Form 1095 Conflicts & Appeals in the Health Insurance Marketplace

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Coverage Overlap Issues and Form 1095 Conflicts

Premium Tax Credit

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PTC Eligibility: Access to MEC

- An individual eligible for government or employer-sponsored insurance (MEC) is not generally eligible for a premium tax credit (PTC)
- For which months is your client eligible for a PTC?
  - Review forms 1095-A, 1095-B, and 1095-C
  - Client interview is important

I.R.C. § 36B(c)(2)

PTC Eligibility: Access to MEC

- Eligibility for employer-sponsored insurance (ESI) is disregarded if
  - Individual did not enroll in the ESI; **and**
  - The plan does not provide minimum value, or
  - Premiums for self-only coverage > 9.5% of household income (as indexed), or
  - Individual is not in the employee's tax household.

Reg. §1.36B-2(c)(3), (c)(4)

PTC Eligibility: Access to MEC

- Several other types of MEC are disregarded if the individual did not enroll:
  - Retiree and post-employment COBRA coverage
  - TRICARE and certain health programs for veterans and related individuals
  - Medicare, if a Part A premium is required
  - Self-funded student health plans
  - See *Effectively Representing Your Client Before the IRS* p. 29-21 (2016)

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Notice 2013-41 and Reg. 1.36B-2(c)

PTC Eligibility: Form 1095 Conflicts

- IRS has posted ACA return preparer best practices for resolving conflicts between forms 1095
  - Go to irs.gov/aca – click on Tax Professionals – scroll to bottom of page

- Form 1095-A vs Form 1095-B
- Form 1095-A vs Form 1095-C

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PTC Eligibility: Form 1095 Conflicts

Form 1095-A vs Form 1095-B

1. Reporting errors: Ask for correction as early as possible
2. Change in coverage: <1 month overlap ok

   Reg. § 1.36B-3(c)(1)(iii); Example 1
3. Retroactive eligibility determinations and enrollments in gov't-sponsored coverage

   Reg. § 1.36B-2(c)(2)(iv)

PTC Eligibility: Form 1095 Conflicts

Form 1095-A vs Form 1095-B

4. Transition from Marketplace to gov't-sponsored MEC – 3 months

   Reg. § 1.36B-2(c)(2)(ii)

5. Dual enrollment due to determination of Medicaid or CHIP ineligibility

   Reg. § 1.36B-2(c)(2)(v)

6. Supplemental private insurance coverage

   I.R.C. § 36B(c)(2)

PTC Eligibility: Form 1095 Conflicts

Form 1095-A vs Form 1095-C

- 1095-A with PTC in months that 1095-C shows affordable coverage?
  - Must ask the TP about circumstances
  - Note Questions 13 & 14, *Questions and Answers on the Premium Tax Credit*, on irs.gov

- ER coverage is affordable if premiums for self-only coverage ≤ 9.66% HHI (2016)
  - Any tax family member offered coverage is not eligible for PTC if self-only coverage is affordable

PTC Eligibility: Form 1095 Conflicts

Form 1095-A vs Form 1095-C

- Indicators of affordability of ER offered coverage
  - Line 15: self-only cost
    - May need adjustment
    - Check against 9.66% of HHI
  - Line 14: 1A – self-only premium ≤ 9.66% of FPL, MV, offer also to spouse and dependents
  - New for 2016: code for conditional offer to spouse (line 14, code 1J or 1K)

PTC Eligibility: Form 1095 Conflicts

Form 1095-A vs Form 1095-C

- Employee Safe Harbor Reg. §1.36B-2(c)(3)(v)(A)(3)
  - Employer coverage treated as affordable if:
    1. TP provided accurate info about cost of employer coverage at enrollment, and
    2. Per Marketplace, TP eligible for APTC – unaffordable based on projected HHI
  - N/A if provided incorrect info with reckless disregard for the facts

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PTC Eligibility: Form 1095 Conflicts

Form 1095-A vs Form 1095-C

- Offers of ER coverage after enrollment
  - TP eligible for PTC to 1st day of first full month ER coverage could have been effective
- Reporting Errors
  - Contact issuer for correction as early as possible

Form 1095-A vs Form 1095-C

- For 2016, two situations where Form 1095-C, Line 15 may need adjustment
  - Does the employer offer an opt-out payment to employees who don't enroll?
  - Does the employer plan include a flex account?
- Notice 2015-87

PTC Eligibility: Form 1095 Conflicts

Form 1095-A vs Form 1095-C

- Example:
  - TP has forms 1095-A & 1095-C
  - APTC was received in months w/an employer offer
  - 1095-C Line 15 cost ≤ 9.66% of final HHI
- Consider:
  - Do either of the forms contain errors?
  - Was the ER coverage really offered to the TP?
  - Employee safe harbor?
  - Opt-out offer $ included in Line 15 cost?
  - Was Line 15 cost reduced by nonhealth flex contributions?

Form 1095-A Dispute Resolution

Form 1095-A Disputes

- Consumers cannot file a Marketplace appeal based on disagreement with their Form 1095-A
- Marketplaces have adopted informal dispute resolution processes specifically for tax forms
- FAQ: healthcare.gov/tax-form-1095/
  - A corrected form is not issued if the only incorrect item on Form 1095-A is the benchmark plan premium

Part III **Coverage Information**

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January			

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Form 1095-A Disputes

- Federal Marketplace Dispute Resolution Process
  - Call the issuer first if coverage dates are in dispute
  - Then call the Marketplace call center
  - The call center enters TP requests into the Health Insurance Casework System (HICS) for review by the Form 1095-A Issue Resolution Team
  - TP will be contacted by telephone when a decision is made

Form 1095-A Disputes

- FFM Dispute Resolution Process (cont.)
  - TP may request a secondary review if the initial decision is unfavorable.
    - 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.

Form 1095-A Disputes

- Did the TP pay the premiums?
  - HHS rules require a 90-day grace period for nonpayment of someone who receives APTC.
  - If the TP isn't caught up at the end of 90 days, coverage is terminated retroactively to the last day of the first month of nonpayment.
  - The health insurance issuer must return any APTC received after the first grace period month.
  - 45 CFR § 156.270(g); § 155.430(d)(4)

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Form 1095-A Disputes

- Was there a technical error?
  - Marketplace enrollees have 60 days after discovering a technical enrollment error to request a retroactive termination
  - 45 C.F.R. § 155.430(b)(1)(iv)

- Is the Form 1095-A incorrect?
  - If the form appears incorrect but the Marketplace won’t amend, evaluate the TP’s chances of success on a deficiency appeal to Tax Court
  - What do the issuer's records show?

Marketplace Eligibility Appeals

Marketplace Eligibility Appeals

- Consumers in the federal marketplace can appeal certain eligibility determinations to the **HHS Appeals Entity (Federal Appeals Entity, or FAE)**
  - Part of HHS separate from marketplace
  - Also handles Medicare appeals

- Consumers in state-based marketplaces (SBM) first appeal to their state's appeals entity
- Once they receive a decision from the SBM, consumers may appeal to the FAE if they disagree with:
  - ✓ The decision of the SBM eligibility appeals entity, or
  - ✓ The SBM appeals entity's refusal to reopen a dismissed appeal
  - ✗ State Medicaid agency decisions by an SBM (or after an FFM assessment) are **<u>not</u>** appealable to the FAE

Not All Determinations Can Be Appealed to the FAE

- A determination must be **final** and of **appropriate subject matter**
- Other types of issues that are not appealable to the FAE can be addressed in other ways:
  - Casework, after escalation by the Call Center
  - Appeal with the insurer
  - File a complaint with the State Department of Insurance

Marketplace Appeals

Appeal to the FFM or SBM

If consumer disagrees with a final marketplace eligibility determination

- Can file an appeal within 90 days of a final eligibility determination
- An eligibility determination that includes an inconsistency issue regarding the consumer's citizenship, immigration status and/or income is not considered final
- For more information, see www.healthcare.gov/marketplace-appeals/what-you-can-appeal

What types of decisions can be appealed to the FFM or SBM?

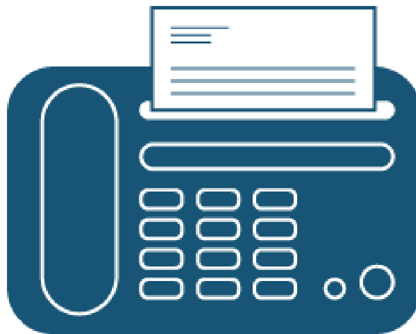
- Denial of APTCs or CSRs
- Amount of APTCs or CSRs
- Adjustment in APTCs or CSRs at end of 90-day inconsistency period
- Denial of eligibility to enroll in marketplace coverage
- Denial of a special enrollment period
- Termination of marketplace coverage
- Denial of coverage exemption
- Denial of eligibility for Medicaid/CHIP

Requesting a Marketplace Eligibility Appeal

Ways to request a marketplace eligibility appeal:

- Complete an appeal request form (best option)
  (available here: www.healthcare.gov/marketplace-appeals/appeal-forms); OR
- Write a letter explaining the reason for the appeal

→ Mail to: Health Insurance Marketplace
Attn: Appeals
465 Industrial Blvd
London KY 40750-0061



→ Fax to: 1-877-369-0129

Timeframes for Requesting Appeals

In FFM states, appeals to the Federal Appeals Entity (FAE) must be submitted within:

- **90 days** of the contested eligibility determination; or
- **30 days** of a notice declining to reopen the appeal after it was dismissed

→ Appeal must be requested by consumer or by designated authorized representative

In SBM states, appeals to the FAE must be submitted within:

- **30 days** of the SBM appeals decision; or
- **30 days** of notice from the SBM declining to reopen the appeal

NOTE: *If 90 days has passed since the eligibility decision, consumers may be able to get an extension of time to file if they can provide a strong reason why they didn't file during the 90-day period.*

When a Marketplace Eligibility Appeal is Received

The Federal Appeals Entity (FAE) receives the appeal and determines the validity of the request

- ✓ If determined valid, the appeal is acknowledged in writing and the appeals process begins
- ✗ If determined invalid, a notice is mailed describing how to fix the problem and resubmit the appeal request

Why might an appeal be invalid?

- → Filed more than 90 days after the eligibility determination notice
- → Filed to contest a “temporary” eligibility determination rather than a final eligibility determination
- → Filed to resolve an issue outside the authority of the FAE to resolve (e.g. whether an insurer covers a particular service)

First Stage of an Appeal: Informal Resolution

The FAE works with appellants to resolve eligibility appeals informally:

- Reviews facts and evidence
- Phone conversation with consumer (and authorized representative)

If consumer is satisfied:

- Appeals decision follows (unless consumer voluntarily withdraws the appeal)

If the consumer is unsatisfied:

- The consumer may request a formal hearing

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Second Stage of the Appeal: Formal Resolution/Hearing

If the consumer is dissatisfied with the outcome of the informal resolution, case proceeds to a formal hearing:

- Written notice will be provided by the FAE at least 15 days prior to the hearing date (unless appeal is expedited)
- Conducted by telephone
- Federal hearing officer presides over the hearing

The Federal Appeals Entity conducts a "de novo review," which means a fresh start for the consumer that doesn't defer to the marketplace's determinations

- Consumers can bring witnesses and present evidence
  - Have right to review the appeals record before and during the hearing (must request record in writing)
  - Consumer and witnesses provide testimony under oath

Expedited Appeals

- Appeals can be expedited when the standard timeframe "could jeopardize the appellant's life, health or ability to attain, maintain or regain maximum function"*
- **Request for an expedited appeal needs to be noted on appeal request**
  - If a consumer's circumstances change, can request expedited appeal after submitting an appeal request
- If a request to expedite is denied, the FAE must:
  - Provide written notice of the reason for the denial
  - Consider the appeal under the standard timelines

Eligibility Appeals Decisions

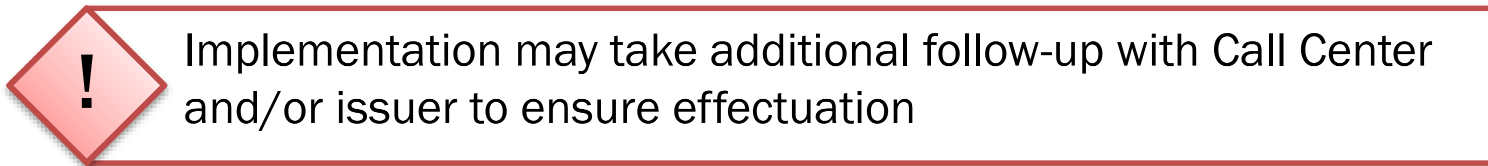
- Following the hearing, the Hearing Officer makes a decision based on the testimony, other evidence and the applicable legal rules
- The decision is in writing and must be issued within 90 days of the date the appeals request is received (as "administratively feasible")

→ **The decision is final and binding but may be subject to judicial review**

Implementing the Eligibility Appeals Decision

If the appeal is successful, the consumer has two options:

- Have the decision implemented on a **prospective** basis
  - Change would be effective following regular effective date rules (e.g. if select a plan prior to the 15th of the month, coverage effective on the 1st of the following month)
- Request **retroactive** implementation
  - Change would be effective back to the coverage effective date the consumer did receive or could have received if the consumer had enrolled in coverage under the initial eligibility determination
  - ***Note:*** For retroactive coverage, the consumer has to pay his share of the premiums and cannot choose a different retroactive date.



Marketplace Exemption Appeals

Marketplace Exemptions

- Certain exemptions from the individual shared responsibility provision can only be granted by the Marketplace.

Form **8965**
Department of the Treasury
Internal Revenue Service

Health Coverage Exemptions

▶ Attach to Form 1040, Form 1040A, or Form 1040EZ.
▶ **Information about Form 8965 and its separate instructions is at *www.irs.gov/form8965*.**

OMB No. 1545-0074
2015
Attachment Sequence No. **75**

Name as shown on return | Your social security number

Complete this form if you have a Marketplace-granted coverage exemption or you are claiming a coverage exemption on your return.

Part I **Marketplace-Granted Coverage Exemptions for Individuals.** If you and/or a member of your tax household have an exemption granted by the Marketplace, complete Part I.

	(a) Name of Individual	(b) SSN	(c) Exemption Certificate Number
1			

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Marketplace Exemptions

- **When to apply:** For general hardship exemptions, apply up to 3 years after the month of the hardship
  - documentation is required in most circumstances so earlier is better

- **If you disagree with the determination:** The Marketplace's decision on an exemption application can be appealed.
  - The appeals process and appeals regulations are the same as for Marketplace eligibility determinations

Contact

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