standalone plan without also enrolling in a qualified health plan for your health coverage. So you would not be able to get that standalone dental coverage, for instance, without also purchasing health coverage through the marketplace.

(Leslie Fried): So it cannot really stand alone?

(Stacey Platte): It's standalone in the sense that it would have to be added to the health coverage. But it could not be standalone in the sense that it could just be picked up by someone with Medicare without also purchasing health coverage through the marketplace.

(Leslie Fried): OK. So if someone signed up for a QHP, then they'd have the option of also signing up for the standalone dental?

(Stacey Platte): Yes, that's correct.

(Leslie Fried): So it's not incorporated – OK.

(Stacey Platte): Right. Right.

(Leslie Fried): Thank you.

(Stacey Platte): At least in the federally facilitated…

(Leslie Fried): Right.

(Stacey Platte): ..marketplace.

(Leslie Fried): I know that you can get it in some of the states. So…

(Stacey Platte): Right. And then regarding the first question, I haven't heard about any notice required for people aging in to Medicare per se that their QHPs would be required to provide. But I have heard that there will be notice required for people who will be losing their eligibility for tax credits or cost sharing reductions once they become eligible and enroll in Medicare Part A.

Debby Higgins: Does that answer your question?

(Leslie Fried): It does, thank you.

(Stacey Platte): Sure.

Operator: Your next question comes from the line of (Mary Ellen) from Magnolia Regional Medical Center. Your line is open.

(Mary Ellen): Yes. (Inaudible) we want to know if a beneficiary has elected to opt out of the traditional Medicare and go with a Medicare Advantage Plan, can I have that marketplace insurance as their secondary insurance?

(Stacey Platte): Everything that just mentioned, it would apply to original Medicare and Medicare Advantage Plan sustain. So, no, they would not be able to pick up a marketplace plan as a secondary to their Medicare Advantage.

(Mary Ellen): And what if the site it has enrolled some of these beneficiaries into a marketplace plan?

(Stacey Platte): I'm not aware of states being able to enroll folks, auto enroll folks into marketplace plan. If you have a specific situation, though, you want to talk about, you can e-mail us at training@cms.hhs.gov.

(Mary Ellen): We did have – our state has enrolled some of our – into the marketplace. And these people are own food stamp or receiving SNAP, whatever you want to call it. And they're automatically getting enrolled into the marketplace.

(Stacey Platte): (Mary) send us a note at the training website and we'll get back to you.

(Mary Ellen): OK. What was that address again?

(Stacey Platte): Training (inaudible) training@cms.hhs.gov.

(Mary Ellen): OK, thank you.

Female: (Inaudible).

Operator: Your next question comes from the line of (Donna Dates) from (Inaudible) Insurance. Your line is open.

(Donna Dates): Yes. I have a client who was on a retiree and they mistakenly did not enroll in Medicare Part A or Part B because of their eligibility for the retiree plan. Now he was on the plan of his wife who is now because she's aging in to Medicare is no longer able to continue that coverage. Now the husband is going to have to wait for coverage to be effective until July 1st. And I'm just wondering if the marketplace is an option for him to have coverage until July 1st when he picks up Medicare?

(Stacey Platte): OK. So this is someone who does not yet have Medicare Part A or Part B, is that…

(Donna Dates): That is…

(Stacey Platte): …correct?

(Donna Dates): …correct. He did not enroll in either Part A or B when he aged in the Medicare.

(Stacey Platte): OK. To that I would say as long as he doesn't have either part of Medicare yet, then that could be an option for him as he waits for his Medicare to become effective.

(Donna Dates): Thank you, I appreciate that.

Operator: Your next question comes from the like of (Semanthie Brooks) from Benjamin Rose Institute of Aging. Your line is open.

(Semanthie Brooks): Hi. You answered part of my question in terms of the notices being sent to individuals who will have Medicare because they've aged into the program. My understanding, however, is that it is incumbent upon the consumer to

cancel their marketplace insurance policy within two weeks especially if they are getting that subsidy or extra help. So you have to do that means the following month they will have to pay the full cost of the insurance and then their discontinuance of the insurance will be effective the month after that. Is that – is that correct? And will that notice also give them that window in which they have to disenrolled by or within that certain time period?

(Stacey Platte): Right. I haven't specifically seen the notice yet so I can't tell you exactly what it says but it should include details about the timeframe and when they would need to do that. What you're saying generally speaking – I mean, it makes sense that they would need to give notice and disenrol or they would be charged the premium for their marketplace plan. They do have that option, though, if they would like to keep it. So for that reason, they wouldn't be automatically disenrolled from the marketplace plan so they would need to take action to do that.

(Semanthie Brooks): Thank you.

Debby Higgins: In the interest of time, we're going to have to move on to our second presentation. But if you do have a question, please submit it to us at our training mailbox, training@cms.hhs.gov. And with that, I'd like to turn the presentation over to (Hilary Dallin) who will talk to us about Marketplace Eligibility Appeals. (Hilary).

(Hilary Dallin): Hi, everybody. And thank you, (Debby). Just a little correction, I used to be with (CCIIO) but I am now with the Office of Hearings and Inquiries working on Marketplace Eligibility Appeals. And that's what I'm going to talk to you about this afternoon.

So, within the marketplace, there will be people who are not happy with some of the decisions that are made. And some of those folks have a right to an appeal. There are two kinds of appeals and this should be familiar to any of you who work with Medicare. The first kind which is the kind that we're going to talk about today have to do with eligibility determinations that are made by the marketplace. And the second kind have to do with coverage decisions that are made by the qualified health plans that are operating within

the marketplace. So to distinguish between the two, a coverage decision would be a decision that's made by a qualified health plan about whether a service or the kind of care that an individual needs is covered by the plan.

So, just as an example, if an individual felt that they should get 15 sessions of physical therapy but the qualified health plan only authorized five, that would be a coverage decision. And if the individual was dissatisfied with that coverage decision, they would do a coverage appeal. That's not what we're going to talk about today. Although I believe that (Stacey) is going to be arranging for you all to have a presentation on marketplace coverage appeals very soon.

Today we're going to talk about eligibility appeals. And we're up to slide three. There are certain kinds of eligibility determinations made by a marketplace that can be appealed. And those kinds of determinations are actually laid out in the regulation. And here's what they are.

The first one is whether or not an individual or a family grouping is eligible to buy a qualified health plan, a QHP within the marketplace. The second is whether there is a special enrollment period available away to apply for coverage outside of the regular open enrollment which as a side note but a really important one as you probably are all aware this month wraps up the first open enrollment period. So very important for folks who need this coverage to go and apply for it now. But there are certain situations in which people have a right to a special enrollment period. And if somebody asks for special enrollment period and did not get that special enrollment period, they have a right to appeal.

The next one is whether or not they qualify for lowering the cost of coverage either through the advance tax credit, the APTC or through cost sharing reduction, or CSR. And the – and the next one which is related to whether people are eligible for the APTC or the CSR is the amount of the premium tax credit or the cost sharing reduction.

Also, because remember that the marketplaces are supposed to be, you know, like no wrong door, one entry way, in certain states under certain

circumstances, there is a right to appeal to us about eligibility for Medicaid and CHIP. This is dependent upon where is people live and what decisions states have made about how to handle Medicaid and CHIP eligibility and whether the federally facilitated marketplace assesses eligibility and leaves the final decision up to the state or whether the state has delegated those decisions to the federally facilitated marketplace.

I am sure, knowing (Debby) and (Stacey) as I do, that they will arrange for you to have a more in depth briefing about these kinds of situations with Medicaid and CHIP. They can get pretty complicated.

And then next kind of eligibility appeal relates to denials of exemptions from the individual responsibility requirement commonly called the mandate. Finally, people do have a right to appeal what they may see as an untimely determination of eligibility in any of the ways that I jus discussed here. So there was – or the kinds of decisions that are eligibility determinations that can be appealed to us and those are the kinds of appeals that we – that we deal with in the Office of Hearings and Inquiries.

So, slide four, how does a consumer appeal one of the eligibility determinations that I just spoke to? Whether there are currently two ways and they both involved mail, there are eligibility appeals requests forms on healthcare.gov and you can see on your slide exactly where to find the right form. There are three different forms. The one that a particular consumer would use depends upon the state that they live in. And the reason for that is because of the Medicaid variations that I very briefly alluded to before.

However, it is also possible to write us a letter. And regardless of whether a consumer downloads, completes, and mails the request form which is designed to be easy to fill out and to get us the information that we need to start working on their eligibility appeals or whether they write us a letter, you can see from the slide that it gets mailed to the health insurance marketplace address in London, Kentucky.

What we like to see, it isn't by no means required but we very much appreciate seeing the reason for the eligibility appeal. Again, it's not required.

A consumer can just say, "I disagree with that determination." And we will work with them to figure out what exactly it is that the person wants to appeal. But the more they can tell us, of course, the easier it is for us to address their concern and see what we can do to find remedy for them.

So what are the timelines for asking for a marketplace eligibility appeal? It depends upon where an individual lives. If the – for consumers who live in federally facilitated marketplace states and that includes partnership states, consumers have up to 90 days to submit their eligibility appeal request. State-based marketplaces set their own deadlines and they must leave at least 30 days for consumers to file their appeals request or it can be up to 90 days. The eligibility determination should contain all of the information about how long a person has to do the appeal.

Now, I should say here that in the state-based marketplace states, the first level of appeal will be with the state-based marketplace. And thereafter, if an appellant who lives in one of those states is dissatisfied with the decision on the eligibility appeal that's rendered by the state-based marketplace, they then have what we call a second tier appeal, another shot at an – at an eligibility appeal and that's to us. And the way that would be requested and remember it has to be after the state-based marketplace renders its decision would be the same way that I discussed on slide four to complete the form or send a letter with as much detail as possible to the address in London, Kentucky.

So what happens after somebody asks for an eligibility appeal? We sent a written acknowledgement of receipt. And we do that as soon as we received the request for the appeal. Thereafter, we contact all appellants by phone to discuss the request. And we do that for two reasons, first of all to make sure that it is a request for an eligibility appeal that we are allowed to handle.

And if you go back to slide – let's see which one is it – three, we have to make sure that the request for the appeal falls into one of those categories of appeals that we can handle. We also need to make sure that the request was filed in a timely way within 90 days if it's in the federally facilitated marketplace or if it's a second tier appeal from a state-based marketplace state that the appeal

was requested within 30 days of the state-based marketplace eligibility decision.

So we call that the validation phase. If we validate the appeals request that is (inaudible) we can handle, then we'll move on to adjudicate that appeal. I'm going to talk in a minute about how we do that. If, however, we can't validate the request, that is it's not something that looks like we can handle, what we are required to do and are currently doing by phone is explain to the appellant what is the problem with their request and explore with them ways that they might address that problem and make their appeal request something that we can handle. Obviously, we want to help as many people as we can but our jurisdiction is limited and so we have to make sure that we're only handling the cases that fall within our jurisdiction.

When we validate an appeals request, we go on to adjudication. And there are two phases of an eligibility appeal. The first and the one we really prefer is informal resolution. And this includes lots of different ways in which we can help to resolve a problem – an eligibility problem informally to the fullest extent possible. If we can resolve the problem informally, what we do is we explain what we can do to the appellant. And if the appellant is satisfied, then we will issue our appeals decision reflecting that outcome with which the appellant was satisfied.

Sometimes that's not possible and all cases in which informal resolution is not possible move on to hearing. A hearing is somewhat more formal. It's by telephone. Basically all our operations are by telephone. But hearing is conducted by a hearing officer. The appellant and any witnesses are either under oath or under affirmation to tell the truth. We consider the case, the hearing officer listens to what the appellant's story is, what the appellant wants to tell the hearing officer about their situation. The hearing officer looks at all of the evidence in the case including any relevant evidence that the appellant submits before or during the hearing. And then after the hearing, we'll render an appeals decision.

So either way, whichever way the appeal gets handled, again, preferably through the informal route because just, you know, basically the easier that we

can work with appellants to resolve things is better for everybody or for those that go to hearing, all eligibility appeals will end in one of two ways either with an eligibility appeals decision or in certain limited cases not what we prefer but in certain instances we have no choice but to dismiss the eligibility appeal.

So, again, just as we prefer to resolve things informally, we prefer to end eligibility appeals with an appeal decision. But there are four situations in which we have no choice but to dismiss the whole appeal. And those four reasons are it's the appellant ask to withdraw the appeal. I can give you a happy example of when that might happen, I'm sure you're all aware that there has been lots and lots of problems with the rollout of the marketplaces and particularly with the website.

Now, a lot of people who had trouble in the beginning to ask for an eligibility appeal, that subsequently as there have been vast improvements to the website, many of those people have gone back in, have reapplied, have been successful, gotten the satisfactory eligibility determination and gone on and enrolled, and many of them has asked to withdraw their appeal request. We're happy to dismiss cases when appellants ask to withdraw because they have an outcome that's good for them and they no longer need the appeal.

Another time that we have to dismiss an appeal is if the request is not one we can validate. And remember I said we explain how the appellants can make the request for the appeal something that falls under our jurisdiction. If they don't do that within 90 days, we have no choice but to dismiss the appeal. We are also required to dismiss appeals when the appellant dies in the course of the appeal. That's what the regulation tells us.

And the final reason for dismissal of an appeal is if we schedule a hearing and the appellant fails to appear. That is to say they don't dial into their hearing at the scheduled date and time and they don't provide us with good cause for their failure to appear. And if they do send us a good cause reason, we'll reschedule. A good example of that, for any of you who lives, you know, in the sort of the mid Atlantic region of the country will know we had a big snow storm yesterday and we actually had to postpone some hearings yesterday. So

we're working very closely with those appellants to make sure that they know when we've rescheduled them and we're certainly going to give them some extra consideration if there's problems with the rescheduling of those.

If we dismiss an appeal, the appellants have 30 days to come back to us and ask us to vacate that dismissal for good cause, you know. If it turned out that someone was in the hospital and couldn't tell us why they failed to appear at the hearing, for example, they can ask us to vacate the dismissal. And if they show us good cause and we do vacate, we just continue on with the appeal.

When appeals ended in decisions, again, it's what we prefer, we issue our appeals decision and mail it out to the person within 90 days of when they requested their appeal or as administratively feasible. And we try to avoid that administratively feasible to the extent possible but we do have by regulation that option of as administratively feasible.

(Inaudible) slide nine. Here are some things to think about in terms of eligibility appeals. Consumers can ask somebody else to help them with their eligibility appeal to – and that includes asking for the appeal, sending that letter or that form into us or to participate in the appeal or just to help support them through the appeal. And that person could be a friend, a relative, it can be a lawyer, it can be whoever they like. That's not required, however. And we anticipate that many people will handle their appeals themselves.

Another thing to think about is the possible need for an expedited or faster appeal. And, again, anybody who has done Medicare appeals work will recognize the standard by which we decide whether to grant a request to expedite an eligibility appeal in the marketplace. And that standard is if the standard process for determining an eligibility appeal could seriously jeopardize the consumer's life or ability to attain, maintain, or regain maximum functions, we will expedite. And when we expedite, we will handle the appeal as quickly as we possibly can. And we will – as with all appeals, we try to handle the expedited ones through informal resolution. But if we can't, we very quickly move on to a hearing.

The last point on this slide is a really important one. The outcome of an eligibility appeal could affect the eligibility of members of the tax filing household who were not parties to the appeal. So that's an important thing to consider in filing an appeal. It is possible that the eligibility – especially the eligibility for the subsidies could possibly change for other members of the household.

So, getting help with an appeal, there are many people who can help with marketplace eligibility appeals. That could be you. It could be somebody from a navigator program. It could be a representative that a consumer has appointed to help with an eligibility appeal. And for more information on all of that – oh, and then, of course, departments of insurance, very important resource for people.

For more information about any of the resources available to consumers to help with marketplace eligibility appeals, the marketplace call center – and you can see the number on page 10 for those of you who haven't memorized that number is a – is a good – a good source of information and referrals for help.

So to wrap this up, to just keep in mind that there are two kinds of marketplace appeals. I've talked today about marketplace eligibility appeals and that's what's handled by my office within CMS' Office of Hearings and Inquiries. And there are also coverage appeals and that's when a qualified health plan makes a decision about coverage about what services or benefits are going to be covered for a particular individual. We do not handle those but, again, I just know that (Debby) and (Stacey) will work on a presentation for you about those kinds of appeals.

To file an eligibility appeal, you can either download, complete, and mail in the right form depending on the state that the consumer lives in. Or you can just write us a letter. Again, while not required, we really preferred detail in the request no matter how it's sent. It helps us to validate the appeals request quickly and move on into adjudication to do what we can to resolve people's disputes about marketplace eligibility. And to remember that there are two ways in which we handle appeals, we prefer informal resolutions. But cases

that we cannot resolve through informal resolution move on to a hearing and all cases – all eligibility appeals cases will end in an appeals decision unless we are compelled to dismiss the appeal.

And that's of my presentation. And I am happy to take questions.

Debby Higgins: OK, we have time for a few questions for (Hilary). So, (Tanya), if you can open up the lines. And if you have questions on marketplace eligibility appeals, (Hilary) is available to respond.

Operator: Just to remind everyone in order to ask a question, press star one on your telephone keypad. Your first question comes from the line of Harles Clarkson from Jewish Family Vocation of Middlesex County. Your line is open.

Harles Clarkson: Hi. I just wanted to confirm, this goes back to the tax rebate for applying for a marketplace plan. I read somewhere that you have to at least enroll in a silver plan in order to have the tax credits. I presumed that is correct, I just wanted to confirm that.

(Hilary Dallin): I'm going to admit to you that I'm not – I'm not the best expert on actual eligibility. We handle the appeals. And I'm not sitting in a place where I can quickly check that but definitely…

Harles Clarkson: No, I tried to – I tried to answer the question earlier but I guess it was carried over.

(Hilary Dallin): That's not a problem. Between (Debby) and myself, we will make sure to get the answer to that question to you.

Harles Clarkson: OK.

(Hilary Dallin): (Debby), I assume we can do that, yes?

Debby Higgins: I think (Stacey) can respond to it now.

(Stacey Platte): Yes. I can take…

(Hilary Dallin): Excellent.

(Stacey Platte): …that one. So, the answer was about tax credits and what level plan you would have to enroll in through the marketplace. And the answer to that is you could enroll in a bronze plan, a silver plan, a gold plan, or a platinum plan and apply the tax credit to any of those plans in the marketplace.

Harles Clarkson: Ooh. Are you sure?

(Stacey Platte): But…

Harles Clarkson: That's not what I read.

(Stacey Platte): I am (inaudible)…

(Hilary Dallin): Wait for the but, wait for the…

(Stacey Platte): Hold on.

(Hilary Dallin): …but, here it comes.

(Stacey Platte): But if someone is eligible for the additional cost sharing reduction, that will save them money on their deductible and also their coinsurance and copayment amounts. Then in that case, they would have to enroll in a silver level plan only in order to get those additional cost sharing reductions.

Harles Clarkson: Ah, OK. Got you, thank you.

Operator: Your next question comes from the line of (Mary Barrett) from Northumberland Agency of Aging. Your line is open.

(Mary Barrett): I wanted to confirm that if someone was employed with 20 and less employees that they could waive their Part B, join the marketplace and not be penalized when they retired to pickup Part B.

(Hilary Dallin): (Stacey), this is all yours.

(Stacey Platte): OK. So the question was about someone who is actively working with 20 or less employees, is that correct?

(Mary Barrett): Yes, correct.

(Stacey Platte): OK. So if someone is actively working and is eligible for Medicare and their employer has 20 or fewer employees, they actually would have Medicare as their primary so they would pick up both Medicare Part A and Part B and then the employer plan would be secondary in that case.

(Mary Barrett): OK.

(Stacey Platte): If someone came from an employer that had more than 20 employees, then in that case, Medicare would be secondary and the employer insurance would be primary.

(Mary Barrett): OK, thank you.

(Stacey Platte): All right.

Operator: Your next question comes from the line of (Angelica Segovia) from (Chester House SBS). Your line is open.

(Angelica Segovia): Hi. We're with families who are immigrant and most of them, there are families on their 100 percent of federal poverty level. And as you might know, these families are eligible for premium tax credit. The marketplace right now is not working in terms of given then eligibility for (inaudible) given them subsidies. So I am currently doing appeals with them. And so my questions – I have a few questions actually. The first one it will – it is what type of – I mean, not hearing they will have? Is this is going to be a hearing or this is going to be an informal resolution?

The second question is how long does it takes for them to get coverage and of course to get subsidies? And if I need to submit, would the appeals some sort of – well, personal information such as (inaudible) and/or (inaudible) and those sort of personal information? Yes, that's pretty much it.

(Hilary Dallin): OK, thanks, (Angela).

(Angelica Segovia): So to take your questions in order, first of all, remember there would need to be an eligibility denial and then they could ask for the appeal. Each

eligibility appeal is considered individually to validate it, as I explained before. Every appeal is – every appellant is offered informal resolution. If there's a way to resolve the problem informally, that's what we want to do. If we can't resolve it informally, then we offer a more formal hearing.

When we issue our decision in appropriate cases, we are able to order retroactive coverage. The…

(Angelica Segovia): OK.

(Hilary Dallin): …effectuation of retroactive coverage may take a little bit longer but the prospect of coverage would be – would be applied faster. In terms of what you should submit with your appeals request, my suggestion would be don't submit anything, wait for the call. When we call to develop the case a little bit and understand what's going on, that would be the time to offer more information. And we will give the appellant an address to send the information to and that would assure that the information gets to the right place.

(Angelica Segovia): OK. Thank you very much.

Operator: Your next question comes from the line of (Claudia Bethel) from (Camerous Health) (inaudible). Your line is open.

(Claudia Bethel): Hi, thank you. My question pertains to a consumer who enrolled – well, she actually applied through the marketplace and she was eligible for the tax credit. However, due to a typo on his application, it turned out that they did not give her the tax credit. She was confused when going through the online process so even though she didn't have the tax credit approval at that point, she went ahead and enrolled in a plan. So it ended up that the plan was charging her the full amount without the tax credit at that point. And this happened for two months.

The consumer did not have the funds to pay the full amount. So at this point, the plan is telling her that if she does not pay that she's going to lose her coverage. The consumer came in to see me after this happened and we were able to catch the typo on the application, called the marketplace and the

marketplace fixed the situation so that she was eligible for the tax credit. Unfortunately, the tax credit does not take place until April. And the marketplace stated that they could not do anything about the previous two months where she was charged the full price of the insurance.

Now, in this situation, would this be an appropriate case for an appeal? Or should the marketplace go ahead and do the retroactive for those two months? What should happen with this consumer since she is about to lose her coverage for not paying those two months?

(Hilary Dallin): So I can't comment on any particular individual situation. I would say, in general, that where there is a satisfactory eligibility determination, there is no eligibility appeal. We would not have jurisdiction over such a case. The cases in which the consumer is ultimately satisfied with the original eligibility determination but is having trouble working through getting the tax credit to attach to the plan in which they enrolled, these matters are generally handled by case work. And (Stacey) or (Debby), I wonder if you wanted to comment more on that.

(Stacey Platte): No.

Debby Higgins: I don't think we have any additional comments too.

(Hilary Dallin): OK.

(Stacey Platte): I don't.

(Claudia Bethel): So basically, end cases like this, it would be ideal to just go ahead and contact the marketplace and for case work…

(Hilary Dallin): I would think…

(Claudia Bethel): …level?

(Hilary Dallin): …that would be – that would be the first place to go.

(Claudia Bethel): OK. Thank you.

(Stacey Platte): And do you remember also, people who are eligible for the tax credit, they do have a 90-day grace period before a plan is able to disenrol them for non-payment of premiums if they have paid at least one month of the premium. So just keep that in mind when you're working with folks who are eligible for the tax credit.

Operator: Your next question comes from the line of Ronny Pill from American Optometric.

(Ronnie Pill): Hi, thank you. I think this question or comment is more for (Stacey) than (Hilary). I think you would – you were talking about standalone vision and dental plans in the marketplaces. Now, I wanted to clarify that the law treats to vision and dental benefits in plans slightly different and so it's hard to make a statement that applies to both types of plans. It's my understanding that all qualified health plans must include the pediatric vision benefit even though not all QHPs have to include the pediatric dental benefits depending on the marketplace. And that none of the federally facilitated marketplaces or the state run marketplaces may offer vision plans standing alone even though some of them may offer standalone dental plans.

I also want to clarify that the state run marketplaces can develop a separate marketplace for supplemental benefits including adult vision and dental. And that these separate marketplaces may link to or mirror the state run marketplaces for QHPs. And then also just to clarify that it's my understanding that anyone can purchase additional vision coverage in what I call the open market just as millions of Americans have chosen to do for decades before the introduction of this new health insurance marketplaces – excuse me. I just wanted to clarify those points.

(Stacey Platte): Sure. Thank you so much for clarify and absolutely. There may be vision and dental plans available to anyone, to folks outside of the marketplace and that's absolutely still an option for folks as well. So thanks for clarifying.

(Ronnie Pill): Thank you.

Debby Higgins: Unfortunately, you know, we have run out of time for today's call. If we didn't get to your question, please send it to us at training@cms.hhs.gov. And

we look forward to you joining us next month. The call is on April the 1st. I want to thank (Hilary) and (Stacey) for their presentations today. So thank you so much, everyone. Have a good afternoon.

Operator: This concludes the conference call, you may now disconnect.

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