Appealing a Decision

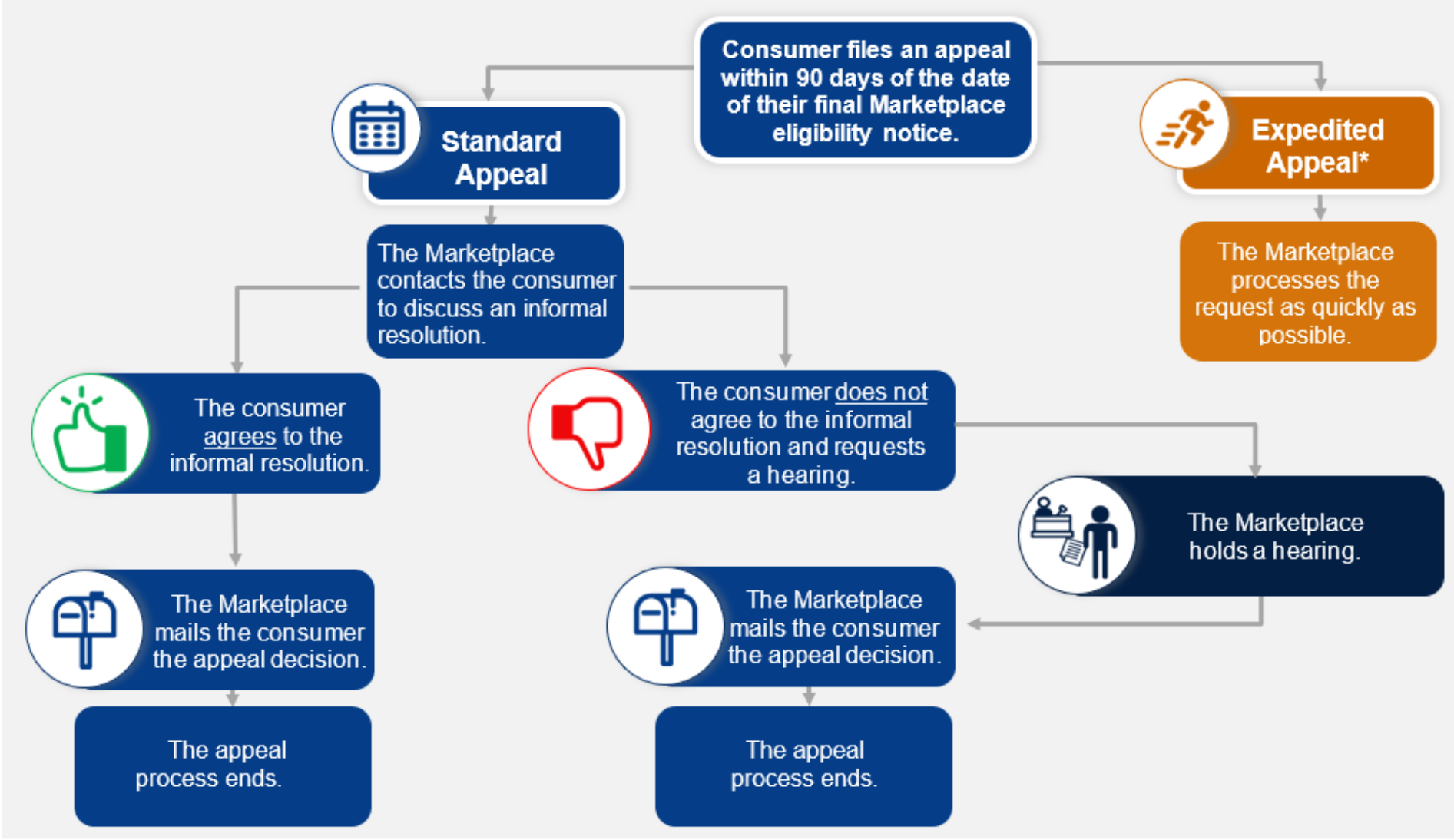
This job aid provides information and guidance that Navigators and certified application counselors (collectively, assisters) in Federally-facilitated Marketplaces need to know in order to help consumers who don't agree with either an eligibility decision made by the Marketplace OR a decision made by their health insurance issuer. Consumers can appeal both types of decisions, but the appeals process is different for each.

How to Appeal an Eligibility Decision Made by the Marketplace

If consumers believe there was a mistake or disagree with certain eligibility determinations made by a Marketplace, they have a right to request an appeal within 90 days of the date of the final eligibility determination from the Marketplace. This appeal process is illustrated in Exhibit 1. Consumers or their authorized representatives can appeal one of these categories of eligibility decisions made by the Marketplace:

- Eligibility for enrolling in a Marketplace plan, including a Catastrophic health insurance plan.
- Eligibility for a Special Enrollment Period to enroll in a Marketplace plan outside the regular Open Enrollment Period.
- Eligibility for lower costs based on their income, including advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs).
- The amount of APTC and CSRs they're eligible for.
- Eligibility for Medicaid or the Children's Health Insurance Program (CHIP). Consumers should contact the Marketplace to confirm where to file a Medicaid or CHIP eligibility appeal. The Marketplace may direct the consumer to file the appeal directly with their state Medicaid or CHIP agency.
- Eligibility for certain exemptions from the requirement to have health insurance.
- Whether the Marketplace made a timely determination about the consumer's eligibility after they applied.

Exhibit 1 – The Marketplace Appeal Process



*Consumers can request an expedited appeal if the time needed for the standard appeal process would jeopardize the consumer's life, health, or ability to attain, maintain, or regain maximum function.

Note: Some consumers appealing a decision about Medicaid eligibility can choose to have their appeal heard by their state Medicaid agency instead.

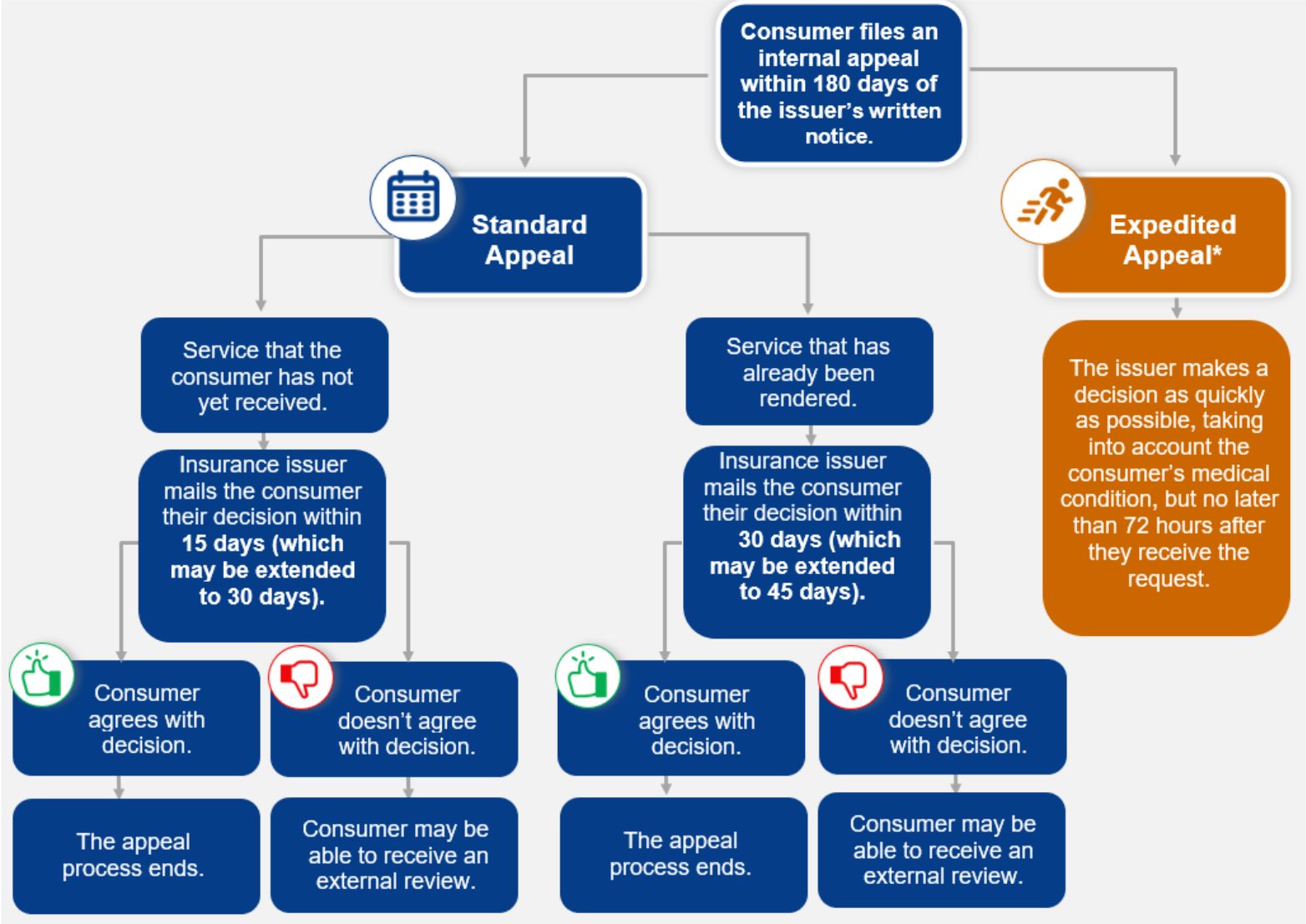
Marketplace appeal decisions are final and binding, but judicial review may be available. For more information, visit HealthCare.gov/marketplace-appeals.

How to Appeal a Decision Made by a Health Insurance Issuer

If consumers believe there was a mistake or disagree with certain determinations made by their health insurance issuer, they have a right to request an appeal. The health insurance issuer must first notify the consumer in writing to explain why they denied coverage and provide the consumer with instructions on appealing the decision. The consumer then has at least **180 days** from the time the health insurance issuer notified the consumer in writing of their decision to file an internal coverage appeal. The appeal process is illustrated in Exhibit 2. Consumers or their authorized representative can appeal one of these categories of decisions made by their health insurance issuer:

- Refusing to pay a claim for a benefit (like a health service, treatment, or prescription drug) the consumer believes should be covered in whole or in part based on the terms of their plan.
- Ending their coverage going back to the date the consumer enrolled because the insurance issuer claims that the consumer performed an act, practice, or omission that constitutes fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.
- Determining the consumer ineligible for coverage after they file a claim.

Exhibit 2 – Insurance Issuer Appeal – Internal Review Process



If consumers disagree with an issuer's decision **after an internal review,** they can request an external review. Some states may choose to have the Federal Government oversee the external review process or contract with an independent third-party review organization (IRO). Other states only contract with an IRO. Consumers can find more information regarding the type of external review process employed by their state by visiting

CMS.gov/CCIIO/Resources/Files/external_appeals. Instructions for requesting an external review are found in health plan documents. Consumers typically have **four months** from receipt of the final internal adverse benefit determination notice to file a request for an external review. The external review process is illustrated in Exhibit 3. Consumers or their authorized representative can request an external review for one of these categories of decisions:

- Any issuer's denial of payment for a benefit (like a health service, treatment, or prescription drug) that is based on the issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit that the consumer thinks should be covered based on the terms of their plan.
- Cancellation of coverage, or rescission,** effective back to the date the coverage started based on the issuer's claim that the consumer performed an act, practice, or omission that constitutes fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

Consumers or their authorized representative can file an internal appeal and an external review request for a denial made by a health insurance issuer at the same time when:

- An adverse benefit determination or final internal adverse benefit determination involves a consumer's medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the consumer's life or health or their ability to regain maximum function.
- A final internal adverse benefit determination concerns the admission, availability of care, continued stay, or health care service for which the consumer received emergency services but has not yet been discharged from a facility.

**An external review of a rescission of coverage may only be available in states using the federal external review process.

Exhibit 3 – Insurance Issuer Appeal – External Review Process

For more information, visit HealthCare.gov/appeal-insurance-company-decision.