Centers for Medicare & Medicaid Services
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Contents

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Welcome

Good afternoon everyone. Welcome to today's assister webinar. My name is Melissa MacLean and I am with the CMS Consumer Support Group. Before we begin today's presentation, I want to go over a few of the technical details with you. All lines have been muted so everyone can have a good learning experience. If you are listening through your computer speakers and have any audio issues or if your slides do not appear to be advancing, please try to refresh the webinar. Press the refresh icon that looks like two arrows. It is the third icon in the row near the volume bar. If you continue to have issues, you can also try to log out and log back into the webinar which sometimes helps to reset things. You are also always welcome to join via telephone. The instructions for that is included in the alternate audio tab. If you would like to ask a question during the presentation, please do so by typing a question into the ask a question tab on your screen. I will now turn our webinar over to Ms. Deborah Bryant. Deborah, please go ahead.

Thank you, Melissa. Good afternoon everyone. Thank you for joining us for today's webinar. My name is Deborah Bryant and I am the Director of Consumer Advocacy and Assister Support for the Marketplace. Just as a reminder, I want to remind everyone that today's call is intended as technical assistance for assisters and is not intended for press purposes and it is not on the record. If you are a member of the press, please email our press office at press@cms.hhs.gov.

Also I would like to remind you that the information presented today is intended as informal technical assistance and it is not intended as official CMS guidance. I want to remind everyone as well that our webinars are recorded and posted online. Please visit Marketplace.cms.gov to access past webinar

presentations as well as written transcripts and video slideshows of the webinars. We will continue to update the list of materials as they are available.

For today, we have a couple of post-enrollment presentations. We will start with an overview of the internal claims and appeals process which is the process for consumers to appeal health insurance plan decisions. The presentation will also include a summary of the coverage appeals regulations and the external review process. After that we will have a presentation about helping consumers cancel or terminate their plans and report changes to the Marketplace. Before we begin our presentations I will turn it over to Michelle Koltov from our Consumer Support Group, who will provide us with updates and moderate the rest of today's webinar. As a reminder, if you have any questions, please feel free to submit them to the webinar chat feature. Michelle?

Marketplace Updates

Thank you, Deborah. For our first update we want to announce a new and exciting resource that we've just released for assisters. We've received many requests for a resource that will help you work with immigrant populations because this community can face unique and challenging eligibility and enrollment issues. The new assister *Guide to the Immigration Section of the Online Marketplace Application* will help you assist consumers with completing the citizenship and immigration questions of the online Marketplace application. The guide provides step-by-step instructions and screenshots that illustrate how to verify identity, provide complete and relevant information about citizenship or immigration status, submit supporting documentation if requested, complete other necessary steps for enrollment in a qualified health plan through the Marketplace, and how to be determined or assessed eligible for Medicaid or the Children's Health Insurance Program. Please check out this new guide by clicking on the link on your screen and we will also include some more information and a link about it in the next newsletter.

For our next update we want to draw your attention that earlier this week we sent out an email regarding the Medicaid coverage gap special enrollment period for consumers who live in states that did not expand Medicaid. Consumers may qualify for this SEP, if they reside in a non-Medicaid expansion state, were previously ineligible for APTC because their household income was below 100% of the federal poverty level, they were ineligible for Medicaid during that same timeframe and experience a change in household income that makes the newly eligible. Please check your email for more information on how to help consumers apply for this SEP. We will also provide a presentation with some more details during our next webinar on April 29th.

Also this week, on April 13th, on Wednesday, we sent out our inaugural edition or our new assister bulletin through our assister listserv. This is a monthly publication featuring updates, announcements and best practices for assisters. If you've already signed up to receive the biweekly assister newsletter, you'll now also receive the bulletin each month. While the newsletter focuses on immediately actionable information for assisters and goes out biweekly, and it will be weekly once open enrollment begins, the bulletin provides a deeper dive into topics that are helpful for assisters to know about but aren't immediately actionable. If you'd like to sign up to receive the newsletter and the bulletin, send a request to the assister listserv inbox and write add to list serve in the subject line. Don't forget to include the email address where you'd like to receive them, in the body of this email request.

The last update is that we want to remind everyone that today's the last day that the Assister Help Resource Center (AHRC) will be taking calls for this season.

So, now let's get started with our first presentation for today. For our first presentation we are joined by Leslie Wagstaffe, Deputy Director of the Consumer Support Group here at CCIIO who will provide an overview of the internal claims and appeals and external review process. As a reminder, if you have questions throughout Leslie's presentation, please feel free to submit them through the webinar chat feature. Leslie?

Internal Claims and Appeals and External Review Processes Overview

Good afternoon and welcome again to today's presentation. As consumers begin to use their health insurance they may encounter situations where plans will not pay or will pay only partially for services contrary to the consumers' expectations. In some of those situations, the consumer may be able to appeal the plan's decision. Today's presentation will give you the basics of the internal claims and appeals and external review processes for private health insurance, which will help you assist those consumers with possible next steps. Please note that this presentation summarizes technical federal statutory and regulatory requirements and due to a summary nature, cannot capture all the details and nuances of the law. All relevant law is contained in applicable statutes and regulations and this presentation is not law and is not intended to provide legal advice. I'd like to begin today's overview with a roadmap to outline what we will be covering. The presentation will begin with a summary of the coverage appeals regulations, then I will move on to discuss internal claims and appeals and external review, and that is both the state and federal forms of external review. Then at the end I will leave you with additional resources so let's begin.

One of the many benefits of the Affordable Care Act is that it ensures private health insurance consumers rights to ask their health plan to reconsider the decision to deny payment for a service or treatment. And, if the plan upholds the initial decision, consumers may be eligible for a second look by an independent third-party reviewer.

The Affordable Care Act through section 2719 of the Public Health Service Act requires that all health plans and issuers implement effective appeals processes for coverage determinations and claims. The coverage appeals regulation incorporated the protections found in the Department of Labor's claim and appeals regulation and added additional protection such as increased requirements for notices and applied those protections across all private health insurance markets. The appeals regulation also established a minimum set of standards for external review. The implementing regulations can be found at 45 CFR part 147.136.

The regulation and subsequent guidance can be found on the CCIIO website at the address provided on this slide. One important item to note is that the appeals regulations do not apply to grandfathered health plans. Questions and answers about grandfather status may also be found on the CCIIO website.

Internal claims and appeals. We should start by defining a few terms. A claim is any request for benefits including items that require prior authorization or reimbursement. Rescissions are any cancellation or discontinuance of coverage that has a retroactive effect. This does not include cancellations of prospective or future effect or retroactive cancellations due to a failure to timely play premiums or contributions towards the cost of coverage.

The next term, internal appeals, those are when a consumer requests that a carrier take a second look at a denied claim. These can occur once the carrier first reviews the initial claim and decides to deny, reduce, or terminate a given benefit and then issues an adverse benefit determination. Once the consumer requests an internal appeal, the carrier can either reverse or uphold the denial. If the carrier upholds its decision, it will issue a final internal adverse benefit determination and consumers can then file for an external review, which is the next term on the slide. External reviews differ from internal appeals in that an independent, third-party conducts the review of the carrier's denials. The regulation provides that insurers must make decisions within 15 days on pre-service claims and 30 days on reimbursement claims. In urgent situations, insurers must make decisions as soon as possible, consistent with the medical contingencies of the case but in no event, later than 72 hours of receipt of the claim. So for instance if you needed a foot surgery and request a prior approval from your insurer, the insurance company would have up to 15 days to issue its decision. If you went to the doctor and paid for the visit out-of-pocket and submitted a claim for reimbursement, the issuer has 30 days to issue a decision on whether to pay the claim. And, if it was an urgent care claim, decisions must be made as soon as possible but in no event can they take longer than 72 hours to make a decision on how to handle your claim.

So if the carrier denies the claim and issues an adverse benefit determination, the notices are required to include the following. A description of the reasons for the denial including specific plan provisions and any scientific judgment used. They are also supposed to include a description of any additional information needed to improve or complete the claim. The notice must also provide sufficient information for consumers to identify the claim and with this, plans and issuers must provide notice that diagnosis and treatment codes are available upon request and that requests for those codes will not be viewed as the initiation of an internal appeal or an external appeal. The notice must provide notice of internal appeals and external review rights and must also inform consumers of the availability of ombudsman or health insurance consumer assistance offices that may be able to assist them with filing appeals and requesting external reviews. Finally, the notices must provide notification that culturally and linguistically appropriate services are available if certain thresholds are met.

Culturally and linguistically appropriate services must be provided to consumers when 10% of the claimant's county is literate only in the same non-English language or languages. If the threshold is met, plans and issuers are required to provide all language services and assistance with filing claims and appeals in applicable non-English language. They are supposed to provide notices upon request in any applicable non-English language upon request and they also need to include a statement indicating how to access the language services provided by the plan or issuer in the non-English language. It's important to note that these requirements are those that are included in the appeals regulation which applies market wide so to plans both inside and outside of the marketplaces. QHP issuers are required to comply with additional language access standards that are defined in the payment notice regulations and subsequent guidance but the focus of this presentation is strictly what's included in the appeals regulations.

On to internal appeals. What types of denials maybe appealed? For non QHPs, all denials can be appealed, either in whole or in part, including eligibility issues to the extent that it is related to a claim for service that also involves a medical necessity denial or experimental or investigational denial. Also rescissions maybe appealed. Consumers have 180 days from receipt of the denial to file an appeal and appeals must be submitted in writing unless it is an urgent situation. In those cases, oral requests are okay. For QHPs this is a little different in terms of what may be appealed and the Marketplace eligibility

issues are not appealable via the insurance issuer -- those are appealable via the Marketplace, which is a separate topic all unto itself. In those presentations, they will go through what is eligible and how to initiate those eligibility appeals. So, continuing with internal appeals. Only one level of appeal is permitted for the individual market. So most QHPs will have one level of internal appeals because they are part of the individual market and the group market, including job-based coverage, up to two levels of internal appeal are permitted. But if there are two levels of appeal, the total time for both levels of appeal may not exceed the time period allowed for the one level of appeal of the individual market. I know that is a mouthful. But as an example, as shown on this slide, decisions on appeals on pre-service claims must be made within 30 calendar days. If there is a case where a group health plan provides two levels of review, on that pre-service claim, both levels of review must be completed within the 30 day period. Continuing on this slide you'll see that decisions must be made within 60 days for post-service claims for appeals and no later than 72 hours for urgent care situations but it maybe less depending on the urgency of that particular case.

Claimants have a right to a full and fair review during an internal appeal, meaning a claimant must have the opportunity to see and respond to any evidence or reasoning under consideration and the reviewers conducting the appeal must not have been involved in the initial decision on the claim. There is also a requirement to provide continued coverage pending the outcome of an appeal which, we also refer to as a concurrent care decision. These are occasions when the appeal occurs concurrent with or while the care is being provided. In those situations, consumers are under adoptive care and are receiving an ongoing course of treatment. If an insurer has already approved an ongoing course of treatment over a period of time or a number of treatments, the insurer must provide the patient with an opportunity for an appeal before they reduce or terminate the ongoing treatment. An example of a concurrent care situation would be if a patient, let's say, with cancer was preauthorized for nine sessions of chemotherapy and they begin that treatment. The insurer cannot reduce the number of sessions and say OK now we only want to pay for six of those sessions or refuse to pay for the sessions at all without providing the patient with an opportunity to appeal that decision so they should still get that treatment.

Now we are moving into special situations. One of those special situations is urgent care, I referred to it several times already before but an urgent care situation is one where issuing a decision within the standard timeframe could seriously jeopardize the claimant's life, health, or ability to regain maximum function, or would subject the claimant to severe pain in the opinion of the doctor familiar with the consumer's condition. In these cases, claimants may file for an appeal orally and the notice of the decision-maker be provided orally. If the decision is provided orally it must be followed by a written notice within three days. Individuals in urgent and concurrent care situations may be able to initiate an internal appeal and an external review at the same time.

Another special situation is deemed exhaustion. In certain situations, consumers must be able to receive an external review even if they have not completed all of the health plans internal appeals processes. An internal appeal must be deemed exhausted thus allowing the consumer to move onto an external review conducted by an IRO -- when an issuer waives the internal appeals requirement – if the consumer simultaneously requests an expedited internal appeal or urgent appeal and expedited external review and, in the third case, if the issuer fails to comply with all internal appeals requirements, except in these cases outlined here. In cases where the violation was minor, or non-prejudicial, so it didn't really impact the medical review, and as long as the plan or issuer demonstrates that the violation was attributable to good cause or matters beyond the plan or issuer's control and a mistake occurred in the context of an ongoing good faith exchange of information and is not reflective of a pattern or practice of noncompliance.

So, now that we've covered internal claims and appeals we can move on to a discussion of state external review. The appeals regulation established a set of 16 minimum consumer protections for state and external review laws. The minimum consumer protections were based on the external review model as promulgated by the National Association of Insurance Commissions or NAIC for short. States with external review laws that meet the same minimum consumer protections are referred to as having a NAIC parallel process. The Departments of Health and Human Services, Labor, and Treasury recognize that it may have been difficult for states to meet the minimum standards established by the regulation in its original timeframe so what they did was, or what we did, was set up a temporary set of standards that relax some of the requirements of the NAIC parallel process. State laws that meet the temporary standards are referred to as being NAIC similar. In July 2011, HHS reviewed external review laws of each state and issued initial determinations. These determinations helped establish a set of external review options for insurers in each of those states. States with processes that meet the NAIC standards may continue to operate an external review process until January 1, 2018. That is the additional time that states have to make changes to their laws which are required to meet the NAIC parallel standard. Plans and issuers in States with laws meeting neither the NAIC-parallel nor NAIC-similar standards this must participate in a federally administered external review process, which can be either the HHS administered process or the private accredited IRO process, and I will describe the differences between these two processes as we continue in the presentation.

So, rules regarding the internal appeals and external review were finalized last fall and the final rule left most things as they were since the interim final rules were last amended review, but one of the changes that we did include was the final extension on the transition period for states to meet the NAIC-parallel standard. Which as I said, is December 31st, 2017, meaning by January 1, 2018, every state must have a NAIC parallel external review process. This slide shows some of the examples of differences between the NAIC parallel and NAIC similar requirements - just to kind of give an idea of differences between the two standards. The minimum consumer protections cover a whole range of areas including -- the time allowed for a review request, the time allowed for an IRO to review a request, and how long a consumer has to request a review. At the end of this, we provide an appendix at the end that has the full listing of the NAIC parallel and NAIC similar standards just for people's references. One note that I wanted to point out is that under filing fee, when the changes that we did implement during the finalization of our rule last fall, was that under the NAIC parallel requirement, plans and issuers may no longer charge a fee for submitting an external review request. Before we allowed a nominal filing fee. However, we allowed states that expressly allowed a filing fee to keep that as long as the filing fee was what we described as nominal, meaning that the fees do not exceed $25, they are refunded if the adverse benefit determination is reversed, there is a fee waiver for financial hardships, there is a $75 annual cap on the fees, and insuring that the cost of the external review is actually born by the issuer and not the consumer. But as I said, a complete listing of both sets of standards is provided in Appendix C at the end of this presentation for your reference.

So, this next slide, it describes the external review options for fully insured health plans. It is meant to outline everything that I just said before because sometimes pictures help really paint what we're talking about here. You'll see that plans in states and territories with an NAIC parallel or NAIC similar process must continue to use the state external review process. That is on the right side of the diagram. Here on the left side of the diagram, we see that issuers in states and territories without complaint external review processes must participate in a federally administered process which can either be the HHS administered or private accredited IRO process. I have it in parentheses here that plans and issuers

may choose which process to follow but that is actually a very important note there. It is not the state that chooses, it is the plan or the issuer that chooses which external review process it will follow.

So, now we will explore the federal administered external review program. That is the HHS administered federal external review program and the private accredited IRO process. Let's see what each one of these entails. As opposed to state external review where the scope is only required to include external reviews of adverse benefit determinations based on medical necessity, appropriateness, healthcare settings, level of care, or effectiveness of a covered benefit, the federal external reviews are available for adverse benefit determinations involving medical judgment and rescission. Medical judgment includes but is not limited to determinations that involve medical necessity, appropriateness, health care settings, level of care, effectiveness of a covered benefit, and experimental and investigational treatments as determined by the external reviewer. It does not include determinations involving contractual or legal interpretations without any use of medical judgment. For example, issues of whether the service is a covered benefit of a contract or whether a deductible has been reached or whether a consumer is eligible for coverage are not within the scope of federal external review. Rescissions of coverage are eligible for external review without regard to whether or not the rescissions have any effect on a particular benefit at that time. That is an important note because most times you need something that says they are not paying a claim or only partially paying a claim to initiate the process. The federal external review process requirements are similar to those in the NAIC uniform model act and those required in the State external review process. The appeals final rule provide specifics for federal external review processes and continues to allow issuers and self-insured non-federal nongovernmental plans not subject to a State external review process the ability to use either a private accredited IRO process or the HHS federally administered review process. This choice has been afforded since 2011 but it was not originally included in the rule – it was only in guidance before. Broadly, the appeals regulation requires that federal external review processes must include a description of external review initiation, procedures for preliminary review of claims, minimum qualifications for IROs, a process for approving IROs, random IRO assignments, standards for IRO decision-making, and rules for providing notice of a final external review decision.

The federal external review process must also include requirements for expedited review of adverse benefit determinations, standards for evaluating claims involving experimental or investigational treatments, binding IRO decisions, IRO reporting requirements, and notice of right to external review on adverse benefit determinations and within plan or policy documents.

The HHS administered process includes minimum consumer protections in NAIC-parallel standards. In the HHS administered process, the federal government pays the cost of appeal and there is no filing fee for consumers. Once again, it applies for health insurance plans subject to the federally administered review process for those that do not choose to participate in the private accredited IRO process. In the private accredited IRO process, the other federal external review process, plans must contract with at least three IROs and rotate external review assignments among them. Plans may use an alternative process for IRO assignment but the plans must document how any alternative process constitutes random assignment and how it ensures that the process is independent and unbiased. There must also be no financial incentives to IROs based on the likelihood that the IRO will support the denial of benefits.

I've just reviewed the basis of external reviews - the basic external review processes. The reason why spend a lot of time on that external review discussion is because the status of the state's external review determinations drive which process the consumer will use for external review. And though the

processes are similar, there are of course the differences that I was trying to highlight and mention for you. So, this chart here shows who consumers should contact for each type of request. As stated earlier in the presentation, adverse benefit determinations should include information about the consumer's rights to appeal or their rights to external review and the offices that can assist consumers with requesting appeals for external reviews. Generally, requests for internal appeals should be directed to the plan in writing except for in the case of urgent situations. Again, generally speaking, if the plan is in a state that runs its own external review process, then the request should go to the state. That can either be the state Department of Insurance or the state Department of Health, but in some states, the requests go to the plan and then are assigned to an IRO by the state. If the plan is in a federally administered process, then the request should go to either the plan or if in the HHS administered process, to the HHS administered external review contractor.

Consumers can lodge complaints against plans or issuers in the event that a plan is either not permitting a consumer to complete the appeals or external review process or is not following procedures as it should. This chart outlines where consumers may direct their complaints.

This concludes the presentation on internal appeals and external review. I would like to bring your attention to the appendices. In Appendix A there is a slide that summarizes when the regulation and the corresponding guidance were released. You may find it helpful because it provides a list of all of the relevant pieces of information regarding internal appeals and external reviews. Appendix B has some additional resources regarding the HHS administered federal external review process and we have a link to the HHS administered process contractor's website and a link to additional consumer information on healthcare.gov. You also find links to the CCIIO website where we have all of the regulations and guidance about the HHS administered process and a list of the states and territories where insurers must follow a federally administered external review process. Because states continue to work on bringing their external review laws into compliance with the federal requirements, this list is subject to change. Keep that in mind. But I think the last time it was updated was in March of this year. It is pretty up-to-date. And, finally, appendix B contains a full listing of the external review process requirements for both the NAIC parallel and NAIC similar processes. That ends my presentation for you today and thank you for your kind attention.

Consumer Options to Cancel or Terminate Plans

Thank you, Leslie. I know there is a lot of information in those appendices. We will be posting these slides so you all can access that information. So, we will move on to our next presentation and then come back and do Q&A at the end. Now we will be joined by IJ Okoye, also from our Consumer Support Group here at CCIIO. She will present on consumer options to cancel or terminate plans and report changes. As a reminder, keep asking questions through the webinar chat feature. IJ?

Thank you, Michelle. Good afternoon everyone. This will be a refresher training to talk about how consumers can cancel or terminate their plans as Michelle had stated. We know there may be various reasons that consumers may want to cancel or terminate their plans. For example, they may want to terminate or cancel their Marketplace plan if they get health coverage outside of the Marketplace, for instance, job-based coverage or through a program like Medicare, Medicaid, or CHIP. I will walk through how consumers can end their plans for everybody on the application or just some people on the application. You all may be wondering what the difference is between canceling a plan and terminating a plan. So, I will go over the differences right now. Canceling a plan means you are canceling it before

your coverage is effective. So, we know that you may be currently helping consumers enroll in coverage through a special enrollment period. If I were a consumer, and I enrolled in coverage today, which is the 15th of April, my coverage becomes effective May 1st. I have a choice to cancel my plan if I want to between now and the end of the month since my coverage is not effective yet. That is an example of canceling a plan. However, terminating a plan occurs when your plan is already effective and you are already enrolled but then you decide that you no longer want coverage. So, those are the differences between the two. I will go over some of the scenarios and steps to cancel and terminate.

Next slide, please. Remember, folks that want to cancel coverage, they shouldn't remove the application from their account. They should actually cancel their application because some people may think by removing the application that means their coverage has been canceled. We want them to follow the steps that I will be going over shortly. Another reminder is that consumers can cancel and terminate at any point of the year. And, if the plan started, then its terminating coverage like I said, they usually need to give at least 14 days notice. Consumers can set the dates in advance if they know, for example that their employer coverage starts at a certain date.

Here is a screenshot of a scenario where consumers will log into their account and cancel a plan. So, the first thing they would do would be to log into their account, go to my plans and programs which is at the top left corner. It is cut off on this screenshot. And then, if you can see the blue arrow, there is a red button that says and -- says end terminate all coverage. A consumer that wants to cancel their plan, meaning their plan is not effective yet, they will press that red button there, beside the blue arrow.

Also, under that red button, below there, it shows any plans that have been canceled before on that account. Here, you can see the word status in the red bar that the plans that have been canceled or the plan that has been canceled ended on April 1st, 2016. Anytime you cancel a plan it will have the date that it was canceled or ended on.

Here is another screenshot. Once a consumer presses end terminate button on the previous slide, this box will appear. The consumer attests that they are canceling the coverage by checking the box and selecting terminate coverage beside the blue arrow.

Here, the consumer just canceled a plan. Another plan. So, there is another status as well that states that the plan was canceled and ended on April 1st as well. Like I said, if I just canceled a plan today, April 15th, and I go through the steps that we just went to, the date will say today's date for the status.

Here, we will walk through how to terminate coverage for the entire enrollment group. We will go through these steps one by one. The only distinction, well, another distinction between termination and cancellation is that the consumer will be offered the date picker tool to help consumers select a date that they want their plan coverage to end. Another really important point to note is that consumers that are ending coverage for everyone on the application, their termination will take effect as soon as 14 days from the day they want to cancel the plan. So, if they are ending coverage for just some people, and some cases the coverage will end immediately. I will repeat that because I know it can be confusing. If a consumer wants to cancel coverage or terminate coverage for everyone on their plan, they need to do it 14 days in advance from the date that they want the coverage to end. If they're going to end coverage for one or two people on the plan, then the coverage will end immediately.

Here are some steps that I will go through for terminating plans. Previous to what I just showed you for canceling a plan, they log in, they select my plans and programs, and this is a screenshot of that. Then, they will press the end terminate all coverage button. Same button. And, next slide.

Coverage has already started. And, it's already effective. They now have the date picker tool like I stated. The consumer can then, say, let's say their job coverage is starting May 1st. We can type in May 1st, 2016 for when their coverage is starting. Now, this is because they are trying to cancel coverage in advance. Okay. After they type in dates, they click the red button terminate coverage.

This screenshot now says terminated. It says status terminated because the consumer has terminated the plan. Next slide.

So, we know sometimes consumers want to remove someone from the application but keep others. This can be done by reporting a life change to the Marketplace. I will also go through those steps. If the applicant on that application now has other coverage, they should be listed as a non-applicant on the application. This is a person who is an applicant but now wants to keep others on the application, they should now be listed as a non-applicant on the application.

These are list of reportable life changes. We do encourage consumers to come back to the Marketplace and report changes to the application because they could be eligible for new financial assistance for they could be eligible for a special enrollment period. I also want to point out that at the bottom of this table where it has the communication preferences, the bottom half I guess, before consumers had to tell their issuer as well as the Marketplace if they wanted to update their phone number or email address. But now, they only have to do it through the Marketplace application. I just wanted to point that out.

So, like I said, this scenario is for a family that wants to just remove one person off the application but keep others. So, as you can see, the consumer will click on report a life change where the blue arrow is. Then they click the green button at the bottom of the page to continue on to report a life change. So, the scenario that I am going to go through quickly involves a husband and a wife. The wife now has other coverage and wants to terminate her coverage and remove herself from the application but the husband wants to remain. So, again, this is when the consumer is going to edit an existing application. The application while pre-populate the information that was previously entered.

On this screen here, you would report the type of life change that you are reporting. So, in this case we will select the last option which says report a change in my household income, size, or other information. Once that is selected, then continue, which is highlighted in green, will be pressed. Next slide.

Then the consumer will look at the list of options for reporting a life change that is listed on this screen to confirm that they want to make one of the changes listed. And, the consumer will click yes if of course they confirm that one of those listed choices are one of the choices they want to make to report a life change. Next slide?

Here, once consumers list the change, or sets of changes, this screen reminds consumers that the update will be updated on their application and they can select continue to proceed which is the green button.

As I said before, the consumer's application will be pre-populated and it will go through the application. They can make any changes if necessary. So, once they get to the who needs coverage page, which is on the screen now, they will select all household members that they want to remove, who no longer need Marketplace coverage. As you can see, on this screen, I have to red arrows. The top one says who are you applying for health coverage for? That one is a little bit grayed out. I am going to say, select, for example, I only want coverage for one person. I no longer want other people on the application. And, then the second arrow toward the bottom, since I want to remove the wife, I will click the remove button.

Then, this window will pop up. Here, the consumer confirms the removals and answers subsequent questions. After saving and submitting the application, they will view their eligibility results and continue through enrollment. So, when you end coverage for just some people on your application, please keep in mind that premium tax credits or other savings may change. So, just keep that in mind when terminating coverage for one person or more than one person on the application.

We just wanted to provide a tip or reminder that consumers can make changes online or by calling the Marketplace. It may be a little difficult for consumers to do the removal of one or more people from the application if they want to keep some people on the application, so, they can definitely call the Marketplace call center if they need additional assistance.

So, we thought it would be helpful to go through a couple of examples. The first one is, my daughter just got a new job and I need to drop her from my QHP. Do I have to wait for open enrollment to do this? I will pause for a moment for you to think about it.

The answer is no. The daughter doesn't have to wait for open enrollment to make this change. The applicant should update their application to indicate that the daughter has a new job. They would do this by reporting a life change and revising the application to remove the daughter like we just did from the application. So, after they do the removal of the daughter from the application, since she now has job-based coverage, she will continue through her application and, depending on the results, she will need to confirm her current plan or may need to change to a different plan.

The second scenario is, a consumer wants to terminate coverage through the Marketplace for themselves and the rest of the family or enrollment group so everyone on the application. What should they do?

If no one on the application needs to keep the coverage, the consumer should follow the terminate coverage process. That was the second process that I showed, where they would login and press the red terminate button. To avoid a gap in coverage the consumer should not terminate coverage for themselves or anyone on their plan until the new coverage is effective. So, remember the date picker. They would need to select a date that would be the day before their new coverage begins so they can avoid a gap in coverage. For example, if the new coverage is May 1st, on the date picker they will select the date the coverage should end, April 30th.

This is the last scenario. A husband and a wife are making changes to their Marketplace coverage. The husband, who is the application filer, or who is eligible for Medicare. The wife will be staying on her Marketplace plan. The husband wants to end his Marketplace coverage once the Medicare coverage starts since it will be duplicative, but the wife wants to keep her QHP. How do the remove the husband from the Marketplace plan?

So, there are a few things you want to point out to you since this specific scenario is related to Medicare. The first thing is that, if the consumer has a Marketplace plan, they can keep their Marketplace plan until their Medicare coverage starts. Then they can end their Marketplace plan once their Medicare coverage starts. If they like, they can keep the Marketplace plan too, but if they are getting premium tax credits or other savings on the Marketplace plan, that they got, these savings will end once their Medicare coverage starts so they will have to pay the full price for the Marketplace plan. Another thing that I wanted to mention is that we know that transitioning to Medicare can be complicated. Some people may be eligible for Medicare savings plans. So, if you have a consumer that is making a transition from Marketplace with APTC to Medicare, we suggest that the consumer works with a SHIP assister to see what would help the consumer may qualify for.

For this case that I just went over, they wanted to indicate the husband no longer needs Marketplace coverage. So, in this instance they would also report a life change using the steps I showed you earlier to remove a member of the household to show that he no longer needs Marketplace coverage. Then, they will be taken to plan compare and they will end their application.

The last slide, this is a list of resources that may be helpful to you all, if you have any additional questions. Thank you all for your time.

Great. Thank you so much, IJ. Now we are going to get to some of the questions. First, we are going to start with some questions about our first presentation from Leslie about appeals. The first question is, if an external appeal is needed, who has to start or initiate that appeal request?

It's the consumer who would initiate that request. If the consumer is working with a consumer assistance program or is working with, in this case, any type of assister, if the assister signed up as the authorized representative, the assister can initiate that request. But if they are just – the authorized representatives are allowed to initiate requests on behalf of the consumers but it's the consumer who initiates it – that request.

Ok. One more question. During the presentation you said that there is one level of internal appeal that is required for individual plans. Can you just clarify and go over what type of review that should be? Should it be conducted by the individual, by an individual, or by a panel?

The regulations don't require specific types or form of an internal appeal. It only requires that the process is full and fair and what that means is that the review includes the ability for the consumers to review the claim and review any evidence and testimony that is part of the internal claims and appeals process. The regulation also provides that the plan or issuer must provide consumers with any new or additional evidence considered or new or additional rationale relied upon or generated by the plan or issuer in connection with the claim, free of charge. The information must be provided to the consumer prior to a final adverse benefit determination so that the consumer can have a reasonable opportunity to respond.

We have a couple minutes left to quickly try to get to a couple questions on our canceling and terminating coverage presentation. So, for our first question, IJ can you go over the difference, again, between canceling a plan and then terminating a plan?

Sure. Canceling a plan means that you are canceling your plan before your coverage is effective. So, if you enrolled during open enrollment and your coverage doesn't start until January, then you can cancel your plan before it begins in January or like I said in my earlier example, if I enroll in coverage today and it is effective May 1st, then I can cancel my plan between now and April 30 because my plan has not been effective yet. And then terminating a plan occurs when your plan is already effective, you already receive benefits or you are already enrolled, then you decide that you no longer want your coverage.

Great. One last question. I will ask my colleague Kendra May, does terminating a dental plan also terminate a health plan?

Yes. If you try to terminate your dental online it will automatically terminate your QHP as well. What you should do is go directly to your dental issuer and ask them to terminate your plan. That is the way to do it.

Great. Thank you everyone for the questions you've submitted. I know there were a lot that we did not get to but we will follow up with some additional answers in our upcoming newsletter. And, a special thanks to our presenters, Leslie, IJ, and Kendra. Our next webinar will be in two weeks on Friday, April 29th at 2 PM. If you would like to sign up for the CMS weekly newsletter listserv and webinar invitations and the assister bulletin, please send a request via the listserv inbox and write add to listserv in the subject line. Finally, thank you again for all of your hard work and we hope you have a wonderful weekend!