Appeals before the Health Benefit Exchange

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Introduction

With the implementation of the Patient Protection and Affordable Care Act (ACA),[1] health insurance status now affects individuals' federal income tax returns. The impact is arguably greatest for taxpayers who wish to claim a Premium Tax Credit (PTC) under section 36B[2] or who must reconcile advance payments of the PTC awarded by an American Health Benefit Exchange. The PTC can provide enormous financial support for the purchase of health insurance. Without it, many more taxpayers would

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (hereinafter "ACA"), and Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, as amended by the Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, 124 Stat. 3285, Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Pub. L. No. 112-9, 125 Stat. 36, Department of Defense and Full-Year Continuing Appropriations Act, 2011, Pub. L. No. 112-10, 125 Stat. 38, and 3% Withholding Repeal and Job Creation Act, Pub. L. No. 112-56, 125 Stat. 711 (2011).
[2] Unless otherwise indicated, section references are to the Internal Revenue Code.

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be uninsured and some would owe an individual shared responsibility payment under section 5000A.

Tax practitioners are familiar with the IRS side of tax credits and penalties, and most are now somewhat comfortable with the PTC and the individual shared responsibility provision (SRP). However, tax practitioners should also familiarize themselves with the appeal rights taxpayers have before an American Health Benefit Exchange (hereinafter exchange).[3] In some cases, an exchange appeal can prevent a tax problem from emerging down the road. In other cases it may be possible to address an individual shared responsibility liability through an exchange appeal.

Exchanges occupy a central role in the ACA's framework. The individual shared responsibility provision is only made possible by the exchanges' promise of affordable access to health insurance. Exchanges determine eligibility for new health insurance products and the subsidies that accompany them, including advance payments of the PTC. Exchanges also share responsibility with the IRS for awarding exemptions from the SRP. *See generally*, Treas. Reg. § 1.5000A-3.

This paper outlines the exchange appeal and dispute resolution procedures available to individual applicants and beneficiaries. Employers and health insurance issuers also have exchange-related appeal rights which are not discussed here.

An exchange may take one of several different forms.[4] This outline focuses on the federal regulations which apply to all exchanges. It describes the appeal procedures in federally-facilitated exchanges and state-partnership exchanges, where appeal functions are performed by the Department of Health and Human Services (HHS) Federal Appeals Entity (FAE). State-based exchanges and federally-supported state-based exchanges may have their own appeal procedures and policies. Each state may also have its own implementing regulations. These generally mirror the HHS regulations.

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[3] American Health Benefit Exchanges are also known as Health Insurance Marketplaces. This article uses the term Exchange because that is the term used in federal statutes and regulations. In marketing, informal guidance, and in other materials aimed at taxpayers, the federal government uses the term Marketplace.
[4] In 2016 there are 13 State-based Exchanges; 4 Federally-supported Exchanges; 7 State-Partnership Exchanges; and 27 Federally-facilitated Exchanges. *See*, *State Health Insurance Marketplace Types*, Kaiser Family Foundation, at kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/.

Scope of Exchange Appeals

What decisions can be appealed? 45 C.F.R. § 155.505(b)

- Eligibility to enroll in an exchange health insurance plan
  - The three criteria to enroll in a plan are: citizenship status or lawful presence, residency, and incarceration status. 45 C.F.R. § 155.305(a)
- Eligibility for advance payments of the PTC
  - Including the amount of PTC that is awarded
- Eligibility for cost-sharing reductions
  - Including the cost-sharing tier that is determined
- Eligibility to enroll or change plans outside of the annual open enrollment period
- Eligibility for an exemption from the SRP
  - Currently, only Connecticut's exchange is making exemption determinations. Residents of all other states must apply to the federal exchange, and go through the federal appeal procedures if they disagree with the decision.
- Failure of the exchange to provide a timely eligibility determination
- Eligibility for a catastrophic health plan
- The HHS Appeals Entity also hears appeals from state-based exchange appeal decisions
  - Review is *de novo*. 45 C.F.R. § 155.535(f); 78 Fed. Reg. 54092 (Aug. 30, 2013).

What cannot be appealed to the Exchange Appeals Entity?

- Eligibility for Medicaid, unless the exchange is authorized to make the Medicaid eligibility determination
  - Currently the federal exchange is authorized to make Medicaid determinations for residents of Alabama, Alaska, Arkansas, Montana, New Jersey, Tennessee, West Virginia, and Wyoming. *See* healthcare.gov/marketplace-appeals/what-you-can-appeal/.
- Disputes regarding Form 1095-A
  - State and federal exchanges have adopted informal dispute resolution procedures to take the place of an appeal. For more information, see below.

- Eligibility decisions that are not completely final
    - Example: Ms. A applies for subsidized health insurance. Ms. A receives an inconsistency notice giving her 90 days to submit proof that she is lawfully present in the U.S. The notice also says that her income is too high for the PTC. Under current federal exchange policy, Ms. A cannot appeal the denial of subsidies until the exchange has made a final determination regarding her immigration status. If she wishes to enroll in a plan pending resolution of the inconsistency, she must pay the full unsubsidized premium.
        - This restriction does not appear in regulations or formal guidance. It is the interpretation of HHS as stated in informal guidance. State-based exchanges may have more generous practices.
    - Example: Mr. B applies for subsidized health insurance. Mr. B's state has not authorized the exchange to make Medicaid determinations. Because Mr. B's income is under the Medicaid limit, the exchange refers his application to the state Medicaid agency for an eligibility determination. Mr. B cannot appeal this action through the exchange. If the Medicaid agency finds Mr. B ineligible, Mr. B can return to the exchange to resume his application.
- Plan benefits and coverage disputes
    - E.g. the issuer denied or limited my claim for physical therapy services
    - These disputes must be appealed through the insurance carrier or through the state insurance commissioner's complaint process.
- Terminations for nonpayment, including grace period disputes
    - These must be appealed through the insurance carrier or through the state insurance commissioner's complaint process.
    - State-based exchanges may have different policies.
        - In Vermont, all premium payments must be made through the exchange, and the exchange is the system of record for payments. Termination and grace period disputes often involve the exchange.

How to File an Appeal

- Appeal forms may be faxed or mailed

Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd.
London, KY 40750-0061
Fax: 1-877-369-0129

- Supporting documents may be submitted with the appeal.
- Consumers may designate a representative for the appeal by submitting an authorized representative designation form with the appeal request or while the appeal is pending.
- Supporting documents and appointments of authorized representatives submitted after the appeal request should be sent to:

  Marketplace Appeals Center
  P.O. Box 311
  Pittson, PA 18640

- For questions about pending appeals, call the Marketplace Appeals Center at 1-855-231-1751 (TTY 1-855-739-2231)
- States that do not use the FAE have their own state exchange appeals procedures.

Timeframes and Deadlines

- Taxpayers must appeal within 90 days of the date of an eligibility determination. 45 C.F.R. § 155.520(b)(1).
  - Including exemption eligibility determinations
- Taxpayers have 30 days to appeal a decision of a state-based exchange appeals entity. 45 C.F.R. § 155.520(c).
- Appeal deadlines may be extended for good cause.
- The FAE must issue a written decision within 90 days of an appeal, "as administratively feasible." 45 C.F.R. § 155.545(b)(1)

The Appeal Process

- Congress directed the implementing agencies to "establish procedures by which the Secretary [of HHS] or one of such other Federal officers hears and makes

decisions with respect to appeals of any determination under subsection (e)." PPACA § 1411(f)(1) (codified at 42 U.S.C. § 18081(f)(1)). Subsection (e) describes both eligibility and exemption verification procedures.

  - The statutory language does not appear to trigger the right to a formal hearing before an Administrative Law Judge under the Administrative Procedures Act. *See*, 5 U.S.C. § 554(a). Nevertheless, the appeal procedures established by HHS regulations are fairly detailed, and appellants have significant procedural protections.

- Acknowledgment and notification of rights
  - Upon receipt of an appeal, the FAE must acknowledge the appeal in writing, or inform the applicant that the appeal is invalid. 45 C.F.R. § 155.520(d). Notice of certain rights and warnings must be given.
  - Example: Taxpayer B was assessed eligible for Medicaid and his application was forwarded to his state Medicaid agency for a final determination. Taxpayer B appeals the exchange's assessment. The FAE will notify him that his appeal has not been accepted, because the decision is not yet final and because the FAE does not have jurisdiction over his state's Medicaid determinations. Taxpayer B must wait for the Medicaid agency to make a final determination.
  - Appellants have the right to maintain their prior level of eligibility while an appeal of a reduction or termination of benefits is pending. 45 C.F.R. § 155.525.
- Informal resolution
  - The FAE must first try to resolve the appeal informally.
  - 45 C.F.R. § 155.535(a)
  - At this stage, the FAE reviews the facts and documents in the record and then holds a telephone call with the taxpayer or authorized representative.
  - An informal resolution notice is sent describing the FAE's proposed resolution. The taxpayer may accept the decision or request a formal hearing.
  - An informal resolution does not give the taxpayer the right to an exemption for months prior to resolution when the taxpayer went without health insurance.
- Hearing
  - Conducted by a federal Hearing Officer who has not had prior involvement with the case. 45 C.F.R. § 155.535(c)(4).

  - Hearings are conducted by telephone.
  - Standard of review is *de novo*. 45 C.F.R. § 155.535(f).
  - The FAE must send written notice of the time, date, and location or format of the hearing at least 15 days before the hearing date. 45 C.F.R. § 155.535(b).
  - An appellant has the right to
    - Present witnesses and documentary evidence
    - Cross-examine any adverse witnesses
    - Present an argument
    - Review the appeal record, including all documents and records to be used at the hearing, both before the hearing and during the hearing
    - 45 C.F.R. § 155.535(d).
  - Testimony is given under oath
- Appeal decisions, 45 C.F.R. § 155.545(a)
  - Must be based on the record below and any additional evidence presented at the hearing.
  - Must summarize the facts and identify the legal basis for the decision
- If an appeal is dismissed, the appellant has 30 days to show good cause why the dismissal should be vacated. 45 C.F.R. § 155.530(d).

Expedited Appeals

- A faster process is required when the standard timeframe "could jeopardize the appellant's life, health or ability to attain, maintain or regain maximum function." 45 C.F.R. § 155.540(a)
  - The taxpayer will not get 15 days' notice of the hearing
- The request for an expedited appeal should be made with the appeal request.
- The request can be made at a later date if the applicant becomes eligible for an expedited appeal while a standard appeal is pending.
- Expedited appeals are to be decided "as expeditiously as possible". 45 C.F.R. § 155.545(b)(2).
- Financial hardship is not a basis for an expedited appeal.
- If the FAE denies a request for an expedited appeal, the appeal is transferred to the standard process and the applicant is notified of the denial. 45 C.F.R. § 155.540(b).

Implementation of Appeal Decisions

- Appeal decisions are generally implemented prospectively. 45 C.F.R. § 155.545(c)(1)(i).
- The appellant may choose to have an eligibility appeal decision implemented retroactively to the date of the incorrect decision. 45 C.F.R. § 155.545(c)(1)(ii).
    - The appellant must pay their share of the premium for any retroactive coverage months.
- A hardship exemption may be available for months before an eligibility appeal decision is implemented.
    - The exemption is available for months in which the applicant was not enrolled in a plan and is later determined eligible for enrollment or for subsidies. *See*, Centers for Medicare and Medicaid Services, *Guidance on Hardship Exemption Criteria and Special Enrollment Periods* (June 26, 2013), available at cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/exemptions-guidance-6-26-2013.pdf; *see also* healthcare.gov, healthcare.gov/exemptions-tool/#/results/2015/details/eligible-based-on-appeal and healthcare.gov/health-coverage-exemptions/hardship-exemptions/.
        - Under informal HHS guidance and practice, this exemption only applies if the applicant completes the formal process and receives an appeal decision. The exemption is not currently being granted following an informal resolution or where the appellant withdraws the hearing request.
        - Taxpayers who would be eligible for this exemption but for the fact that their appeal was resolved without a formal decision should request a hardship exemption using the "other" category. Currently, this is hardship category 14 on the application. *See*, healthcare.gov/health-coverage-exemptions/hardship-exemptions/.

Form 1095-A Disputes

- Most consumers and tax practitioners are surprised to learn that exchange appeal rights are not available for disputes involving Form 1095-A.
    - The exchange appeal regulations don't address the tax forms specifically. Neither does the authorizing statute. *See*, 42 U.S.C. §§ 18081(f)(1), -(e).
    - Is there an argument that Form 1095-A is a final determination of an enrollee's APTC, premiums, and benchmark plan?
        - 45 C.F.R. § 155.505 permits an appeal of both an initial determination and a redetermination of eligibility. *See also* 42 U.S.C. §§ 18081(f)(1), -(e).
    - This interpretation does not appear in formal guidance. State-based exchanges appear to be following the federal exchange's (HHS's) interpretation of the regulations.
- State and federal exchanges have adopted informal dispute resolution procedures for 1095-A issues.
    - Are these procedures sufficient under a constitutional due process standard?
- Exchanges are required to correct errors on Form 1095-A and report corrections to the Service and taxpayers "as soon as possible." Treas. Reg. § 1.36B-5(d)(3).
- There is no general cause of action to sue a third party in order to correct a tax form or get damages for an incorrect form.
    - For certain tax forms, there is a cause of action for fraud under section 7434, but that section does not apply to Forms 1095-A.
- The Service can impose financial penalties for false or missing information returns. The penalty is fairly small, and there is no provision to compensate individuals.
    - Sections 6721, 6722, and 6723
- Individuals can file their tax returns based on their own records and what they believe is correct, and then exercise their deficiency appeal rights when the IRS proposes to adjust the tax return to match Form 1095-A.
    - In other income tax deficiency contexts, taxpayers have sometimes prevailed in U.S. Tax Court by disputing a third-party information return. *See, e.g.*, McCormick v. Comm'r, T.C. Memo. 2009-239.

    - However, this is a long and difficult process for taxpayers especially if the tax refund is frozen. Taxpayers are generally better served by resolving disputes at the exchange level.

The Federal Exchange's Form 1095-A Dispute Process

- Taxpayers are directed to call the Marketplace Call Center if they believe their Form 1095-A is incorrect
- The call center enters taxpayer requests into the Health Insurance Casework System (HICS) for review by the Form 1095-A Issue Resolution Team.
- The taxpayer will be contacted by telephone when a decision is made.
- If the taxpayer disagrees with the Issue Resolution Team's decision, the taxpayer may request a secondary review. This should be requested during the phone call in which the taxpayer is notified of the initial decision.
- If the secondary review upholds the initial decision, the taxpayer will receive written notice. This will include instructions on how to submit a statement of disagreement.
    - It is unclear what legal effect a statement of disagreement will have.

Judicial Review

- Is judicial review of an FAE decision available?
    - The ACA did not create a statutory cause of action or an independent right to judicial review.
    - CMS materials say only that appeal decisions "may be subject to judicial review." *See*, *e.g.*, CMS, *Eligibility Appeals Process Overview*, at https://marketplace.cms.gov/technical-assistance-resources/marketplace-eligibility-appeals.pdf (Feb. 2016).
    - The potential arguments and basis for appeal may depend on the case.
    - This outline provides a very basic overview of potential bases for judicial review of an FAE decision. Each topic below has generated volumes of scholarship and caselaw.
- Administrative Procedures Act
    - 5 U.S.C. Part I, Chapter 7
    - "Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review." 5 U.S.C. § 704

- A court may compel a discrete action that an agency is legally required by statute to take. *Norton v. Southern Wilderness Alliance*, 542 U.S. 55, 64 (2004) (interpreting 5 U.S.C. § 706(1)).
  - Akin to mandamus
- A court may set aside agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law…" 5 U.S.C. § 706(2)
  - Is the agency's interpretation of its regulations arbitrary and capricious? *See generally*, *Auer v. Robbins*, 519 U.S. 452 (1997) and cases following *Auer*.
  - Is the agency's interpretation of the statute arbitrary and capricious, or does it contradict an unambiguous statutory provision? *See generally*, *Chevron v. Nat'l Resources Defense Council*, 467 U.S. 837 (1984) and cases following *Chevron*.
  - It is not certain that courts will apply *Chevron* deference to decisions of federal appeals officers in the exchange context. *See*, Kent H. Barnett, Against Administrative Judges, 49 U.C. Davis L. Rev. 1643, 1686-1989, n. 271 (2016) (noting that decisions of Immigration Judges sometimes receive only *Skidmore* deference), *available at* papers.ssrn.com/sol3/papers.cfm?abstract_id=2658138.

- The *Bivens* doctrine
  - Federal common law doctrine allowing limited constitutional claims against federal officials. *Bivens v. Six Unknown Named Agents*, 403 U.S. 388 (1971).
  - The courts have not been generous to *Bivens* plaintiffs in recent years. The scope of the *Bivens* doctrine is now quite narrow. *See*, Martin A. Schwartz, *Section 1983 Litigation* (3rd ed. 2014), *available at* fjc.gov.
  - *Bivens* provides a limited federal analogue to 42 U.S.C. § 1983 (civil action for deprivation of rights under color of state law).
  - It is very unlikely that a *Bivens* claim would succeed in the ACA context. *Bivens* is included here to distinguish the federal context from 42 U.S.C. § 1983, which provides a very important (though not unlimited) basis for public benefits litigation against state agencies and officials.
- Fifth Amendment due process
  - Jurisdiction: 28 U.S.C. § 1331 (federal question jurisdiction)

- For possible issues and arguments, look also to Medicaid cases and other public benefits cases brought under 42 U.S.C. § 1983, interpreting the due process clause of the Fourteenth Amendment.
  - *Goldberg v. Kelly*, 397 U.S. 254 (1970): public benefits can constitute a property interest triggering the due process protections of the Fourteenth Amendment; due process requires that welfare benefits be administered in a non-arbitrary manner.
- What process is constitutionally required?
  - *Matthews v. Eldridge*, 424 U.S. 319 (1976), sets out a three-part balancing test. (The case held that the due process clause of the Fifth Amendment does not require an evidentiary hearing prior to termination of Social Security disability benefits.)
- Substantive due process and equal protection
  - Fundamental liberty interests implicate the Fifth Amendment's due process clause. For example:
    - "Discrimination may be so unjustifiable as to be violative of due process." *Bolling v. Sharpe*, 347 U.S. 497, 499 (1954), *supplemented sub nom. Brown v. Bd. of Educ. of Topeka, Kan.*, 349 U.S. 294, (1955) "We hold that racial segregation in the public schools of the District of Columbia is a denial of the due process of law guaranteed by the Fifth Amendment to the Constitution." *Id.* at 500.
    - Denial of Social Security benefits to children born outside of marriage violated the Fifth Amendment. "To conclusively deny one subclass benefits presumptively available to the other denies the former the equal protection of the laws guaranteed by the due process provision of the Fifth Amendment." *Jimenez v. Weinberger*, 417 U.S. 628, 637 (1974).
- For a detailed overview, *see* Center For Human Rights And Constitutional Law, *Fundamentals of Constitutional Law for Legal Services and Pro Bono Practitioners: Due Process and Equal Protection* (Feb. 2014), *available at* centerforhumanrights.org/Support%20Services.html.

- Mandamus
  - Jurisdiction: 28 U.S.C. § 1361

- Mandamus relief requires a "clear nondiscretionary duty" that the plaintiff has a right to have performed. *City of New York v. Heckler,* 742 F.2d 729, 739 (2d Cir. 1984). The plaintiff must have exhausted all other avenues of relief. *Id*.
- Ambiguity in the meaning of a statute does not preclude a determination that the federal official's obligation is nondiscretionary. *In re Cheney*, 406 F.3d 723, 729 (D.C. Cir. 2005) (en banc). However, the statute as interpreted by the court must create a "clear and compelling duty." *Id.*
- Mandamus has been used in the public benefits context, often as an alternative to another basis of jurisdiction. *See, e.g.*, *City of New York*, 742 F.2d at 739 (concerning disability benefits under the Social Security Act).