§ 155.505 General eligibility appeals requirements.

(a) General requirements. Unless otherwise specified, the provisions of this subpart apply to Exchange eligibility appeals processes, regardless of whether the appeals process is provided by a State Exchange appeals entity or by the HHS appeals entity.

(b) Right to appeal. An applicant or enrollee must have the right to appeal—

(1) An eligibility determination made in accordance with subpart D, including—

(i) An initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with the standards specified in §155.305(a) through (h); and

(ii) A redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with §§155.330 and 155.335;

(2) An eligibility determination for an exemption made in accordance with §155.605;

(3) A failure by the Exchange to provide timely notice of an eligibility determination in accordance with §§155.310(g), 155.330(e)(1)(i), 155.335(h)(1)(ii), 155.610(i), or 155.715(e) or (f), reviewed by an appeals entity.

Appeals entity means a body designated to hear appeals of eligibility determinations or redeterminations contained in notices issued in accordance with §§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.610(i), or 155.715(e) and (f).

Appellant means the applicant or enrollee, the employer, or the small business employer or employee who is requesting an appeal.

De novo review means a review of an appeal without deference to prior decisions in the case.

Evidentiary hearing means a hearing conducted where evidence may be presented.

Vacate means to set aside a previous action.

§ 155.510 Appeals coordination.

(a) Agreements. The appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. Such agreements must include a clear delineation of the responsibilities of each entity to support the eligibility appeals process, and must—
(1) Minimize burden on appellants, including not asking the appellant to provide duplicative information or documentation that he or she already provided to an agency administering an insurance affordability program or eligibility appeals process;

(2) Ensure prompt issuance of appeal decisions consistent with timeliness standards established under this subpart; and

(3) Comply with the requirements set forth in—

(a) 42 CFR 431.10(d), if the state Medicaid agency delegates authority to hear fair hearings under 42 CFR 431.10(c)(ii) to the Exchange appeals entity; or

(b) 42 CFR 457.348(b), if the state CHIP agency delegates authority to review appeals under §457.1120 to the Exchange appeals entity.

(b) Coordination for Medicaid and CHIP appeals. (1) Where the Medicaid or CHIP agency has delegated appeals authority to the Exchange appeals entity consistent with 42 CFR 431.10(c)(1)(ii) or 457.1120, and the Exchange appeals entity has accepted such delegation—

(i) The Exchange appeals entity will conduct the appeal in accordance with—

(A) Medicaid and CHIP MAGI-based income standards and standards for citizenship and immigration status, in accordance with the eligibility and verification rules and procedures, consistent with 42 CFR parts 435 and 457.

(B) Notice standards identified in this subpart, subpart D, and by the State Medicaid or CHIP agency, consistent with applicable law.

(ii) Consistent with 42 CFR 431.10(c)(1)(ii), an appellant who has been determined ineligible for Medicaid or CHIP eligibility, the appeals entity must transmit the eligibility determination and all relevant information provided as part of the initial application or appeal, if applicable, via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable.

(3) The Exchange must consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.

(c) Data exchange. The appeals entity must—

(1) Ensure that all data exchanges that are part of the appeals process, comply with the data exchange requirements in §§155.260, 155.270, and 155.345(i); and

(2) Comply with all data sharing requests made by HHS.

§155.515 Notice of appeal procedures.

(a) Requirement to provide notice of appeal procedures. The Exchange must provide notice of appeal procedures at the time that the—

(1) Applicant submits an application; and

(2) Notice of eligibility determination is sent under §§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), and 155.610(i).

(b) General content on right to appeal and appeal procedures. Notices described in paragraph (a) of this section must contain—

(1) An explanation of the applicant or enrollee’s appeal rights under this subpart;

(2) A description of the procedures by which the applicant or enrollee may request an appeal;

(3) Information on the applicant or enrollee’s right to represent himself or herself, or to be represented by legal counsel or another representative;

(4) An explanation of the circumstances under which the appellant’s eligibility may be maintained or reinstated pending an appeal decision, as described in §155.525; and