Marketplace Appeals

This job aid provides information and guidance that Navigators, Certified Application Counselors (CACs), and Enrollment Assistance Personnel (EAPs) (collectively, assisters) need to know to help consumers appeal a Marketplace decision.

Note: This job aid provides information on Marketplace eligibility appeals only. Consumers can appeal both Marketplace eligibility and health insurance issuer coverage decisions, but the appeals process is different for each. For guidance on coverage appeals, refer to the Coverage Appeals job aid.

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Version 2.0 October 2024. This information is intended only for the use of entities and individuals certified to serve as Navigators, Certified Application Counselors (CACs), or non-Navigator assistance personnel in a Federally-facilitated Marketplace. The terms “Federally-facilitated Marketplace” and “FFM,” as used in this document, include FFMs where the state performs plan management functions. Some information in this manual may also be of interest to individuals helping consumers in State-based Marketplaces and State-based Marketplaces using the Federal Platform. This material was produced and disseminated at U.S. tax filer expense.

Overview

If a consumer believes there was a mistake or disagrees with certain eligibility determinations made by a Marketplace, they have a right to request an appeal[i]. A consumer's eligibility determination notice will describe their appeal rights.

Navigators are required to help consumers understand the process of filing Marketplace eligibility appeals[ii]. The Centers for Medicare & Medicaid Services (CMS) interprets this assistance with Marketplace eligibility appeals to include, where relevant to consumers' needs:

- Providing information about free or low-cost legal help in the consumer's area, including local legal aid or legal services organizations and other state offices to help with the Marketplace eligibility appeals process.

- Referring consumers to Consumer Assistance Programs (CAPs), Ombudsmen, and other state agencies to help with Marketplace eligibility decision appeals.

    - Certified application counselors (CACs) and Enrollment Assistance Personnel may, but are not required to, provide assistance with appeals and other "post-enrollment" activities.

Marketplace Determinations for Appeal

Consumers generally have 90 days from the date of their eligibility notice to appeal a Marketplace eligibility decision to the Department of Health and Human Services (HHS) Appeals Entity, also known as the Marketplace Appeals Center. Consumers who miss the 90 day timeframe to file an appeal may be able to request an extension.[iii] When the appeal is filed, the consumer should explain why they missed the deadline.

Exhibit 1 describes decisions that can and can't be appealed.

Exhibit 1 – Appealable Marketplace Decisions

Decisions a consumer <u>can</u> appeal*:	Decisions a consumer <u>can't</u> appeal:

▪ If the Marketplace said they aren't eligible to:
  ▪ Buy a Marketplace plan or a Catastrophic plan.
  ▪ Enroll in or change their Marketplace plan with a Special Enrollment Period (SEP).
  ▪ Get an exemption.
▪ Eligibility for lower costs, including the amount of advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs).*
▪ If the Marketplace didn't let them know their eligibility results soon enough.
▪ The date their Marketplace coverage started.
▪ Eligibility for Medicaid or the Children's Health Insurance Program (CHIP) for residents of states that have delegated appeals of certain types of Medicaid and CHIP determinations made by the Federally-facilitated Marketplace (FFM) to the Marketplace Appeals Center[iv].
▪ Other decisions if they live in certain states.
*Including eligibility for APTC due to the expanded eligibility thresholds under the American Rescue Plan Act of 2021, currently extended to PY 2023 through PY 2025 by the Inflation Reduction Act.
	▪ The date the Marketplace ended their coverage.
	▪ Information on their Form 1095-A, or they want a corrected form.
	▪ If their health insurance company:
	  ▪ Didn't apply their premium tax credit (PTC) correctly.
	  ▪ Refuses to pay a claim or ends their coverage. (Instead, they can file an appeal with their plan. For more information, refer to the Coverage Appeals job aid).
	▪ If they want to change information on their Marketplace application.
	▪ If they filed their federal income tax return and have to pay back some or all of the PTCs they used during the year to lower their monthly premiums.

Filing an Appeal

All consumer eligibility determination notices include instructions on how consumers may request an appeal. Consumers can file their appeal request online, or they can mail or fax their appeal request to the Marketplace Appeals Center in the form of a letter, or a completed and signed appeal request form.

Consumers may appoint someone as their authorized representative to file an appeal and communicate with the Marketplace Appeals Center on their behalf.

Consumers must designate their representative in writing and sign the document.

Note that the Marketplace generally considers a consumer's application filer to be their authorized representative without a written designation.

How to file an Appeal Request Online

Step 1. Direct consumers to log into their Marketplace account.

Step 2. Choose the application they want to appeal, then select "Eligibility & appeals" from the menu. Consumers should follow the instructions to file their appeal.

How to File an Appeal Request by Mail or Fax

File a Paper Appeal Request Form

Step 1. Direct consumers to the Marketplace Eligibility Appeal Request form to find the correct appeal request form for their state, download it, and print it out. Instruct consumers to completely fill out the form and have all tax filers on their application sign it.

Step 2. Explain to consumers that they may also include copies of any documents to support their appeal, such as pay stubs or W-2 forms. If they do not choose to submit documents with the appeal request, the Marketplace Appeals Center will request any necessary information or documents relevant to the issue on appeal. Remind consumers to send copies of their supporting documents, not originals, and include their appeal number on each document.

Step 3. Consumers should either mail or fax their completed appeal request form to:

Health Insurance Marketplace®[v]
ATTN: Appeals
465 Industrial Blvd.
London, KY 40750-0061
Fax: 1-877-369-0130

Submit a Letter

Step 1. Explain to consumers that their letter should include the following information:

a. Name;

b. The name of the household member who the appeal is for (such as their child), if applicable;

c. Address; and

d. The reason for the appeal.

Step 2. Explain to consumers that they may also include copies of any documents to support their appeal. If they do not choose to submit documents with the appeal request, the Marketplace Appeals Center will request any necessary information or documents relevant to the issue on appeal. Remind consumers to send copies of their supporting documents, not originals, and include their appeal number on each document.

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Appeals Process

Receiving an Appeal

When an appeal is received, the Marketplace Appeals Center will determine if the appeal is valid:

- Timeliness: the request must be received within:
  - 90 days of the notice of the contested Marketplace eligibility determination;
  - 30 days of the date of a State-based Exchanges on the Federal Platform (SBE) notice of appeal decision; or
  - 30 days of notice from an SBE declining to reopen the appeal after it was dismissed by the SBE.
- The request must be about a matter that's appealable.
- The appeal must be requested by a consumer, the application filer for the consumer, or by an authorized representative appointed by the consumer

If the appeal is valid, the consumer will receive a letter from the Marketplace Appeals Center that:

- Acknowledges receipt of their appeal.
- Includes their appeal number, which uniquely identifies their case. Consumers should write their appeal number on any documents they submit to the Marketplace Appeals Center.
- Provides a description of the appeals process.
- Includes instructions for submitting additional material for consideration, if necessary.

If the appeal request doesn't meet these requirements, the consumer will get a notice explaining why the request is invalid and how to fix the problem and resubmit the appeal.

Appeal Resolution

Once an appeal request is submitted, a consumer becomes an appellant. This language may appear on communications a consumer receives related to their appeal. There are two types of appeal resolutions:

- Informal Resolution
- Hearing

Informal Resolution

If possible, the Marketplace Appeals Center will try to resolve the appeal based on the available information, working with appellants to resolve eligibility appeals informally by:

- Reviewing facts and evidence submitted by the appellant and those that are available from the Marketplace.
- Sometimes contacting appellants by phone or mail.
- Sending an Informal Resolution Notice that describes proposed resolution and decision.

If appellant is satisfied, the appeal decision follows. Appellants who aren't satisfied may request a hearing.

Hearing

When a consumer requests a hearing, they will receive notice of the scheduled hearing in writing at least 15 days prior to the hearing date unless:

- The appellant requests an earlier hearing date (and one is available) and waives their right to 15 days' written notice.

- A hearing date sooner than 15 days is necessary to process an expedited appeal as agreed to by the appellant.

Hearings are conducted by telephone and presided over by a Federal Hearing Officer. During the hearing the appellant may represent himself or herself, or be represented by an authorized representative, legal counsel, a relative, a friend, or another spokesperson.[vi] After the hearing concludes, the Federal Hearing Officer carefully considers all evidence and testimony of the appellant and any witnesses. The Federal Hearing Officer issues the eligibility appeal decision and the decision is mailed to the appellant within 90 days from the receipt date of the appeal request, as administratively feasible. The notice will include instructions on next steps, including those on enrollment and re-enrollment and, if applicable, choosing to implement the appeal decision on a retroactive or future start date. As of January 1, 2024, consumers can request review of an eligibility appeal hearing decision by the CMS Administrator prior to a judicial review.

If the decision finds the contested eligibility determination was incorrect when it was made by the Marketplace, the consumer may be able to have the decision implemented retroactively based on the date when the consumer received the incorrect determination. Exhibit 2 describes the situations where a Marketplace plan or an appellant may owe money after an eligibility appeal decision is made.

Exhibit 2 - Retroactive Effectuation Actions

A Marketplace plan may owe an appellant a refund if:	An appellant may owe money to their Marketplace if:
▪ The appellant had paid Marketplace plan premiums to the plan before the appeal was decided; and ▪ They're now eligible for a larger premium tax credit and/or lower copayments, coinsurance, and deductibles as a result of the appeal.* ▪ The appellant did not pay premiums because their net APTC was $0, and they are now eligible for a different amount of CSR. **The appeal does NOT consider or resolve any of these monetary amounts.*	▪ They're now enrolling in Marketplace coverage for an earlier date; or ▪ They haven't paid their past premium balance(s). ▪ Their eligibility for CSRs, or the amount of CSRs they are eligible for, has changed.

Consumers in SBEs generally must appeal any SBE eligibility determinations to the SBE appeals entity. They may submit an appeal to the CMS Marketplace Appeals Center upon exhaustion of the SBE appeals process. Consumers may also appeal a State-based appeal entity's denial of a consumer's request to vacate the dismissal of their appeal to the CMS Marketplace Appeals Center.

Post-Appeal: Marketplace Administrator Review[vii]

- If an appellant is dissatisfied with the result of their eligibility appeal hearing decision, they can request a Marketplace Administrator Review (MAR). The MAR process is separate, independent, and distinct from the Marketplace eligibility appeals process.

Appellants can request a MAR by following the instructions in their eligibility appeal hearing decision notice. Requests must be made within 14 calendar days from the date of the appeal hearing decision.

Appellants requesting a MAR are encouraged to provide new information (verbal or written) that was not considered during the appeal hearing. The CMS Administrator conducts reviews within 30 calendar days from the appellant's request.

- MAR may also be initiated by the CMS Administrator within 14 days of the eligibility appeal decision. The CMS Administrator has 30 days from the date they initiate review to make a decision.

Assister Tips

Consumers can get additional help with Marketplace eligibility appeals:

- The Marketplace Call Center can help explain how to request an appeal at 1-800-318-2596. (TTY users should call 1-855-889- 4325.)
- After appeals are submitted, the Marketplace Appeals Center can answer appellants' questions about their appeal at 1-855-231-1751. (TTY users can call 711.)
- After a hearing decision is issued, the Marketplace Appeal Center will explain how to request MAR.

Resources

- If consumers require further assistance with the appeals process, assisters can refer them to the Consumer Assistance Program or legal services program available in their state.
- HealthCare.gov:
  - How to Appeal a Marketplace Decision
  - How to appeal a SHOP decision
- Marketplace Eligibility Appeals: Eligibility Appeals Process Overview webinar
- Medicare.gov: Claims & Appeals

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[i] 45 CFR 155.505(b), 45 CFR 155.505(b)(1)(ii), and 42 CFR 431.220(a)(1)(i),
[ii] 45 CFR 155.210(e)(9)(i) (reinstating the requirement that Navigators in Federally-facilitated Marketplaces provide information and assistance with regard to certain post-enrollment topics).
[iii] 45 CFR 155.520(d)(2)(i)(D) and 86 FR 53412, 53421 (Sept. 27, 2021).
[iv] For consumers who live in states that have delegated to the Marketplace Appeals Center appeals of certain types of Medicaid determinations made by the Federally-facilitated Exchange. As of August 2024, these states include Alabama, Alaska, Louisiana, Montana, North Carolina, West Virginia, and Wyoming. For more information, refer to HealthCare.gov/marketplace-appeals/. Individuals in these states also have the right to request their appeal be heard by their state Medicaid agency per 42 CFR 431.205(b)(1)(ii). For all other states and the District of Columbia, consumers should contact their state Medicaid agency regarding their Medicaid eligibility determination and their right to a fair hearing. For information and contact information for each state, refer to Medicaid.gov/state-overviews/index.html
[v] "Health Insurance Marketplace®" is a registered service mark of the U.S. Department of Health & Human Services
[vi] 45 CFR 155.505(e) and 42 CFR 431.206(b)(3).
[vii] Authority derived from Marketplace Appeals – 45 CFR 155.505(g)(1). (Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024 (CMS-9899-P) 87 Fed. Reg. 78206 (Dec. 21, 2022)) – General Eligibility Appeals Requirements Under the Affordable Care Act, as amended.