Health Advocate

E-Newsletter of the National Health Law Program

Volume 19 November 2013

Health Advocate: Due Process

Prepared by: Sarah Somers and Kim Lewis

Key Resources

NHeLP Issue Brief: Due Process in California's Early Medicaid Expansion Waiver Program, available here.

NHeLP Issue Brief: Appeal Rights and Medicaid Benefit Reductions, available here.

NHeLP Comments on Medicaid and Exchanges, available here.

Additional NHeLP Medicaid Fact Sheets and Q&As, available here.

Coming in December's Health Advocate:

NHeLP's 2013 Litigation Roundup

Introduction

While almost everyone has heard about the new opportunities that the Affordable Care Act (ACA) brings to millions of uninsured Americans to obtain health coverage, many are not aware of the rights and protections that the newly insured will have protecting them against wrongful denials of coverage. These rights stem from the Fourteenth Amendment of the U.S. Constitution, which prohibits governmental deprivations of "life, liberty, or property, without due process of law." These rights are well-established for Medicaid beneficiaries and applicants. Now, federal regulations explicitly extend these rights to individuals seeking insurance coverage and other benefits through the newly created Health Insurance Exchanges. This issue of the *Health Advocate* describes the due process requirements governing the Exchanges and changes made to Medicaid notice and hearing regulations intended to coordinate and align the Exchange and Medicaid requirements.

Medicaid Due Process Rights

Applicants for and beneficiaries of publicly funded benefits have rights to notice and a hearing when their claims are denied or not acted upon with reasonable promptness.[1] Due Process rights specific to Medicaid are set forth in statute and regulations and provide an array of crucial protections for applicants and beneficiaries.[2] The essential elements of due process in Medicaid are an adequate written notice and the opportunity to challenge an adverse state action before an impartial decisionmaker. A beneficiary who requests a hearing prior to the effective date of the adverse action also generally has the right to receive continued benefits (also called "aid paid pending") at the previously authorized level pending the outcome of the hearing.[3] Beneficiaries and applicants are also entitled to present a case without interference, cross examine witnesses, and have access to their case file. These due process rights are what make Medicaid an entitlement and a source of dependable insurance for the vulnerable population that needs it.

---

[1] *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970), *see, e.g.,* 42 U.S.C. § 1396a(a)(3).
[2] 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250. *See* 42 C.F.R. § 431.205(d).
[3] *Goldberg*, 397 U.S. at 267; *see also* 42 C.F.R. § 431.230.

Changes Pursuant to the Affordable Care Act

The ACA permits states to expand their Medicaid programs to most citizens with family incomes under 138% of the federal poverty level (about $26,000 for a family of 3). The ACA requires states to establish eligibility for this expansion population and most other Medicaid applicants and beneficiaries using a new type of income calculation termed "Modified Adjusted Gross Income" (MAGI).[4]

The ACA also authorized the creation of state Health Insurance Exchanges, through which individuals can purchase Qualified Health Insurance Plans (QHPs). The Exchanges must determine whether applicants are eligible for Advanced Premium Tax Credits (APTCs) and cost sharing reductions to make these plans more affordable. Exchanges must also screen individuals for eligibility for Medicaid and the Children's Health Insurance Program and, if a state has delegated this responsibility to them, determine such eligibility.[5] If states do not choose to operate an Exchange, these responsibilities will be carried out by a federal entity, known as the Federally Facilitated Marketplace.[6]

Exchanges are responsible for providing due process rights, including notice and an opportunity for a hearing to appeal a denial of eligibility or failing to act on applications in a timely manner.[7] The Department of Health and Human Services (HHS) has established regulations that govern notice and appeals for eligibility determinations made by the Exchanges. In addition, they have amended and augmented the Medicaid due process regulations to coordinate appeals between the two systems. These notice and appeals regulations were initially proposed in January 2013 and finalized in two parts over the summer. The final regulations provide robust due process protections for applicants and recipients of Exchange coverage that are comparable to those provided in the Medicaid program.

Changes to Medicaid Regulations

The regulations authorize the single state Medicaid agency to delegate MAGI-based Medicaid eligibility determinations to the Exchange. The SSA may also delegate fair hearings on denial of MAGI-linked Medicaid eligibility to the Exchange, as long as Exchange appeals are heard by a government agency or public authority maintaining personnel standards on a merit basis.[8] Individuals must also be given the alternative to elect a hearing before the Medicaid agency.[9]

When the Medicaid agency makes such a delegation, it must monitor and oversee the actions of the Exchange, and take corrective action when necessary. The agency also has the option of reviewing conclusions of Medicaid law made in Exchange decisions on Medicaid eligibility.[10]

---

[4] 45 C.F.R. § 155.305(g)(4) (Exchange); 42 C.F.R. § 435.603(d) (Medicaid).
[5] 42 U.S.C. § 18031. The federal government has been referring to the Exchanges as "Marketplaces." Because the regulations use the term "Exchange," we do so in this article.
[6] 45 C.F.R. § 155.105(f).
[7] 45 C.F.R. subpt. F.
[8] 45 C.F.R. § 431.10(c)(2).
[9] 42 C.F.R. § 431.10(c)(1)(ii); 45 C.F.R. § 155.510(b)(1)(ii).
[10] 42 C.F.R. § 431.10(c)(1)(ii).

Exchange Regulations

The regulations governing the Exchanges were finalized in August 2013.[11] They provide for the right to appeal:

- determinations or redeterminations of APTC and cost sharing reductions;
- determinations of exemptions from the requirement that individuals have minimum essential insurance coverage;
- failure to provide timely notice of an eligibility determination; and
- refusal to vacate a dismissal.

Exchange appeals may be conducted by the Exchange itself, an entity designated by the Exchange, or a federal appeals entity operated by HHS (the HHS appeals entity). Individuals have a right to seek review of state Exchange decision with the HHS appeals entity.[12]

Individuals who appeal have the right to be represented by an authorized representative, legal counsel, relative, friend, or another spokesperson.[13] In addition, hearings must be accessible to people with disabilities and who have limited English proficiency.[14]

Similar to Medicaid, notice of Exchange appeal procedures must be provided when applications are submitted, when eligibility is determined or re-determined, and when a decision is made on an exemption from the individual responsibility provision. The notice must include an explanation of and factual and regulatory basis for the action taken, an explanation of appeal rights and procedures, information on right to self-representation or representation by legal counsel or another representative, circumstances under which eligibility must be maintained or reinstated pending appeal, and a statement that an appeal decision for one household member may result in a change of eligibility for other household members.[15]

Exchanges must accept appeal requests by phone, mail, internet, and in person.[16] Appellants must generally be provided a 90 day time limit to file an appeal. A state can impose a shorter time limit in order to coordinate it with the time limit for requesting a Medicaid appeal, but such a limit may be no less than 30 days.[17] Finally, individuals have 30 days to appeal a final decision of the Exchange appeals entity to the HHS appeals entity.[18]

---

[11] Medicaid, Children's Health Insurance Programs and Exchanges, 78 Fed. Reg. 4594 (Jan. 22, 2013) (Proposed Rule); Patient Protection and Affordable Care Act; Program Integrity, SHOP; and Eligibility Appeals, 78 Fed. Reg. 54070 (Aug. 30, 2013) (Final Rule).
[12] 45 C.F.R. § 155.505(c).
[13] *Id.,* § 155.505(e)
[14] *Id.*, § 155.505(f).
[15] *Id.,* § 155.515**,** 155.230(a).
[16] *Id.,* § 155.520(a).
[17] *Id.,* § 155.520(b); *see also* Preamble to Final Rule, 78 Fed. Reg. at 54099.
[18] *Id.,* § 155.520(c).

If an appeal request is deemed invalid, written notice that the appeals request has not been accepted must be sent promptly, along with an explanation of why and how to resubmit the request.[19] An appeal must be dismissed under certain circumstances, including written withdrawal of the request, failure to appear without good cause, and failure to submit a valid appeals request. A dismissal must be vacated if appellant, within 30 days of notice of dismissal, shows good cause why the dismissal should be vacated. If the request to vacate is denied, the appeal agency must provide timely written notice of the denial.[20]

Exchange eligibility will generally be redetermined annually. Individuals appealing redetermination decisions are entitled to eligibility pending the outcome of appeal if they choose. Exchange coverage pending appeal is available regardless of when they are requested during the 90 day time frame.[21]

Exchanges may offer an informal resolution process to resolve an appeal but the right to a formal hearing is preserved. Once there is an informal resolution agreed to by the appellant and the Exchange and the appellant agrees to cancel the request for a hearing, that resolution is final and binding. Individuals using the HHS appeals process will also have access to an informal resolution process in addition to the right to a hearing. Appellants who request an informal hearing generally have the same procedural rights as those at a formal hearing, including the right to present evidence and witnesses, and to challenge evidence submitted in opposition. [22]

The Exchange must also allow for expedited hearings when waiting for a "standard appeal could jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function."[23]

A written appeals decision must be generally be issued within 90 days of the date the request is received. Expedited decisions must be "issued as expeditiously as reasonably possible, consistent with a timeframe to be established by the Secretary." Eligibility of household members who have not appealed their own eligibility, but whose eligibility may be affected by the appeal decision, must be redetermined promptly after the appeal is decided.[24]

[19] *Id.,* § 155.520(d).

[21] *Id.,* § 155.525(a). By contrast, Medicaid beneficiaries must request eligibility pending appeal within 10 days or before the action takes effect. 42 C.F.R. § 431.230.
[22] *Id.,* § 155.535.
[23] *Id.,* § 155.540(a).
[24] *Id.,* § 155.545(a).

Conclusion

Medicaid's due process protections are an essential element of the program because they protect applicants and benficiaries from wrongful denial or termination of coverage. Those same protections are now required and available to individuals who apply for Exchange coverage, establishing a standard framework for appeals processes in most insurance affordability programs. These explicit appellant rights and protections will help ensure that appellants receive important procedural safeguards in health coverage. As HHS stated:

> [W]here the due process rights involved are related to access to affordable, quality health care coverage, we consider it important to implement a standard framework for appeals processes with explicit appellant rights and protections to ensure that appellants receive full and fair review.[25]

These rights are a critical component of health reform. Careful monitoring and engagement with policymakers and Exchange personnel will be necessary to ensure that these regulations actually provide the protection for which they were designed.

[25] Preamble, 78 Fed. Reg. at 54106.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels.

Author

The following NHeLP attorneys contributed to this month's *Health Advocate*:

Sara Somers
Managing Attorney
NC Office

Kim Lewis
Managing Attorney
LA Office

Offices

Washington, DC
1444 I Street NW, Suite 1105
Washington, DC 20005
(202) 289-7661
nhelpdc@healthlaw.org

Los Angeles
3701 Wilshire Blvd, Suite 750
Los Angeles, CA 90010
(310) 204-6010
nhelp@healthlaw.org

North Carolina
101 East Weaver Street, Suite G-7
Carrboro, NC 27510
(919) 968-6308
nhelpnc@healthlaw.org

Support

NHeLP's work is supported by individual donations, which are tax deductible. To learn more, please