The Health Consumer Alliance

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March 3, 2015

Ms. Diana Dooley, Chair
Covered California Board

Mr. Peter Lee, Executive Director
Covered California

RE: Consumer barriers in the appeals process

Dear Madame Chair and Mr. Lee:

The Health Consumer Alliance (HCA) serves as Covered California's independent consumer assistance program and has a strong working relationship with Covered California. For more than a year, we have helped consumers throughout the state navigate the complex path to obtaining and using health insurance in the age of the Affordable Care Act. This includes advice and advocacy to help consumers overcome application barriers, challenge incorrect eligibility determinations, enroll in or disenroll from a Covered California plan as needed, and overcome delays or barriers in accessing services from their plan. The HCA has been able to resolve many consumers' problems with Covered California's "Research and Resolution" team and the "back office" through our role as Covered California's statewide consumer assistance program. These administrative resolution processes and our regular meetings with Covered California have also helped Covered California identify systemic problems.

For consumers whose Covered California eligibility or enrollment problems could not be resolved by the Research and Resolution team, the HCA represents consumers in formal appeals to Covered California by requesting a hearing with the California Department of Social Services (DSS) State Hearings Division, Covered California's designated appeals entity.[1] However, due to Covered California's lack of adequate responses to these appeals and inability to comply with hearing decisions, eligible California consumers are currently unable to enroll in affordable coverage, access health care services, and are incurring unnecessary medical debt. Over the last

[1] Title 10 California Code of Regulations Section 6606.

several months, we have provided Covered California with specific consumer stories in our monthly reports and in our meetings, but the problems with the appeal process continue today.

We are now raising our concerns in writing with the Board because there is a systemic failure in the current appeal process, at times even beyond Covered California's staff control, which leaves eligible consumers – those represented by HCA advocates and those who are not - without coverage and without any other recourse to address the problem. As discussed in detail below, the HCA has faced multiple, repeated challenges throughout the appeals process and in ultimately connecting consumers to needed care even when they properly request an appeal, present their case at an administrative hearing, and obtain a favorable decision from a DSS Administrative Law Judge. The problems with the appeal process also prevent the HCA from ultimately resolving our clients' problems, providing effective assistance, and meeting our obligations to our clients. Given the difficulties the HCA is currently experiencing with navigating Covered California's appeal process, it is more than likely that consumers without assistance are facing additional hurdles and may have given up attempting to resolve their problem altogether. We know these are outcomes that Covered California does not want for its consumers, but can prevent, with a more effective and efficient appeal process that works for all California consumers.

Background

Under state and federal law, applicants and enrollees of Covered California coverage have the right to appeal:

a) An initial eligibility determination of coverage or premium assistance;
b) A redetermination of eligibility for coverage or premium assistance (e.g., annual renewal);
c) A failure to receive proper or timely notice; and
d) A failure to receive a timely determination.

After a consumer files a valid appeal, Covered California must provide the consumer notice and the opportunity to informally resolve the appeal prior to a hearing, and if that is not possible, the consumer has a right to hearing.[2] At the hearing, consumers should have the opportunity to review all relevant evidence and cross-examine the other parties.[3] After a hearing decision is issued by DSS, Covered California must "promptly implement the appeal decision" either prospectively or retroactively.[4]

[2] 10 CCR §§§ 6606,6612,6614.
[3] 10 CCR § 6614
[4] 10 CCR §§ 6602(b),6618(c)

Violations of state appeal obligations

Based on our clients' experiences, which we have provided to Covered California in our monthly reports and can share with the Board, we outline below the patterns in the violations of Covered California's legal obligations as they occur during the length of the appeal process.

A. Prior to a Hearing

1) Failure to contact the designated Authorized Representative prior to and after filing a request for hearing

Consumers may designate an Authorized Representative to represent them in an appeal who Covered California must permit to "act on behalf of the applicant or enrollee in all other matters with the Exchange" once designated.[5] Consumers have the right to choose someone who can best represent their interests. Working with an Authorized Representative can also be helpful to Covered California because the representative is often more familiar with eligibility and enrollment rules than a consumer and can quickly help identify both the problem and a solution.

However, Covered California has repeatedly ignored this obligation by not properly communicating with the designated Authorized Representative during the Research and Resolution process or after a request for hearing is filed by the consumer. This frustrates the ability to resolve cases efficiently and quickly and deprives consumers of effective legal assistance. Specifically, HCA advocates who are designated by consumers as their Authorized Representative sometimes learn from either the consumer or from Covered California that Covered California contacted the represented consumer without an attempt to contact the designated Authorized Representative. In one such instance, the limited-English–proficient consumer was contacted by a Research and Resolution representative who did not speak in the consumer's primary language and did not offer to communicate with the consumer through an interpreter, as required by state law. As a result, the consumer was unable to understand the information provided and could not subsequently explain to her Authorized Representative what information had been provided by Covered California or if the problem was being resolved by Covered California.

In some instances, HCA advocates have had no other option but to file a hearing request just to obtain information about a consumer's case because they were unable to talk to anyone at Covered California about the details of the consumer's case or because Covered California refused to provide the advocate information, even though he or she is the consumer's Authorized Representative. When this has occurred, the HCA reports these problem to Covered California and requests that staff be trained on the role of the Authorized Representative; however, the failure to properly communicate with consumers' Authorized Representatives remains a consistent problem for HCA advocates prior to and after filing a request for hearing.

[5] 10 CCR §§ 6602(e),6508(f).

2) Lack of an informal resolution appeal process

Often, an appeal can be informally resolved without going to a hearing if a consumer or the Authorized Representative can communicate with the appeals specialist handling the appeal. Consumers who are appealing an issue with Covered California "shall have an opportunity for informal resolution prior to a hearing" and the burden is on Covered California to "contact the appellant ***to resolve the appeal informally*** and to request additional information or documentation, if applicable, prior to the hearing date." 10 CCR §§ 6612(a), (b) (emphasis added). This informal resolution requirement is intended to conserve state resources, expedite the appeals process for simple errors, and reserve hearings for more complicated issues that may require an interpretation of law by an Administrative Law Judge.

An example of an effective informal appeal process is the one currently in use by the counties' social services agencies for appeals involving Medi-Cal eligibility and enrollment issues. After a consumer requests a hearing with DSS that involves a Medi-Cal issue, the relevant county's social services agency assigns an "appeals specialist" who provides the consumer and the Authorized Representative written notice of receipt of the appeal and his or her contact information, or his or her contact information to DSS prior to the hearing. That appeals specialist is responsible for contacting the Authorized Representative or consumer to attempt to resolve the appeal prior to a hearing and has the authority to conditionally withdraw the appeal in order to informally resolve the problem while preserving the consumer's right to a hearing. If the county appeals specialist does not initiate contact, a consumer or Authorized Representative can contact DSS to obtain the appeals specialist's contact information. If the appeal cannot be informally resolved, the appeals specialist is responsible for writing the county's position statement and sending it in a timely manner to the Authorized Representative, the consumer, and the Administrative Law Judge who is assigned to the case. The county must comply with the hearing decision in the time required, unless the decision is alternated by the California Department of Health Care Services (DHCS). Whether an appeal is informally resolved or a hearing decision has been issued by DSS, the county appeals specialist remains the contact person for the consumer or Authorized Representative if there are problems implementing the decision. Under the counties' well-established informal resolution process, the HCA is able to resolve the vast majority of our Medi-Cal appeals quickly and efficiently, eliminating the need for time-consuming hearings.

Unfortunately, Covered California's lack of a similar informal appeal process, as described in detail below, has often left consumers and advocates without an effective way to informally resolve appeals involving Covered California eligibility and enrollment issues. For example, the HCA has not seen or received a notice from the Covered California's appeals office confirming receipt of the appeal or providing information on how to contact the Covered California appeals office or the appeals specialist who is handling the appeal, unlike most county appeals offices. The only written notice that HCA advocates currently receive after filing an appeal regarding a Covered California decision is from DSS, which does not identify who to contact at Covered California.

When HCA advocates have attempted to track down the Covered California appeals specialist prior to the hearing, we have been bounced back and forth between Covered California and DSS without success because DSS does not have with the contact information of the Covered California appeals specialist handling the appeal but Covered California refers us back to DSS since we are calling about an appeal. In addition, Covered California's appeals office often does not inform the county appeals specialist who is working on the appeal with Covered California (if the appeal involves a Medi-Cal and Covered California determination), preventing that specialist from working with Covered California to attempt to resolve the appeal prior to the hearing. If no contact information to an appeals specialist is provided, the expectation is that Covered California will contact the Authorized Representative prior to the hearing date to informally resolve the appeal, as is required by state law. Yet in some cases, HCA advocates were never contacted by Covered California prior to the hearing. Without this basic contact information to an appeals specialist, a consumer or Authorized Representative has no way to even attempt to informally resolve an appeal and is forced to wait until a hearing.

In the few instances where HCA advocates attempted to informally resolve an appeal prior to the hearing with Covered California's appeals office, the appeals office was unwilling to connect the HCA advocate to the appeals staff handling that appeal, or provide a contact name or number of any appeals specialist, or allow an Authorized Representative to follow up with the same appeals specialist with whom the Authorized Representative had recently discussed the appeal. To make matters worse, when HCA advocates subsequently contact the Research and Resolution team for help to resolve the consumer's problem because they are unable to informally resolve the appeal with the appeals office, the Research and Resolution staff report that they cannot work on resolving the appeal once a request for hearing is filed. At this point, the only option HCA advocates have to even speak with Covered California about the appeal as well as resolve the problem is at the hearing, even for issues that could easily be resolved with one phone call.

Finally, even when an HCA advocate was able to speak with a Covered California appeals specialist prior to the hearing, the appeals specialist representatives declined to informally resolve the appeal, even if in agreement with the consumer's position. Instead, all parties proceeded to a formal hearing weeks later, during which the appeals specialist subsequently agreed to stipulate to the consumer's proposed resolution, and resulted in the Administrative Law Judge issuing a type of stipulated decision. This is a clear example of an unnecessary delay and an inefficient use of state resources that could have been easily avoided with the same outcome.

Covered California's failure to provide an informal appeal process, thereby requiring almost every appeal to be resolved at a hearing, puts a strain on the state's and HCA's limited resources, creates a backlog of appeals at Covered California that could be resolved without a hearing, and leads to an appeals process that is ineffective and frustrating. We strongly recommend Covered California adopt the same informal appeal procedures already used by county social services

agencies for Medi-Cal appeals and assign an appeals specialist to every appeal, who can be contacted by the consumer or Authorized Representative.

3) Failure to provide a position statement in a timely manner

Covered California must provide a Statement of Position (hereafter referred to as "the position statement") to the consumer, Authorized Representative and DSS at least two business days prior to the hearing date. 10 CCR § 6612(e)(2). However, HCA advocates have received the position statement the night before or ***during*** the hearing. In one instance, the HCA advocate was assured by the Covered California appeals specialist that the advocate would receive the position statement the day before the hearing, but still never received it. The advocate and consumer appeared at the hearing despite not knowing Covered California's evaluation of the case. When the advocate informed the Administrative Law Judge and the Covered California appeals specialist at the hearing that the position statement had not been sent, the appeals specialist sent it to the advocate via e-mail ***during the hearing in progress***.

Without adequate time to review the position statement with the consumer prior to the hearing, the HCA advocate has had to either take time during the hearing to review it with the client, proceed with the hearing without adequate review of the position statement, or request that the hearing be rescheduled for another date. Rescheduling the hearing is unfair as well as inconvenient to the consumer, the Authorized Representative, as well as the Administrative Law Judge when the consumer was otherwise prepared to proceed with the hearing. More importantly, the longer the appeal goes unresolved due to scheduling delays, consumers are unable to access care, may incur medical debt, and may be increasing their potential tax liability if they are continuing to receive premium tax credits during the appeal for which they may not ultimately be eligible.

By failing to provide the position statement at least two business days prior to the hearing date as required, Covered California is interfering with the consumer's right to have the unfettered opportunity to "question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses," or "present an argument without undue interference."[6] It appears Covered California has also been unable to provide position statements to DSS as required by law in a timely manner.[7] In fact, Administrative Law Judges have informed HCA advocates that Covered California is overwhelmed with preparing for hearings and is consistently late in providing its position statements. This may increase the likelihood of a hearing being rescheduled or result in an ineffective hearing.

Covered California must immediately comply with providing its position statement to the claimant, Authorized Representative, and DSS at least two business days prior to the hearing date. We also suggest that Covered California provide on a regular basis to the Board and HCA the number of

[6] 10 CCR § 6614(d)
[7] 10 CCR § 6612(e)(2)

appeals in which position statements were provided within the two business day requirement in order to help monitor compliance. Yet the most effective way to ensure position statements will be provided to all parties in a timely manner is to drastically reduce the number of hearings Covered California appeals staff are preparing for by creating an effective informal resolution process.

B. At the Hearing

1) Inadequate position statement

Covered California's position statements are not only frequently provided late, but are often incomplete or inadequate. Specifically, HCA advocates have received position statements that do not correctly address the underlying facts, fail to explain why the consumer's evidence is not valid, or do not respond to the county's arguments. It appears that because Covered California can only provide the position statement at the last minute, there is no quality control being conducted prior to releasing the position statements to ensure the statements are accurate or complete. If a consumer or Authorized Representative does not receive an adequate position statement, the consumer's opportunity to review Covered California's claims, present an argument, or refute evidence is severely impaired.

2) Inability to cross-examine parties

In many cases, a Covered California appeal requires representatives from Covered California and the county to evaluate the appeal and for each to provide its agency's determination. However, HCA advocates have attended hearings where a representative from either Covered California or the county was not available for the hearing, resulting in the hearing being rescheduled. In some instances, to avoid rescheduling the hearing, the Administrative Law Judge repeatedly attempted to reach the missing agency representative without success. Failure of both parties to attend the hearing creates unnecessary delay for consumers who are eligible for either Medi-Cal or Covered California with premium assistance, but remain without coverage during the appeal process due to an incorrect eligibility determination by one of the agencies. Yet even when both the Covered California and county representatives are present at the hearing, HCA advocates have observed that each agency appeals specialist does not appear to know the other agency's arguments in the case at hand, let alone program rules. This has resulted in the Administrative Law Judge or, at times, the HCA advocate, having to piece together what has happened in the consumer's case because of the lack of communication between the agencies and its representatives. For more efficient resolution of appeals, Covered California must ensure that its appeals specialists are coordinating with the relevant county's appeals specialist throughout the appeal process for appeals that involve a Medi-Cal determination.

HCA advocates have also recently represented consumers at a hearing where Covered California was the appropriate entity at the hearing, but the HCA advocate was not informed until the hearing about information provided by a county representative prior to the hearing and was not given the

opportunity to question that individual at the hearing. While DSS should help ensure this does not occur, the Covered California representative also has a duty to object or raise due process concerns when a consumer and Authorized Representative is not provided the same information that the Administrative Law Judge or Covered California receives prior to a hearing and instead, should immediately share the relevant information with the consumer or Authorized Representative.

C. Post Hearing

Failure to comply with a hearing decision

The most troubling issue HCA advocates are facing is Covered California's lack of compliance with hearing decisions. DSS' hearing decision is final (unless appealed to the U.S. Department of Health and Human Services) and Covered California must "implement the appeal decision effective (A) Prospectively, on the first day of the month following the date of the notice of appeal decision or (B) Retroactively, to the date-the incorrect eligibility determination was made, at the option of the appellant."[8]

Nevertheless, HCA advocates have had multiple cases where Covered California is unable to comply with the hearing decision completely or without additional intervention. Initially, when HCA advocates investigated why their clients' hearing decision had not been implemented in the time required, Covered California often responded that the IT system was preventing implementation of the decision. Covered California staff members are only able to file a "service request" or trouble ticket to the "help desk" requesting the problem be fixed and can only advise HCA advocates to simply wait for a response. When HCA advocates request that the trouble ticket be expedited due to the hearing decision, Covered California staff are not sure if it is possible.

More recently, HCA advocates have at least two cases involving hearing decisions that require action by a Covered California Qualified Health Plan (QHP) to retroactively enroll or refund the consumer for premiums overpaid, but the relevant QHP refused to comply with the hearing decision as required. When HCA reported the lack of compliance to Covered California, staff explained they were not able to intervene and require the plan to comply. Despite repeated attempts to elevate these compliance problems within Covered California, HCA advocates and the consumers have faced numerous delays and responses from Covered California that the issue can only be resolved by the QHP. If Covered California contracts with all QHPs, yet is unable to ensure a QHP complies with the hearing decision, a consumer certainly will not be able to do so.

[8] 10 CCR §§ 6618(a)(7),6618(c)

Unfortunately, during the time that a favorable appeal decision remains unresolved, consumers continue to be without access to services and continue to incur medical debt or tax liability if incorrectly receiving premium tax credits.

However, QHPs are legally obligated to comply with DSS hearing decisions that deal with eligibility and enrollment under existing contracts with Covered California. Specifically, Sections 1.06 and 3.20 of the model QHP contract requires QHPs to comply with the eligibility and enrollment decisions of Covered California. Because Covered California has designated DSS as its appeal entity, QHPs are currently obligated by contract to comply with any DSS decision that involves eligibility and enrollment into a Covered California plan. A QHP's refusal to comply with a DSS hearing decision should be considered a breach of contract by Covered California. If Covered California fails to enforce its rights under the QHP contract on this provision and does not require contract compliance, the QHPs may choose to violate other contract provisions. For future QHP contracts, Covered California may want to ensure this existing compliance requirement is made more explicit, by specifying the penalties and fines for failing to comply, requiring a QHP representative to be present at the state fair hearing as a party or witness, establishing a clear process between Covered California and the QHPs to ensure compliance with DSS decisions, and confirming a consumer's private right of action against the QHP for failure to comply, including for any resulting harms.

Because Covered California currently claims it cannot compel the QHPs to comply with DSS decisions requiring action by the QHPs, the HCA advocates have been forced to file a complaint with the California Department of Managed Health Care (DMHC) against the plan, even though the appeal solely involves receipt of premium tax credits, which is squarely within Covered California's jurisdiction. When the HCA also reported the compliance barriers to DSS, HCA advocates have been asked to notify the Presiding Judge at DSS when a hearing decision is not complied with and recently did so when a QHP failed to retroactively enroll a consumer in a timely manner as required by the hearing decision. Nevertheless, Covered California will often be the only entity that can implement the hearing decision. Covered California is required by law to comply with a hearing decision and its inability to ensure compliance – through necessary IT fixes or intervention with a QHP - violates this obligation and may leave consumers without any recourse.

Covered California must prioritize IT fixes that may be needed to comply with hearing decisions, provide more oversight regarding QHPs' compliance with hearing decisions, and otherwise ensure that hearing decisions are implemented in the time required. Covered California's failure to appropriately enforce state hearing decisions increases the injuries suffered by consumers.

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Conclusion

Covered California continues to be seen as a model across the nation for a well-functioning and effective marketplace. Unfortunately, the current lack of an effective appeals process for applicants to and enrollees of Covered California jeopardizes its reputation as being consumer-friendly. As a result, the problems with the appeals process as detailed in this letter need to be immediately addressed by the Board.

We understand that there currently is considerable demand on Covered California staff. We also appreciate that Covered California has tried to work with HCA and other stakeholders to resolve these due process issues over the past year; nevertheless, these problems persist. The current failures in Covered California's appeals process violates existing law, inefficiently uses limited state resources, and ultimately prevents consumers from accessing affordable coverage, which is contrary to Covered California's mission. As these problems appear to be systemic, we recommend that Covered California review the problems we have identified and consider adopting internal appeals policies and procedures that are comparable to DSS' Manual of Policies and Procedures and the appeals procedures currently utilized by the counties' social services agencies. We look forward to working with the Board and Covered California staff to address these concerns.

Sincerely,

The Health Consumer Alliance

CC:

Jennifer Kent, California Department of Health Care Services

Manuel A. Romero, Chief Administrative Law Judge
Charles DeCuir, Presiding Judge
California Department of Social Services State Hearings Division

Frank J. Mecca, California Welfare Directors Association

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